



A QUARTERLY REPORT FOR

FARRELL

VS.

CATE

AS REQUIRED BY
THE CONSENT DECREE

SUBMITTED FOR
JANUARY 31, 2009,

FOR

4TH QUARTER,
2008

California Department of
Corrections and Rehabilitation

Division of
Juvenile Justice

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INTRODUCTION

The California Department of Corrections & Rehabilitation (CDCR), Division of Juvenile Justice (DJJ), submits this Quarterly Report in compliance with the *Farrell vs. Cate* Consent Decree (“Consent Decree”). In response to requests and notations found in previously filed reports of the Special Master and Expert audits, DJJ revised the Quarterly Report contents and format to provide more comprehensive information, restructured to reflect accurately the progress and compliance with the action items identified in the Consent Decree and the related six *Farrell* Remedial Plans (“Remedial Plans”). It is the goal of DJJ to ensure that each Quarterly Report provides accurate, traceable information in a consistent manner, which reflects DJJ’s commitment that implementation of the Remedial Plans remain transparent to all stakeholders.

The Quarterly Report has been restructured and contains four key sections, each of which will be further described below:

1. Progress;
2. Compliance with Dates;
3. Actions Taken this Quarter; and
4. Report Improvements.

Section 1: Progress

The purpose of Section 1 is to report progress as documented by audits conducted by the Court-appointed Experts of each of the six Remedial Plans. In completing the audits, the experts use Court-approved audit tools specifically designed to capture compliance with the individual action items of their assigned Remedial Plan. The statistical information compiled in Section 1 is drawn from completed audit reports which have been submitted by the *Farrell* Experts to the Court and/or Office of the Special Master. The statistical information allows DJJ to provide all stakeholders with objective, data-based results of the information submitted by each of the Experts after the completion of their audits.

Section 2: Compliance with Dates

Section 2 is designed to report DJJ’s commitment to complete action items by specific due dates. This information is based entirely on the data extracted from the audit tools created from the six Remedial Plans. It should be noted that not all items identified within the audit tools have specific dates attached to their completion. Therefore, Section 2 reports information only on items with specific due dates identified in the audit tools. In the future, dates may be set with the Court in relation to action items that currently have no due date, or existing due dates may be adjusted; in such cases, this report will accommodate and include those new or revised dates.

In this version of the restructured Quarterly Report, significant discussion describing the process that was used on an interim basis to reset dates for a selected set of action items is included. Future reports may contain similar descriptions of the project management processes used to revise action item dates.

Section 3: Actions Taken This Quarter

The purpose of Section 3 is to report on significant accomplishments completed during the past quarter and to add descriptions of significant efforts being made to achieve the completion of action items for each of the six Remedial Plans. These are listed in bullet point fashion and generally refer to the action item(s) that the work effort is related to.

In future versions of the Quarterly Report, we expect that this section will not significantly change, though it may also report new projects that combine multiple action items into related groups.

Section 4: Report Improvements

Section 4 describes the revisions that were made to the Quarterly Report; reasoning and explanations supporting the changes; potential future changes; and the processes in place to manage those changes. Each Quarterly Report will contain information describing changes made and/or planned for future Quarterly Reports.

1 PROGRESS

1.1 Farrell Compliance Summary

1.1.1 Farrell Compliance Summary

The following chart identifies the current compliance percentage for each of the six *Farrell* Remedial Plans within their current round on audits. The chart identifies the current number of items rated as being either in Substantial Compliance, Partial Compliance, or Non-compliance. Substantial Compliance is the highest compliance rating possible. At the bottom of the chart, the compliance data from all six of the *Farrell* Remedial Plans have been combined to provide a cumulative “*Farrell* Roll-up” compliance percentage.

Sexual Behavior Treatment Program	# of Items Rated	Round 2 (complete)
Substantial Compliance	45	40%
Partial Compliance	51	45%
Non-compliance	17	15%
Total #	113	
Education Services	# of Items Rated	Round 4 (In progress – 2 facilities complete)
Substantial Compliance	172	76%
Partial Compliance	24	11%
Non-compliance	30	13%
Total #	226	
Wards with Disabilities Program	# of Items Rated	Round 3 (complete)
Substantial Compliance	418	68%
Partial Compliance	191	31%
Non-compliance	8	1%
Total #	617	
Safety & Welfare	# of Items Rated	Round 1 (in progress - 6 of 7 facilities)
Substantial Compliance	111	27%
Partial Compliance	111	27%
Non-compliance	187	46%
Total #	409	

Health Care Services	# of Items Rated	Round 1 (in progress – missing HQ audit)
Substantial Compliance	2898	71%
Partial Compliance	81	2%
Non-compliance	1078	27%
Total #	4057	
Mental Health	# of Items Rated	Round 1 (in progress - partial HQ and facility items)
Substantial Compliance	27	30%
Partial Compliance	40	44%
Non-compliance	24	26%
Total #	91	
FARRELL ROLL-UP	# of Items Rated	As of February 1, 2009
Substantial Compliance	3671	67%
Partial Compliance	498	9%
Non-compliance	1344	24%
Total #	5513	

1.1.2 Remedial Plan Compliance Charts

The charts on the next page provide a visual of the compliance percentages for each of the six *Farrell* Remedial Plans. Sections in green identify the total percentage of audit items that are found to be in Substantial Compliance, sections in yellow identify the items that are in Partial Compliance, and the red sections identify those that are in Non-compliance.

Important items to note include:

- “*Farrell* Roll-up”: Substantial Compliance combined with Partial Compliance is 76%
- Listing of Non-compliance percentage for each Remedial Plan from high to low:
 - Safety & Welfare – 46%
 - Health Care Services – 27%
 - Mental Health – 26%
 - Sexual Behavior Treatment Program – 15%
 - Education Services – 13%
 - Wards with Disabilities Program – 1%

Current *Farrell* Compliance Progress Remedial Plan Audit Results As of February 1, 2009

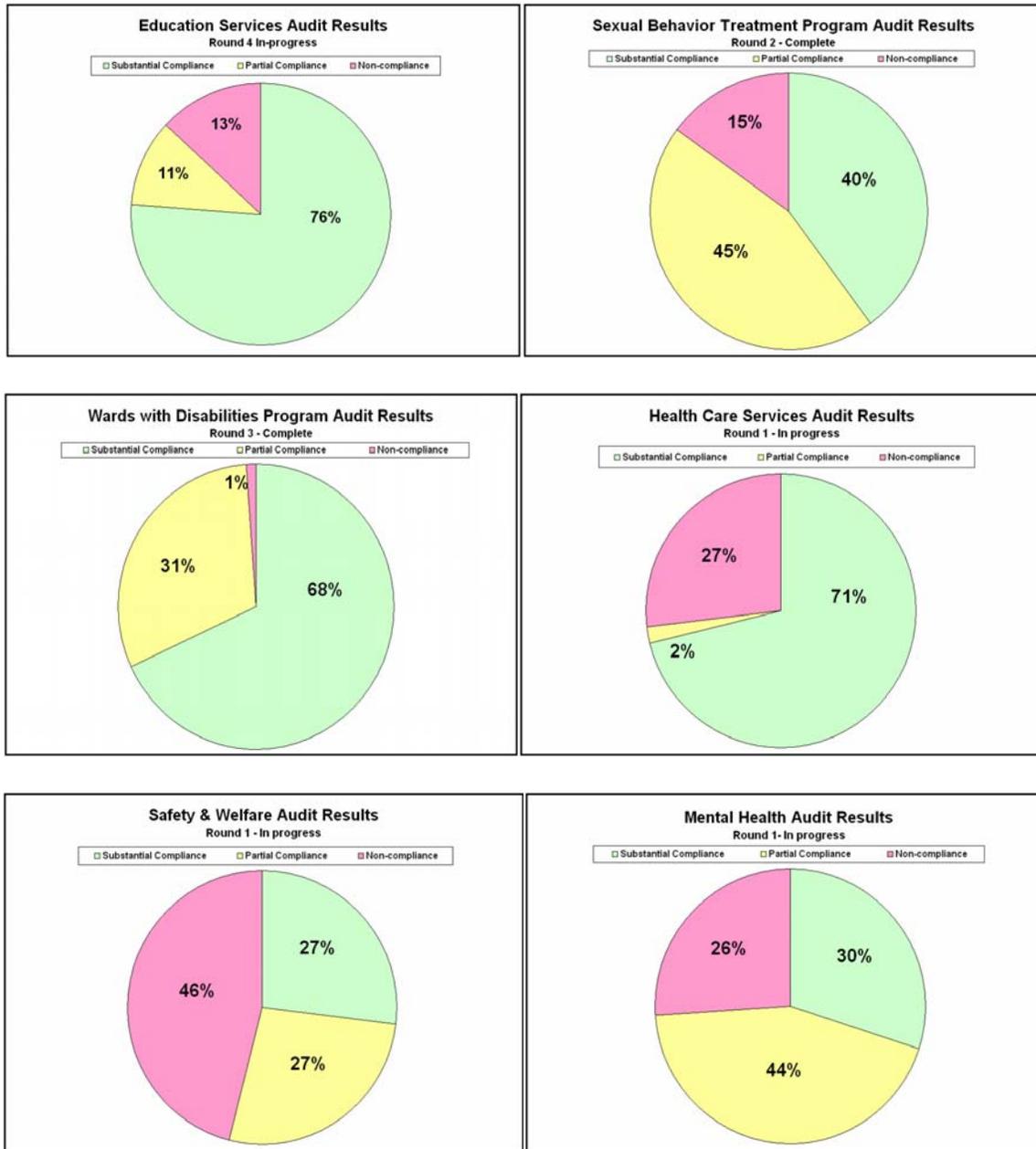


Figure 1: Remedial Plan Compliance Summaries

Current *Farrell* Compliance Progress Cumulative Audit Results As of February 1, 2009

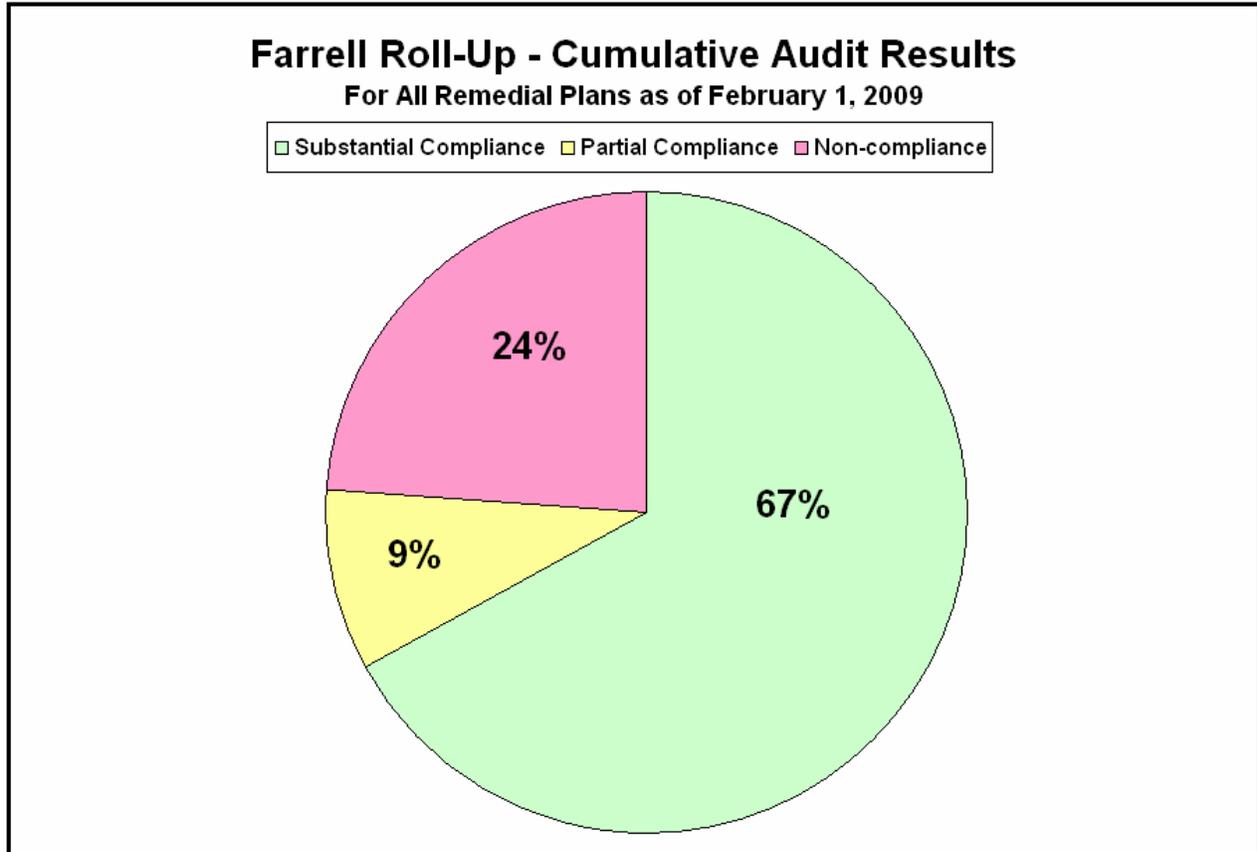


Figure 2: *Farrell* Compliance Cumulative Audit Results

2 COMPLIANCE RESULTS

2.1 Education Services Remedial Plan Compliance Status

2.1.1 Historical Audit Perspective

Court Filings

The Education Services Remedial Plan filed with the Court on March 1, 2005, was the first of the six *Farrell* Remedial Plans to be filed. The audit tool, also referred to as the Standards and Criteria, was included with the Remedial Plan at the time of the filing.

Audit Tool

The Education Services audit tool consists of a total of 115 different action items. Currently associated with these 115 action items are 690 audit items. The audit item number is derived from the number of sites in which the action item is to be audited. The number 690 represents the total number of items that will be assessed for a given round of audits across all applicable sites.

A unique feature of the Education Services audit tool is that, unlike the other five *Farrell* audit tools, there are no Headquarters-specific audit items. All audited items occur at each of DJJ's six facilities.

Of the 115 action items within the Education Services audit tool, only 12 of the action items have a specific deadline for implementation.

Audit Tool Breakdown

Audit Item Numbers Based on Six Facilities	Filing Dates		"Action Items"			"Audit Items"		
	Remedial Plan	Audit Tool	# of Action Items with a Deadline	# of Action Items without a Deadline	Total # of Action Items	# of Audit Items with a Deadline	# of Audit Items without a Deadline	Total # of Audit Items
Education Services	3/1/05	3/1/05	12	103	115	72	618	690

Audit History

Because the Education Services Remedial Plan was one of the first *Farrell* Remedial Plans to be filed and because the Education Experts have maintained a steady pattern of facility audits, DJJ has received three complete years, or rounds, of compliance data.

The Education Experts' first facility audit was conducted at the DeWitt Nelson Youth Correctional Facility in September 2005. The following are the time-spans for each of the three rounds of audits that have been completed to date:

- Round One: September 2005 to April 2006
- Round Two: September 2006 to April 2007
- Round Three: October 2007 to March 2008

The chart below provides a more detailed listing of all of the Education Services' audits by facility.

EDUCATION SERVICES	ROUND ONE	ROUND TWO		ROUND THREE	
Facility	Date Audited	Date Audited	Time Since Last Audit	Date Audited	Time Since Last Audit
DeWitt Nelson	Sept. 2005	Feb. 2007	17 months	Oct. 2007	8 months*
El Paso de Robles	Oct. 2005	Sept. 2006	11 months	N/A**	N/A**
Ventura	Nov. 2005	April 2007	17 months	Jan. 2008	9 months
SYCRCC	Dec. 2005	April 2007	16 months	Jan. 2008	9 months
Heman G. Stark	Dec. 2005	Jan. 2007	13 months	Mar. 2008	10 months
N.A. Chaderjian	Feb. 2006	Oct. 2006	8 months	Dec. 2007	14 months
O.H. Close	Mar. 2006	Oct. 2006	7 months	Oct. 2007	12 months
Preston	April 2006	Feb. 2007	10 months	Feb. 2008	12 months

* Will not be audited in the future due to facility closure

**Not audited due to announced facility closure

Future Audit Schedule

The Education Experts are currently conducting their Round Four audit. The schedule below identifies the remaining facilities yet to audited for this current cycle:

- Preston Youth Correctional Facility — February 9-11, 2009
- Southern Youth Correctional Reception Center and Clinic — May 11-12, 2009
- Ventura Youth Correctional Facility — May 13-15, 2009

2.1.2 Most Recent Audit Findings

Audit Reports Received During Last Quarter

The Education Experts provided DJJ with two facility audit reports during the last quarter. These reports were for O.H. Close Youth Correctional Facility and N.A. Chaderjian Youth Correctional Facility. Both facilities increased their Substantial Compliance by over 10% from their previous audit.

O.H. Close Youth Correctional Facility was found to be in 78% of Substantial Compliance, a 10% increase, and their Non-compliance totaled 15%, a 1% decrease. N.A. Chaderjian Youth Correctional Facility was assessed to be in 74% Substantial Compliance, a 13% increase, and their Non-compliance totaled 11%, a decrease of 12% from their previous audit.

The current cumulative compliance percentages thus far for Round 4 are 76% in Substantial compliance, 11% in Partial Compliance and 13% in Non-compliance. It is important to note that these current averages only reflect the data received from two of the six facilities that will be audited during this round.

2.1.3 Education Services Audit Results

The Education Services charts on the following pages document the most up-to-date compliance ratings for each site audited by the Education Experts. These charts also include the cumulative results of the most recent round of audits as well as a comparison of a facility's prior audit results in previous rounds. Attached to these charts is the statistical data for each audit performed for the identified facility.

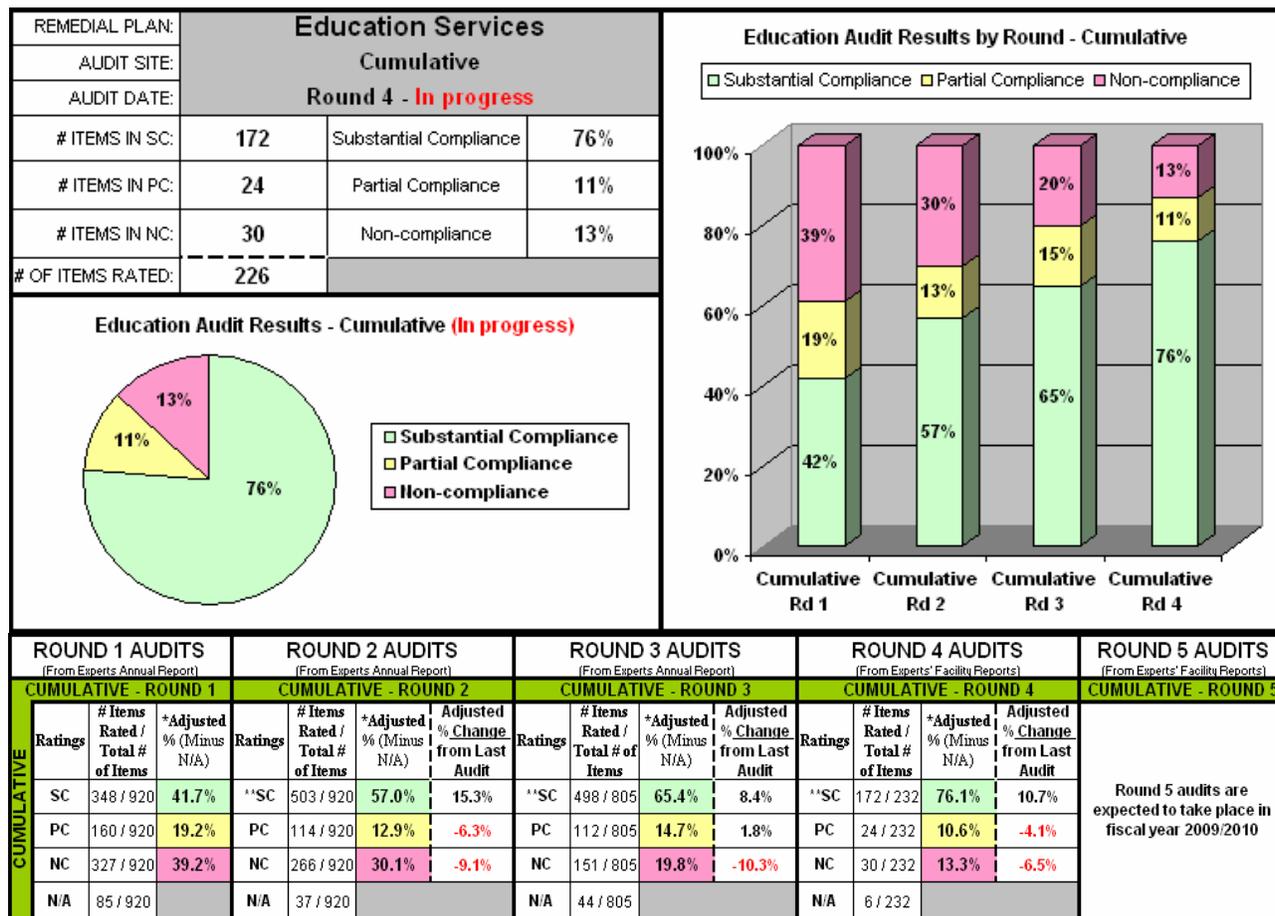
The percentages identified have been rounded off and therefore, may have a slight variance of no more than 1% of either less than or greater than 100%. For example, in adding up the different compliance percentages, the sum total for a given item could either be 99%, 100%, or 101% due to rounding.

To help fully understand the charts on the following pages, the items below are more clearly defined:

- **SC** = Substantial Compliance
- **PC** = Partial Compliance
- **NC** = Non-compliance
- **N/A** = Not Applicable
- **Numbers in red font** = A negative number denoting a decrease in a compliance percentage.
- **Raw %** = The compliance percentages with the N/A items included in the calculations.
- **Adjusted %** = The compliance percentages with the N/A items excluded from the calculations.
- ***UPDATED THIS QUARTER:** = Identifies charts and graphs that have been updated since the last Quarterly Report.

***UPDATED THIS QUARTER: CUMULATIVE AUDIT RESULTS**

The pie chart below identifies the cumulative compliance averages for the current round of audits. This data is from two of the six facilities scheduled to be audited during this current round of audits. The bar graph on the right provides a compliance comparison of the three previous complete rounds of audits plus the in-progress Round 4 data. Below these diagrams are the cumulative statistical data of each round of Education audits to date.



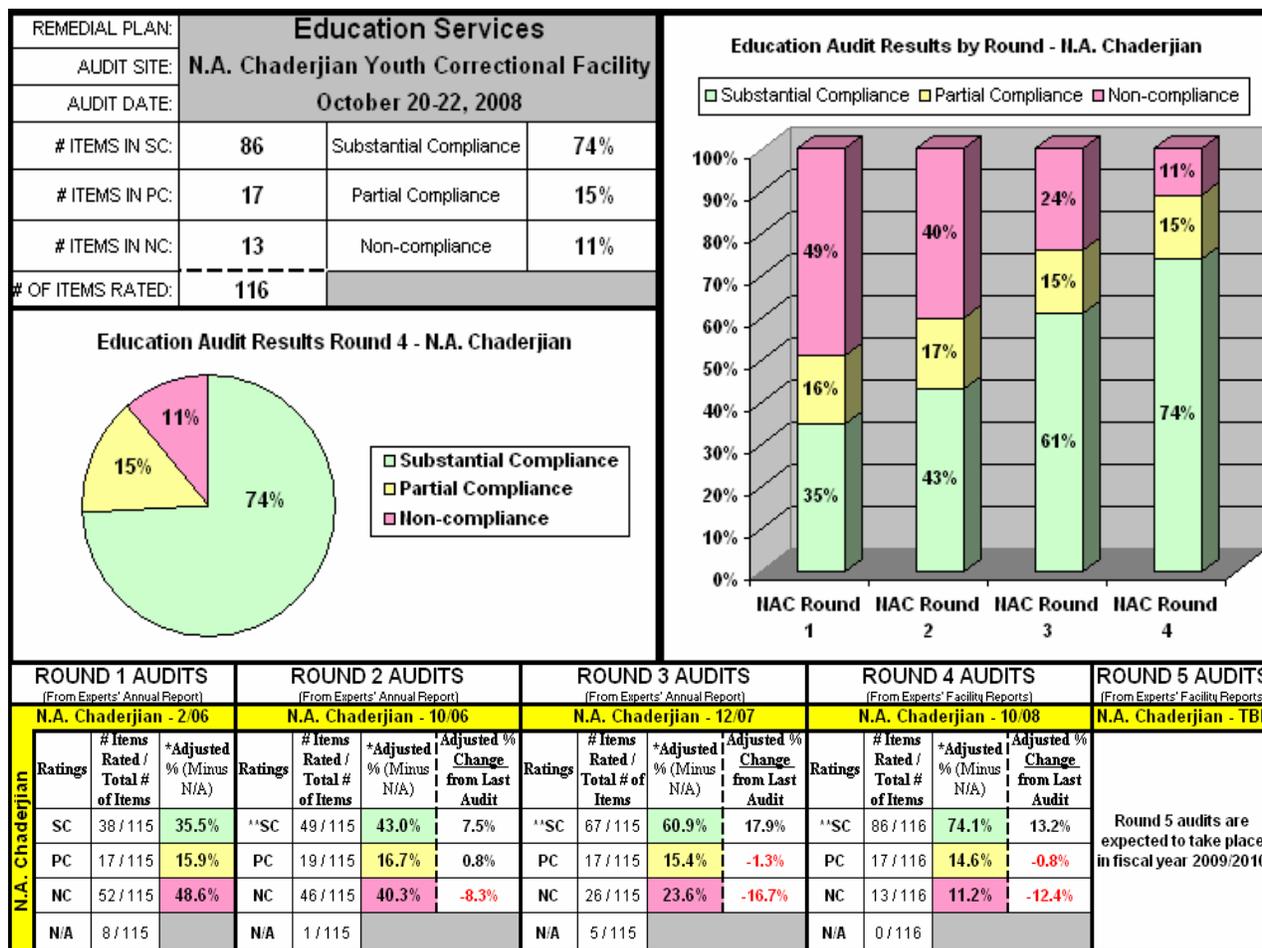
*Adjusted % - "Not Applicable" rated items are excluded from compliance calculation.
**Relieved items are counted as SC.

Figure 3: Education Services Audit Results – Cumulative for Round 3

- DJJ has increased its cumulative Substantial Compliance percentage after every round of audits and correspondingly decreased its Non-compliance percentage after each round.
- DJJ's cumulative Substantial Compliance percentage has increased by an average of 11% after each round of audits, including data received thus far for Round Four.
- DJJ's cumulative Non-compliance percentage has decreased by an average of 9% after each round of audits, including data received thus far for Round Four.
- DJJ's current cumulative combined Substantial Compliance and Partial Compliance percentages for Round Four total 87%.

***UPDATED THIS QUARTER: N.A. CHADERJIAN YOUTH CORRECTIONAL FACILITY**

The Education Experts last audited N.A. Chaderjian Youth Correctional Facility on October 20-22, 2008. The pie chart below identifies the results from this audit, and the bar graph on the right provides a side-by-side comparison from the facility's previous audits. Below these diagrams are the statistical data from each of those audits.



*Adjusted % - "Not Applicable" rated items are excluded from compliance calculation.
**Relieved items are counted as SC.

Figure 4: Education Services Audit Results – N.A. Chaderjian Youth Correctional Facility

- The facility has increased its Substantial Compliance percentage after every round of audits and correspondingly decreased its Non-compliance percentage after each round.
- The facility's Substantial Compliance percentage has increased by an average of 13% after each round of audits.
- The facility's Non-compliance percentage has decreased by an average of 12% after each round of audits.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 89%.

***UPDATED THIS QUARTER: O.H. CLOSE YOUTH CORRECTIONAL FACILITY**

The Education Experts last audited the O.H. Close Youth Correctional Facility on October 23-24, 2008. The pie chart below identifies the results from this audit, and the bar graph on the right provides a side-by-side comparison from the facility's previous audits. Below these diagrams are the statistical data from each of those audits.

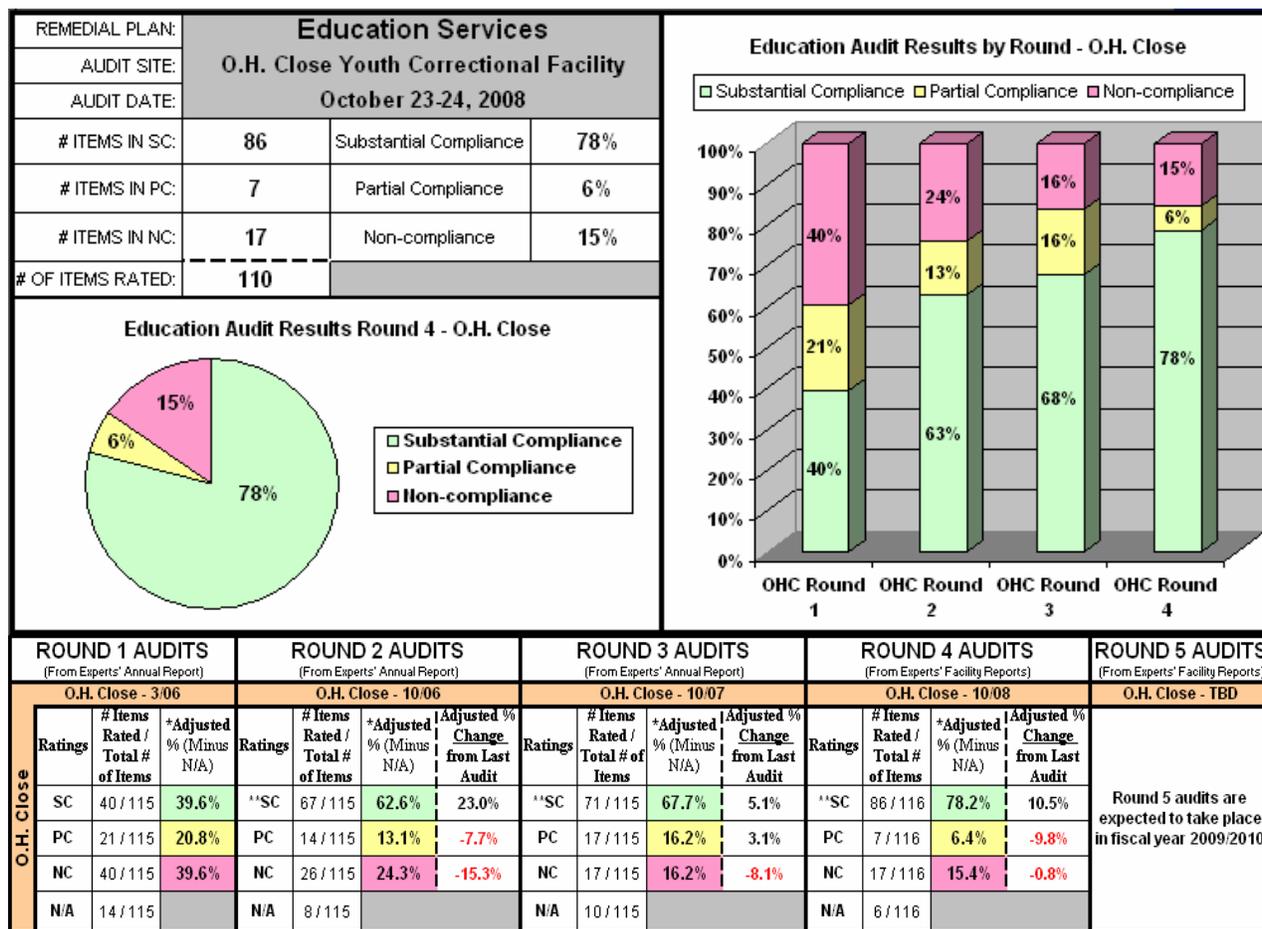


Figure 5: Education Services Audit Results – O.H. Close Youth Correctional Facility

- The facility has increased its Substantial Compliance percentage after every round of audits and correspondingly decreased its Non-compliance percentage after each round.
- The facility's Substantial Compliance percentage has increased by an average of 13% after each round of audits.
- The facility's Non-compliance percentage has decreased by an average of 8% after each round of audits.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 85%.

HEMAN G. STARK YOUTH CORRECTIONAL FACILITY

The Education Experts last audited Heman G. Stark Youth Correctional Facility on March 11-12, 2008. The pie chart below identifies the results from this audit, and the bar graph on the right provides a side-by-side comparison from the facility's previous audits. Below these diagrams are the statistical data from each of those audits.

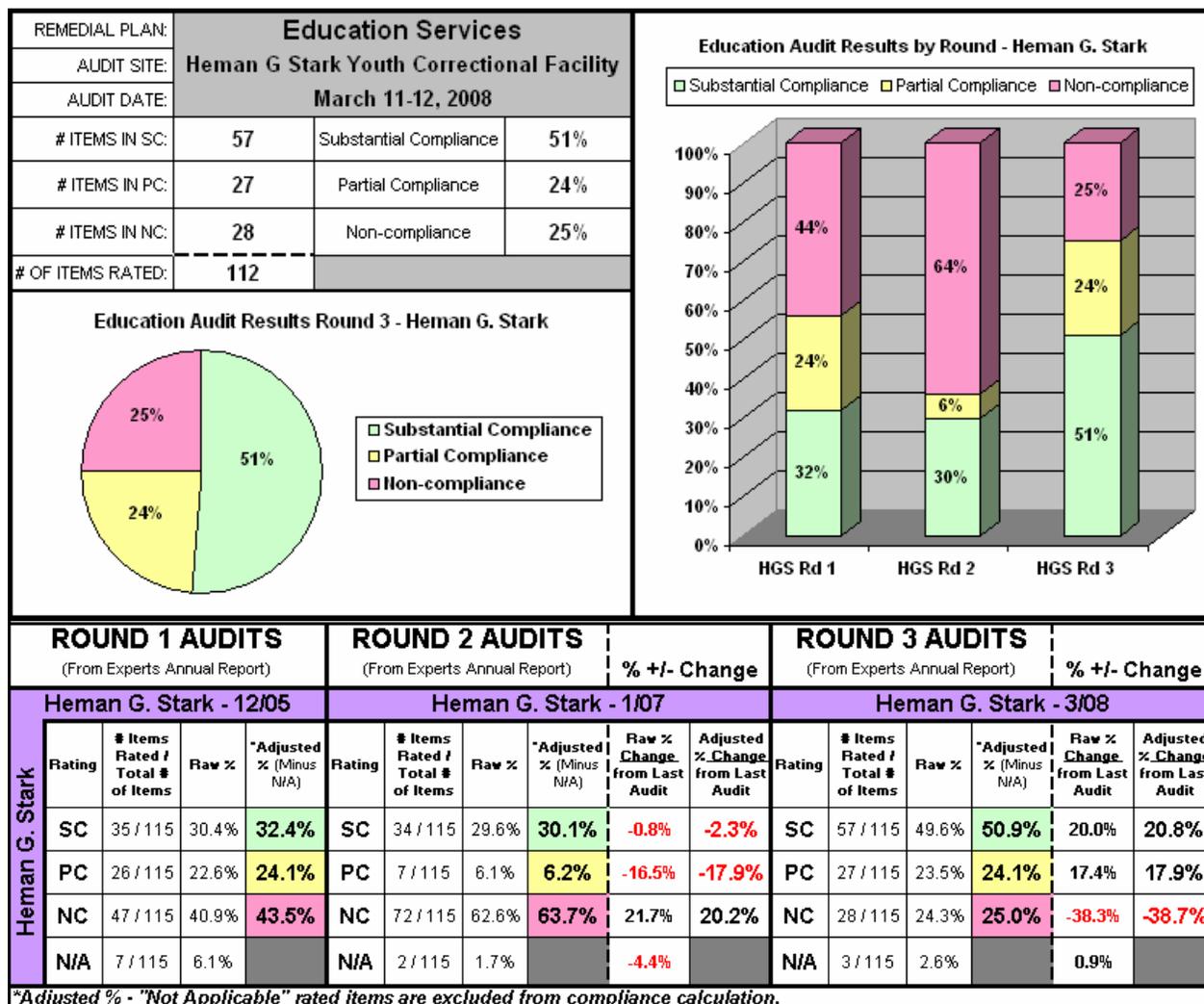


Figure 6: Education Services Audit Results – Heman G. Stark Youth Correctional Facility

- The facility's Substantial Compliance decreased in Round Two from Round One by 2%.
- The facility's Substantial Compliance percentage has increased by an average of 9% after each round of audits.
- The facility's Non-compliance percentage has decreased by an average of 9% after each round of audits.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 75%.

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER-CLINIC

The Education Experts last audited the Southern Youth Correctional Reception Center-Clinic on January 11-12, 2008. The pie chart below identifies the results from this audit, and the bar graph on the right provides a side-by-side comparison from the facility's previous audits. Below these diagrams are the statistical data from each of those audits.

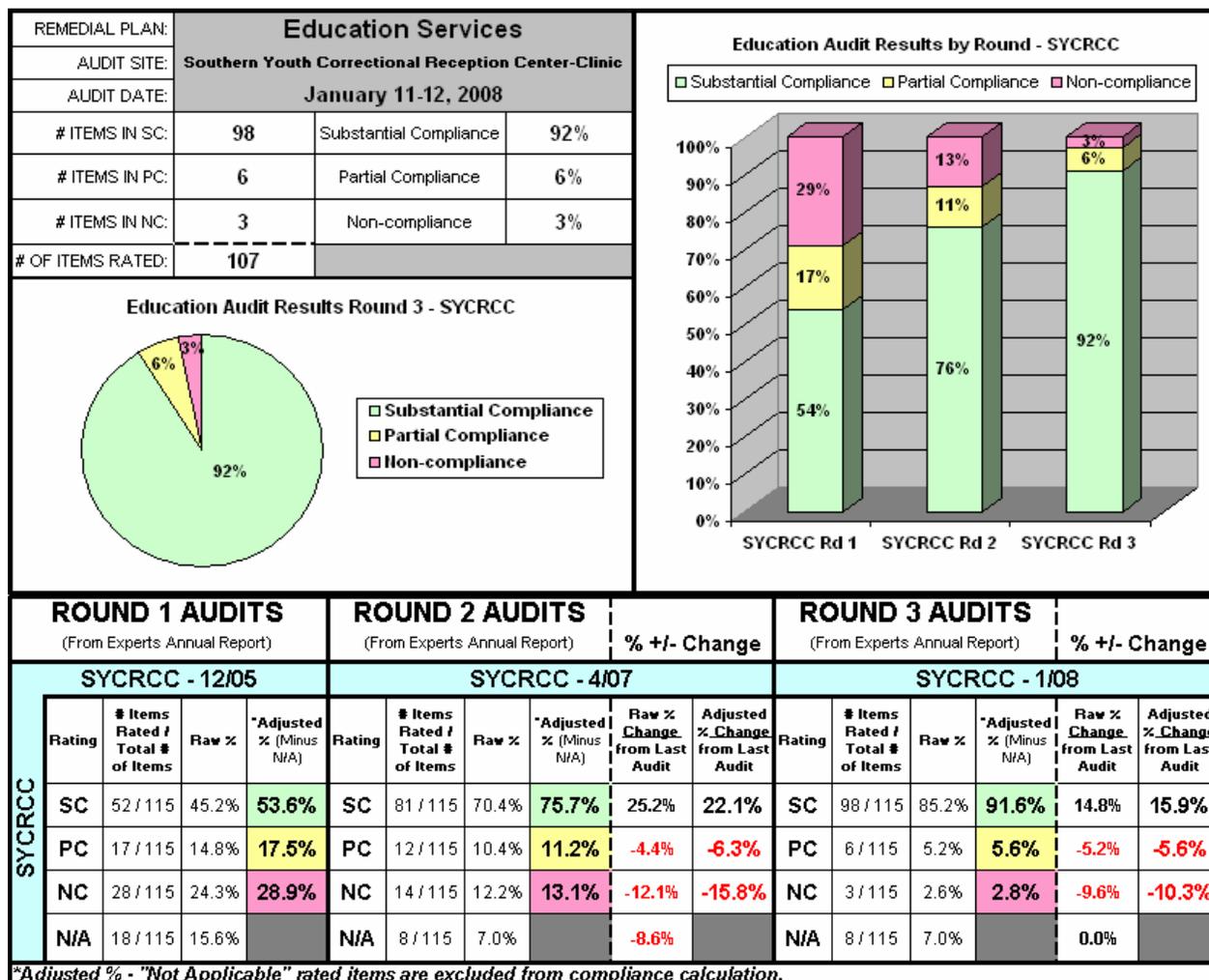


Figure 7: Education Services Audit Results – Southern Youth Correctional Reception Center-Clinic

- The facility has increased its Substantial Compliance percentage after every round of audits and correspondingly decreased its Non-compliance percentage after each round.
- The facility's Substantial Compliance percentage has increased by an average of 19% after each round of audits.
- The facility's Non-compliance percentage has decreased by an average of 13% after each round of audits.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 98%.

PRESTON YOUTH CORRECTIONAL FACILITY

The Education Experts last audited Preston Youth Correctional Facility on February 25-27, 2008. The pie chart below identifies the results from this audit, and the bar graph on the right provides a side-by-side comparison from the facility's previous audits. Below these diagrams are the statistical data from each of those audits.

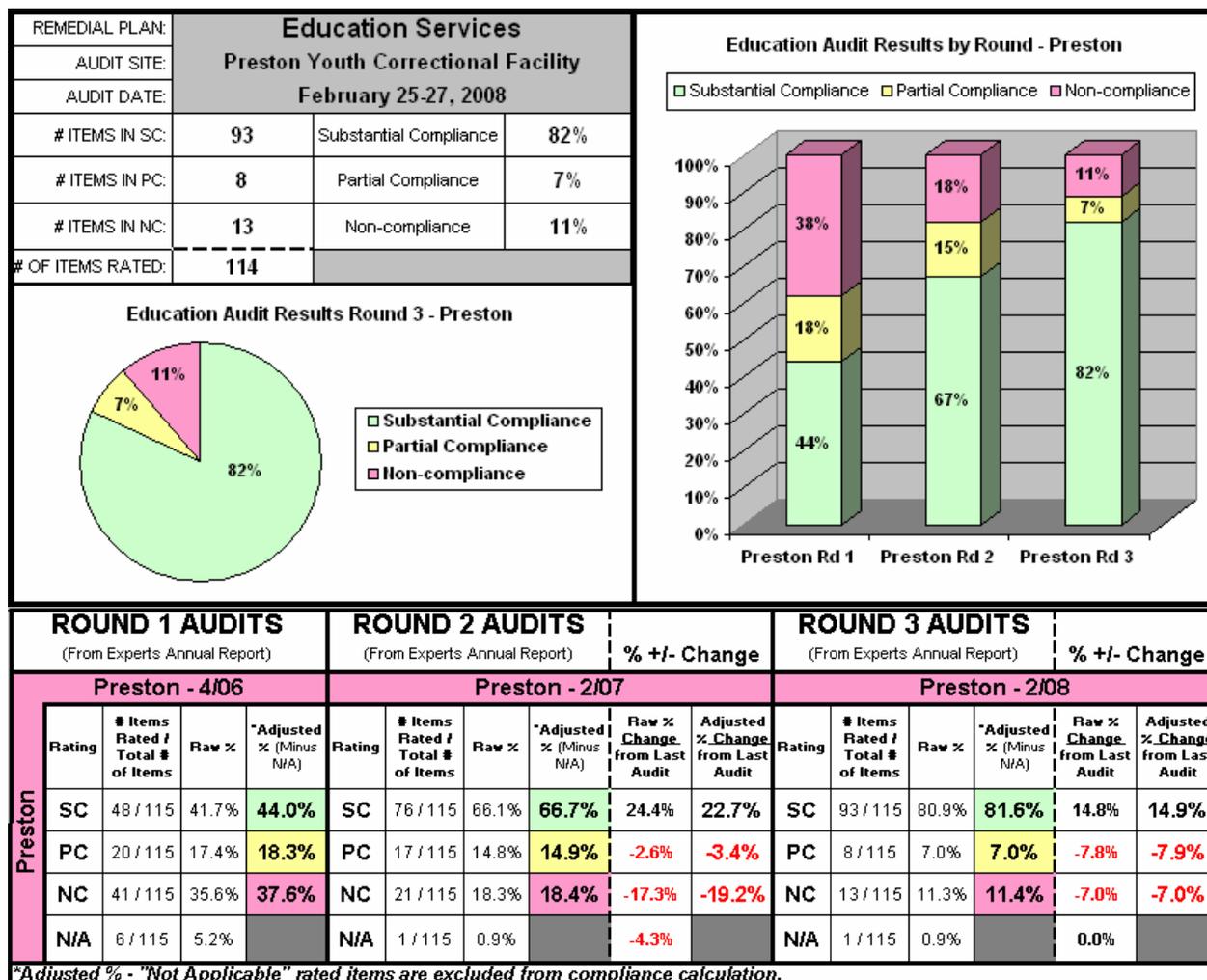


Figure 8: Education Services Audit Results – Preston Youth Correctional Facility

- The facility has increased its Substantial Compliance percentage after every round of audits as well as decreasing its Non-compliance percentage after each round.
- The facility's Substantial Compliance percentage has increased by an average of 19% after each round of audits.
- The facility's Non-compliance percentage has decreased by an average of 13% after each round of audits.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 89%.

VENTURA YOUTH CORRECTIONAL FACILITY

The Education Experts last audited the Ventura Youth Correctional Facility on January 7-9, 2008. The pie chart below identifies the results from this audit, and the bar graph on the right provides a side-by-side comparison from the facility's previous audits. Below these diagrams are the statistical data from each of those audits.

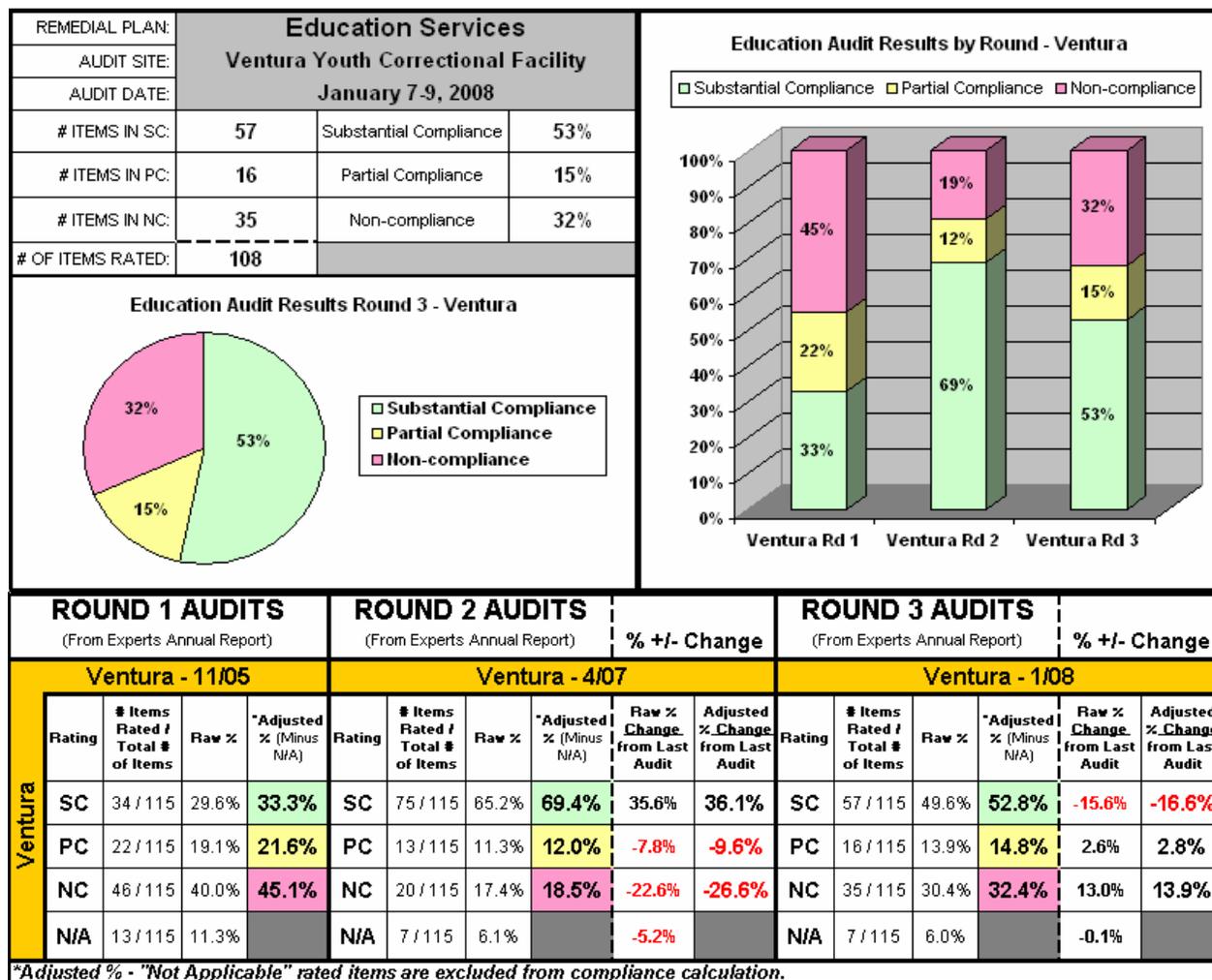


Figure 9: Education Services Audit Results – Ventura Youth Correctional Facility

- The facility's Substantial Compliance decreased in Round Three from Round Two by 17%. This was due to the facility not having documentation ready for the Experts upon their arrival to the facility for their audit.
- The facility's Substantial Compliance percentage has increased by an average of 10% after each round of audits.
- The facility's Non-compliance percentage has decreased by an average of 6% after each round of audits.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 68%.

DEWITT NELSON YOUTH CORRECTIONAL FACILITY

The Education Experts last audited DeWitt Nelson Youth Correctional Facility on October 22-23, 2007. The pie chart below identifies the results from this audit, and the bar graph on the right provides a side-by-side comparison from the facility's previous audits. Below these diagrams are the statistical data from each of those audits. It is important to note that since this last audit took place, the facility has since closed due to a decline in the population and therefore will not be audited in future rounds.

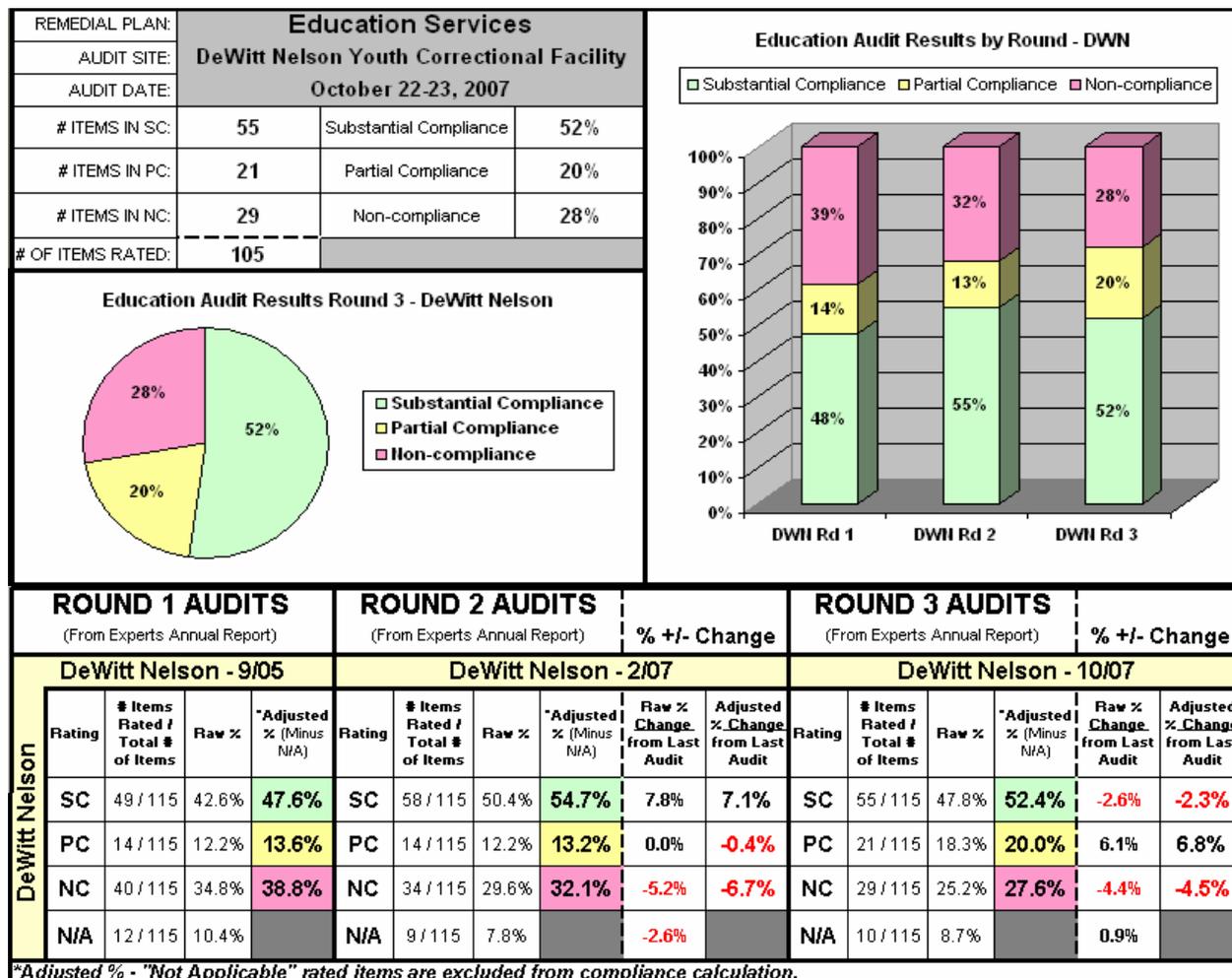


Figure 10: Education Services Audit Results – DeWitt Nelson Youth Correctional Facility

- The facility's Substantial Compliance decreased in Round Three from Round Two by 2%.
- The facility's Substantial Compliance percentage has increased by an average of 2% after each round of audits.
- The facility's Non-compliance percentage has decreased by an average of 6% after each round of audits.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 72%.
- The facility is now closed due to a decline in the population and therefore will not be audited in future rounds.

SITE COMPARISON FOR ROUND THREE

The graph below illustrates the compliance percentages for the seven facilities that were audited during Round 3 and the cumulative average of those audits. Since the Round Three audits took place, the DeWitt Nelson Youth Correctional Facility has been closed. The Education Experts are currently conducting Round Four audits, and after that round has been completed and the Experts have provided DJJ with all of the compliance data, this chart will be updated.

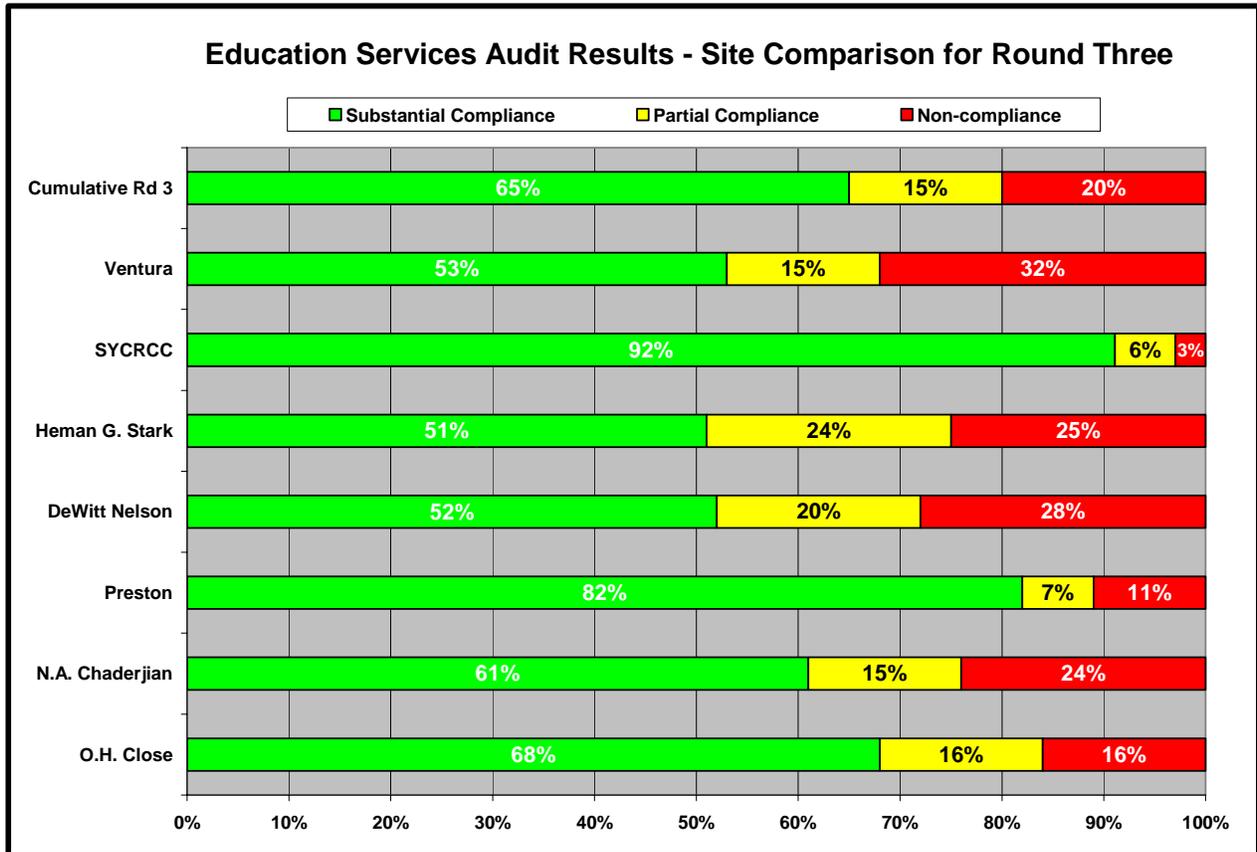


Figure 10: Education Services Audit Results – Site Comparison for Round Three

- For Round Three, the Substantial Compliance percentages ranged from a high of 92% for the Southern Youth Correctional Reception Center-Clinic to a low of 51% for Heman G. Stark Youth Correctional Facility.
- The Partial Compliance percentages ranged from 24% to 6%.
- Non-compliance ranged from a high of 32% for Ventura Youth Correctional Facility to a low of 3% for the Southern Youth Correctional Reception Center-Clinic.

***UPDATED THIS QUARTER: SUBSTANTIAL COMPLIANCE COMPARISON**

The graph below illustrates the Substantial Compliance percentages of DJJ's six facilities for each round of audits as well as the cumulative Substantial Compliance average for each of those rounds. Currently, the cumulative Substantial Compliance average for Round Four reflects that of the two facilities that DJJ has received compliance ratings on to date. Also, due to facility closures, data from El Paso de Robles Youth Correctional Facility and DeWitt Nelson Youth Correctional Facility have been removed from this graph, but their compliance data are still used for calculating the cumulative averages for Rounds One through Three.

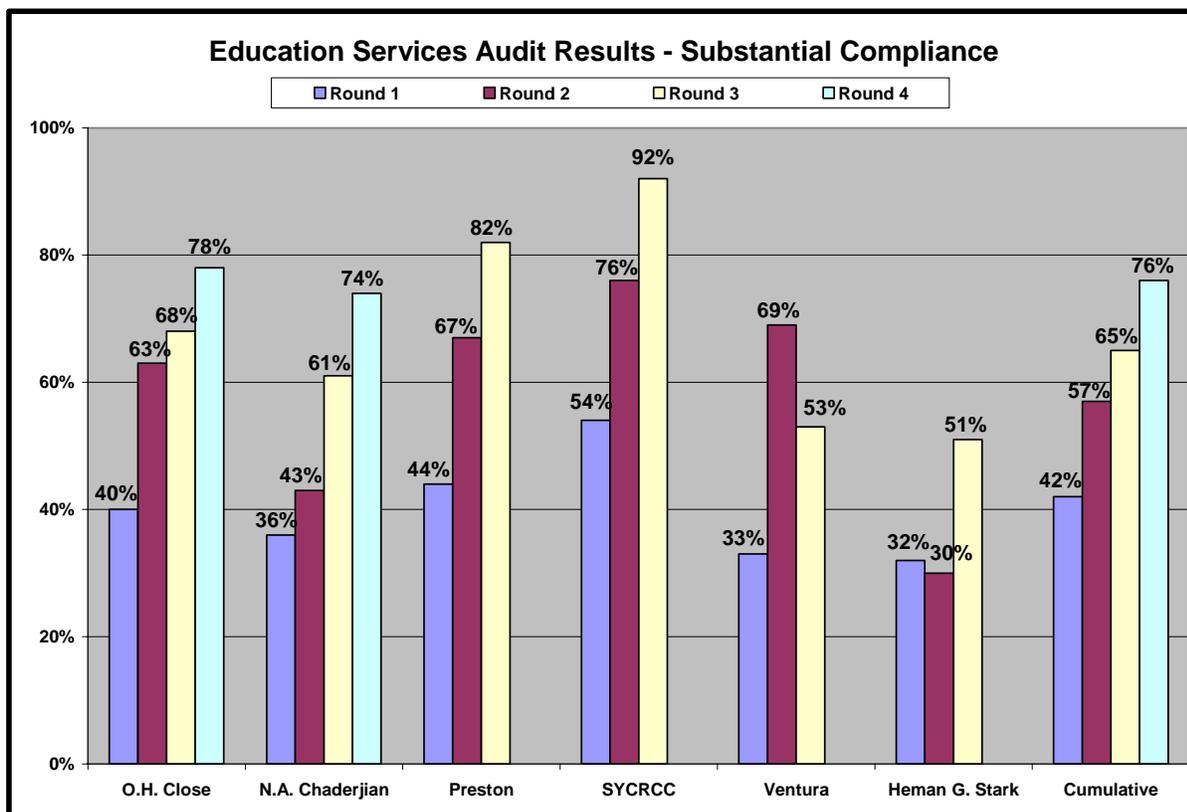


Figure 11: Education Audit Results: Substantial Compliance by Facility & by Round

- The 92% Substantial Compliance rating for the Southern Youth Correctional Reception Center-Clinic during the Round Three audit is the highest rated audit for any facility under any *Farrell* Remedial Plan to date.
- The two facilities that have received compliance ratings thus far for Round Four, O.H. Close Youth Correctional Facility and N.A. Chaderjian Youth Correctional Facility, both increased their Substantial Compliance percentage by 10% or more.
- Presently, four of the six facilities are at or greater than 74% in Substantial Compliance.
- Even though Heman G. Stark Youth Correctional Facility is rated the lowest of any facility at 51% for the third round, it still represents a 21% increase in its Substantial Compliance from the previous round.
- The Ventura Youth Correctional Facility declined in its Substantial Compliance percentage from Round 2 to Round 3 and was due in large part to a recent change in the local administration that took place just shortly before the Round Three audit took place.

***UPDATED THIS QUARTER: SUBSTANTIAL PLUS PARTIAL COMPLIANCE**

A Partial Compliance rating, while not at the same high level as Substantial Compliance, does demonstrate that progress and work effort have been achieved to move a given audit item towards Substantial Compliance. The graph below combines the Substantial and Partial Compliance percentages for each of DJJ’s six facilities for each round of audits to demonstrate the amount of work that has been put forth in working toward Substantial Compliance. A percentage of 100% indicates that the facility does not have any audit items rated as being in Non-compliance. Due to their closures, El Paso de Robles and DeWitt Nelson Youth Correctional Facilities are no longer represented on this graph.

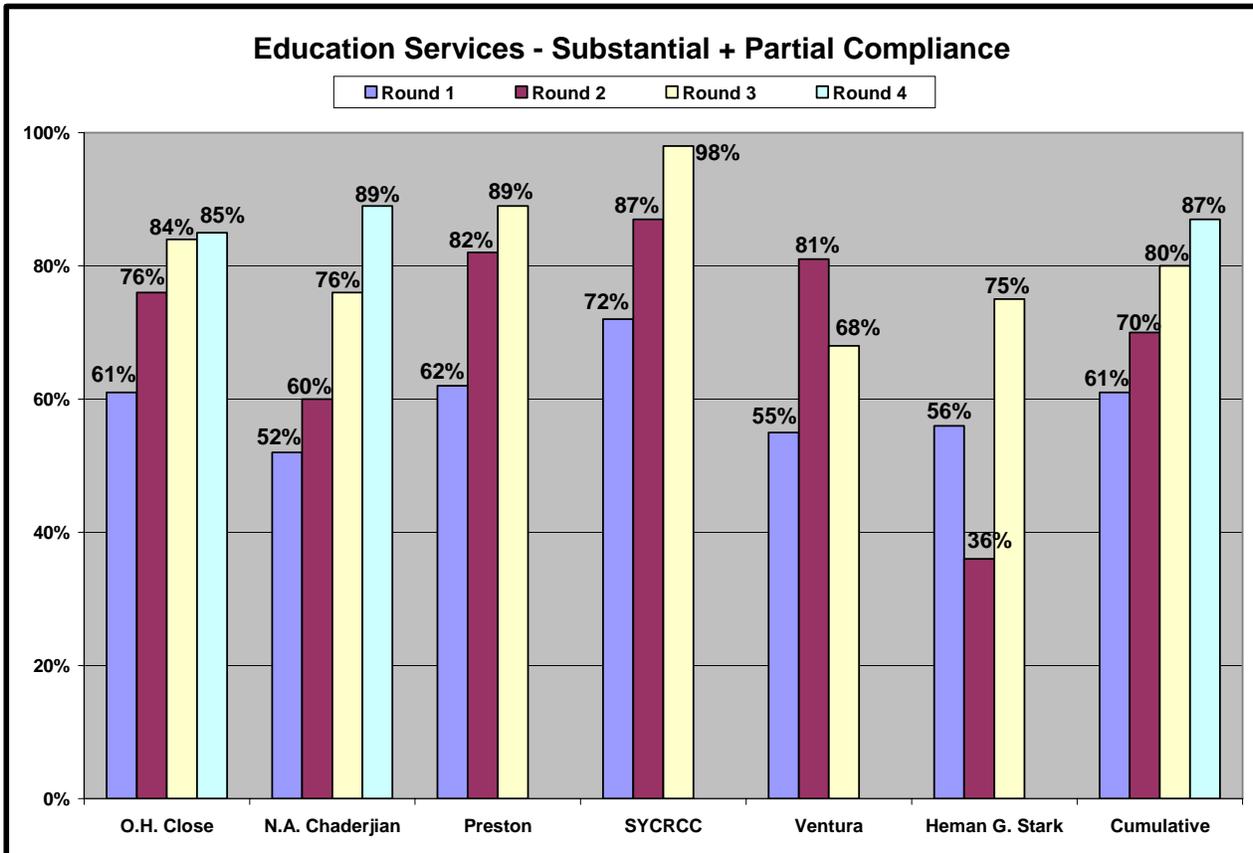


Figure 12: Education Audit Results Round 3: Substantial Compliance by Facility & by Round

- The Southern Youth Correctional Reception Center-Clinic is currently at 98% when combining the Substantial and Partial Compliance percentages and is the highest rated facility. The facility had only three Education audit items rated in Non-compliance out of the 107 items that received a compliance rating.
- Ventura Youth Correctional Facility is the lowest rated facility at 68%. This was a significant decline from the 81% it received in Round Two. DJJ believes this decline was due to a change in the local administration and a lack of a clear understanding by the new administrators of how to prepare for an Education Services audit. The new administrators were not fully aware of the documentation that they needed to provide to the Education Experts in order to demonstrate compliance with certain audit items. As a result, the facility received many Non-compliance ratings solely because “No documentation provided.”

2.1.4 Expert Feedback

As stated earlier, DJJ has received two facility audit reports from the Education Experts during this last quarter. These reports provide DJJ with information on areas of progress as well as identifying areas in need of further attention and work. The comments below are a sampling of the comments made by the Education Experts in the two latest audit reports received by DJJ.

Education Experts' Comments - O.H. Close Youth Correctional Facility

- Item 1.8 – “A list was provided of 14 students who were paroled between 7/23/08 and 10/23/08. Records review and verification of class enrollment indicated that transition planning had been provided for all these students.”
- Item 2.2 – “File review indicated that sufficient classes were offered in each content area to meet the graduation requirements of the student population. The large number of teachers on staff enables JBHS to offer more than enough classes to meet graduation requirements.”
- Item 2.6 – “During the month of September 2008, there were 1970 open class periods. Of this total, 15 classes were closed due to a lack of available substitute teachers. The total number of classes scheduled for the 3rd quarter was 1326. The average class cancellations for the 3rd quarter were 84. It is recommended that the school administration consider combining classes or assigning excess teachers to teach in classes when substitute teachers are not available.”
- Item 2.7 – “At this facility during the current school year, there have been no teaching vacancies in excess of 45 days requiring the use of an in-field substitute teacher.”
- Item 2.8 – “A review of service provider logs, IEP documents and assessment reports indicated that related service personnel, including school psychologists, actively participate in IEP development. A random review of 7 assessments conducted by the psychologists and other related service personnel indicated that reports at the facility are completed in a timely manner. The related service providers are available to staff and students for consultation.”
- Item 2.9 – “Five special education students had been referred for testing since July 2008. Three (3) assessments were completed within allowable timelines. Two (2) assessments had been delayed due to the lack of signed assessment plans from parents. The program maintains excellent documentation of on-going efforts to obtain signed documentation as required.”
- Item 3.3 – “A review of data related to 100 student enrollments at the facility indicated that all students were enrolled in appropriate educational programming within 4 school days (an average of 2.96 days).”
- Item 3.8 – “A review of the records for 10 students not making minimal progress on their HSGPs verified that referrals had been made to the SCT for all 10 of the students.”

- Item 3.15 – “Students attending school are routinely pulled from their classes by residence hall staff. This occurs after the student has checked into the classroom and is counted present. This practice distorts attendance data and makes it virtually impossible to accurately determine whether students are attending school for 240 minutes daily as mandated by the remedial plan.”
- Item 3.16 – “At the June 2008 SWAT meeting, educational staff presented data regarding what was happening after daily attendance was taken. The report indicated that over a 15 day period (May 27-June 16, 2008), 1361 students were called out of class to leave the school area for varied reasons (gang issues, conflict resolution, medical, mental health, treatment groups, security issues, etc.). This information was not tracked by the SWAT data because students were being called out after the class count was cleared. Education staff were not being informed where the students were going. Unreported student absences of this magnitude do not support the idea that the cooperative agreements are being implemented.”
- Item 3.19 – “Corrective action plans fail to address or correct the removal of students from classes that prevents the DJJ from complying with the agreed upon education remedial plan mandate of students attending school an average of 240 minutes daily.”
- Item 3.20 – “During the month of September 2008, there were 15 class closures out of the total of 1955 open classes at this facility. Safety/Security was responsible for 0 closures. Lack of available substitute teachers caused 15 class closures.”
- Item 3.23 – “The facility has a very good system in place that records exclusion from school. Students excluded from school forms were appropriately recorded and maintained. There were 7 students listed as temporary detentions; these detentions ranged from 11 to 26 days.”
- Item 3.28 – “This site has not fully implemented nor are they following attendance policies and procedures (see Policy Attendance Accounting E.T. 09 3200-3215, p.2-3, and School Day Schedule and Annual Academic Calendar E.T. 10 3220-3224, p. 2-3.)”
- Item 3.29 – “A list of incentives to promote school attendance was provided. These incentives included perfect attendance certificates, good time recommendations from teachers, special education behavior contracts and points from the psychologist store for perfect attendance. The program staff documented efforts to encourage increased attendance, including the use of incentives and certificates.”
- Item 3.32 – “The school was approved for 3 modular units. These units are in place and currently being used. There is more than adequate space to meet the needs of the student population.”
- Item 4.8 – “Mini-libraries are available on the living units. Direct observation verified that students are able to access these materials. This site is commended for its efforts to provide reading materials for students on the living units.”

- Item 4.12 – “The new process for trade advisory committees is that vocational teachers make contacts with others in their field in the public sector and then arrange trade visits. With the budget crisis this year, travel has been curtailed for state employees, making trade visits impossible. The School Principal indicated that when the travel freeze is lifted, vocational teachers will resume their trade visits.”
- Item 4.15 – “During the semester beginning 1/7/08, the school offered distance learning in computer electronics. Students can now earn Microsoft certification using distance learning technology.”
- Item 4.17 – “Distance learning classes are now being conducted. On October 20, 2008, Global Classroom transmissions began between Johanna Boss and Chaderjian High Schools.”
- Item 4.19 – “The site uses the Alexandria library system that consists of a main information server called the data station. This system can perform all of the library functions such as circulation, cataloging, and searching for specific subjects, titles or authors. Each item and patron is assigned a unique bar code number that can be read quickly, making the job easier and decreasing the probability of errors. Direct observation of the program indicated that the support system is very good and that the system works well.”
- Item 4.20 – “Classroom teachers were observed using a course syllabus and lesson plans. Teacher interviews indicated that teachers are aware of this requirement and that the use of lesson plans as part of the instructional effort is a common practice. This site has many outstanding teachers who are actively involved in teaching the youth. Student interviews indicate that they appreciate the efforts of many of the teachers.”
- Item 4.24 – “Staff cannot access policies electronically. This is a matter that must be corrected immediately.”
- Item 5.5 – “A review of student files (N=8), with records and IEPs documenting psychological, educational and related service assessments completed, confirmed that students were being referred for psychological assessments to update expired eligibility as needed. A review of the last three Principal’s Monthly Reports indicated that report completion is within acceptable time lines. A sample of 4 psychological assessments conducted by the school psychologists was reviewed during the audit; they were found to be well written and complete.”
- Item 5.7 – “The school program does not provide a continuum of available special education services. Students are routinely removed from their IEP mandated classes at the request of residence hall staff and denied access to FAPE. This practice must stop immediately.”
- Item 5.8 – “Special Education eligible students are routinely pulled from their classes. This practice prevents students from receiving required segments and from attending school for full instructional days. Special education teacher and student interviews confirmed that the removals were frequent. There were a total of 2933 general and special education absences for the period 09/20/18 to 10/20/08.”

- Item 5.12 – “Document review indicated that the site has made efforts to implement the revised assessment procedures. Full implementation of county intake procedures could not be documented based on information available.”
- Item 5.17 – “Documentation indicated the participation of the school psychologists in the IEP meeting and the IEP minutes confirmed their active participation in the eligibility process.”
- Item 5.22 – “The program provided a copy of the Compensatory Services Monitoring. The provision of compensatory services currently meets student obligations. The cumulative impact of continuous non-school related pull outs, however, continues to be of concern. It is recommended that the school and facility administration closely monitor class pull outs for non educational reasons to ensure that compensatory services requirements are accurately recorded. It is also recommended that related service personnel and the school administrative staff carefully review actual attendance records for students being pulled from their classes to ensure that all required compensatory services are documented and provided as required.”
- Item 6.6 – “Students failing at least one part of the exam are provided remediation through test preparation classes or enrollment in a course designed to review and specifically remediate areas where remediation is needed.”
- Item 6.8 – “Students have access to a full range of educational opportunities. Program wide alternatives that include GED preparation classes, the California High School Proficiency Examination and focused reading initiatives, vocational programming, ELL courses, etc. are being offered to these students.”

Education Experts’ Comments – N.A. Chaderjian Youth Correctional Facility

- Item 2.4 – “File review of vacancies on 10/10/08 indicated that there are currently 14 vacant teaching and support positions. The position of teacher of the emotional learning handicapped has been vacant since 11.1.06. A school psychologist position has been vacant since 11.1.07. All other vacancies have exceeded the 30-60 day window. It currently takes 60-90 days to complete the hiring process; continued work is necessary to streamline this process.”
- Item 3.6 – “The SCT committee functions at this facility. File review indicated that there were 67 referrals between 7/02/08 and 10/05/08. Referrals to SCT have increased significantly since the date of the last review.”
- Item 3.9 – “The SCT chair does a very thorough job of tracking students with referral sources, interventions, SCT meeting dates and actions taken.”

- Item 3.14 – “A copy of the written procedures to inform teachers of missing students was provided. Teachers complete a student absentee list at the beginning of each class. School security lists the codes for absences and teachers are notified as to the reasons for the students’ absences through a copy of the list placed in each teacher’s mailbox. Teachers can access the information in the WIN data as well. While the process is in place and teachers are aware of the process, it was evident that not all teachers follow up on student absences or use the system as a means of identifying the causes of students’ absences.”
- Item 3.15 – “A review of the September 2008 principal’s monthly report indicated that the cumulative number of general education absences for the month was 2367 out of a total of 12582 student periods, resulting in an absence factor of 18.81%. In the SDC classes, there were 42 student absences out of a total 358 available student periods, resulting in an absence factor of 11.73 %. While these rates of student absence fail to meet the goal, they are an improvement over the previous month. Efforts are being made to improve student attendance.”
- Item 3.17 – “Documentation provided via the Compstat reports indicated that quarterly monitoring of school attendance, including review of absences, school closures and teacher absences, was being conducted. Continued emphasis is being placed on student attendance.”
- Item 3.19 – “The agreement between the Superintendent and the Principal was provided. The 3rd quarter COMPSTAT report indicated that the site has exceeded the 7% absence rate allowed by the action plan. A corrective action plan has been developed and needs to be implemented.”
- Item 3.24 – “The overall accuracy of the WIN data system continues to improve; however, some problems were noted. For instance, when class rolls were pulled up for the previous week, the system provided data reflecting student enrollment for the current day.”
- Item 3.25 – “Management team logs and minutes for the previous 3 months were provided that documented efforts to remove barriers to the 240 minute instructional day. The minutes indicated that an effort is being made to enable the victims to attend school and address the perpetrators.”
- Item 3.29 – “A list of incentives to promote school attendance was provided. These incentives included perfect attendance certificates, good time recommendations from teachers, special education behavior contracts and points from the psychologist store for perfect attendance. The program staff documented efforts to encourage increased attendance, including the use of incentives and certificates. The proposed Principal’s Honor List for students who excel during the semester has not yet been implemented. It is recommended that an ongoing schedule of activities be developed by the school administration and staff to provide encouragement and incentives for students to attend school. This should be stressed at faculty and staff meetings.”

- Item 3.32 – “There are many classrooms available on the main line due to the reduced student population. There are adequate academic classrooms in the restricted units however; there is a need to provide vocational classrooms in the restricted units. According to the “notice to proceed” document approved by Director Sandra Youngen, there will be 2 additional education rooms on American, 2 on Smith, 3 on Kern and 2 on Sacramento.”
- Item 3.34 – “A copy of the Alternative Behavior Learning Environment system was provided. Written verification of the training and implementation of the ABLE program at this site was provided. The program began on August 18, 2008. There were 30 students referred and served during month of September.”
- Item 3.36 – “A file review of the one special education student who had received programming in the restricted unit in excess of 30 days revealed that the school psychologist assigned to the unit had not conducted a functional behavioral assessment or developed a formal behavioral intervention plan. Behavioral goals, however, had been developed and implemented. It is recommended that documentation of efforts, including the development of formal behavior intervention plans, be made part of the IEP document.”
- Item 3.38 – “Review of class rolls vs. actual student attendance in the SMP school program did not verify that students are served on a consistent basis. Students on the units continue to be registered for 5 class periods daily, but they do not consistently receive mandated educational services. High school graduation plans and IEPs failed to match the actual instruction provided.”
- Item 3.39 – “Interviews and direct observations indicated that the instructional program on the restricted units did not afford a 240 minute educational instructional day to all students. Course credit and progress towards high school graduation continues to be sporadic and unsatisfactory. There were no vocational program offerings for students on these units.”
- Item 4.12 – “TAC minutes and documentation of industrial visitation were provided. There is an ongoing need to visit sites and secure work opportunities for youth in the DJJ vocational programs.”
- Item 4.15 – “A limited number of students participated in distance learning through Coastline Community College. All GED and high school graduates who are expected to be at Chaderjian for the entire semester are eligible to enroll. At the time of the review, there were 14 students enrolled in these courses; eight of these students were in restricted units.”
- Item 4.17 – “Distance learning classes began on October 20, 2008 and are currently being transmitted between Johanna Boss and Chaderjian High Schools.”
- Item 4.18 – “Observation and records review indicate that 8 students on the restricted units have access to and are participating in distance learning classes.”
- Item 4.19 – “The automated library system was implemented on April 30, 2008. The library has an automated tracking system for checking books in and out for student use.”

- Item 4.24 – “Staff cannot access policies electronically. This is a matter that must be corrected immediately.”
- Item 5.2 – “A review of 45 special education files and supporting documents confirmed that students transferring to the facility were enrolled in and received full educational programming within 4 school days of admission.”
- Item 5.3 – “File review verified that the facility follows DJJ screening procedures and that students identified as potentially eligible for special education services are referred for psychological assessment.”
- Item 5.6 – “A review of the four day schedules for the week prior to the review indicated that students assigned to the unit were apparently scheduled to receive staggered amounts of instruction, with some students receiving 5 periods daily and others receiving 2, 3 or 4 periods daily. The School Principal was not able to explain this practice.”
- Item 5.7 – “Teachers and administrators continue to verify that the facility fails to provide a continuum of special education services to all eligible students. The failure is systemic in the school programs conducted in restricted units outside of the main line school.”
- Item 5.9 – “Comparisons of the special education data collection system (including type of disability, number and type of segments, etc.) with hard data verified the completeness and accuracy of reporting procedures at the time of the review. It is noted that this system continues to improve.”
- Item 5.16 – “IEP minutes and supporting documents from 4 of 10 IEPs examined provided for changes in service delivery. IEP minutes in 2 of the 10 files were non-specific and failed to adequately document the rationale for change. There has been noticeable improvement in efforts by the program’s teachers to justify reduction in service hours.”
- Item 5.17 – “Documentation and teacher interviews confirmed that the IEP team’s eligibility decisions are based on current assessment data and participant input. Procedures for triennial assessments and eligibility determination, including vision and hearing screenings, were well documented in the files reviewed. Significant improvements have been made at this facility in this area since the last review.”
- Item 5.19 – “DJJ staff is reminded that the development of any statement of transition services (including courses of study) must be designed to assist the student in reaching the transition goals. The statement of transition services should relate directly to the student’s postsecondary goals and should: 1) define every activity that must occur; 2) identify who has primary responsibility for each activity; and 3) specify the dates that each activity will begin and end.”
- Item 5.22 – “The Compensatory Services Log was not current and did not reflect any hours provided during the current calendar month. It is noted that one teacher stated that he provided compensatory hours simply by providing extra work; this practice does not meet the requirements for compensatory services.”

- Item 6.8 – “There has been a reduction of students being pulled from school for treatment. Program wide alternatives that include pre-GED and GED preparation classes, the California High School Proficiency Examination and focused reading initiatives are now being offered to students at this site.”

2.1.5 Status of Specific Action Items

Relieved Items

Page 11, paragraph 23, of the Consent Decree states:

When a facility is found to be in substantial compliance on an issue for one full year, and is found to remain in substantial compliance after review by the relevant expert(s) one year later, expert tours regarding that issue at that facility shall end.

A “relieved” audit item is one that has met or exceeded the two-year Substantial Compliance threshold and one that the appropriate Expert has formally noted is removed from that Expert’s future monitoring.

The chart below identifies the 11 action items that the Education Experts have identified as relieved from future independent monitoring as a result of sustained Substantial Compliance ratings. Although the Experts have removed these 11 action items from future audits, DJJ is still responsible for ensuring that these 11 action items are maintained at their current level of compliance.

Education Services Action Items Relieved from Future Expert Monitoring			
DJJ #	Item#	Action Item	Deadline
2	1.2	FACILITY ACTION ITEM – The CYA will Provide written verification that their courses are California Education Standards driven and that they meet state curriculum standards.	N/A
59	4.1	FACILITY ACTION ITEM – Verify with written documentation that the CYA curriculum meets the Content Standards and Curriculum Frameworks for the California Public Schools.	N/A
60	4.2	FACILITY ACTION ITEM – Verify with written documentation that there is a process in place to coordinate curriculum revisions and develop curriculum guides on a cyclical basis.	N/A
61	4.3	FACILITY ACTION ITEM – Verify that Curriculum Guides with content, performance standards and process for instruction exist for all core area courses (English/Language Arts, Science, Mathematics, Social Studies) and vocational education courses taught in the CYA schools.	N/A
62	4.4	FACILITY ACTION ITEM – Verify that the core academic guides are available to all staff electronically in December 2005.	12/1/05
63	4.5	FACILITY ACTION ITEM – Compare the number of textbooks and library books at each site with applicable standards.	N/A
64	4.6	FACILITY ACTION ITEM – Verify in August 2005 that the annual inventory and needs assessment has been conducted.	N/A
81	4.23	FACILITY ACTION ITEM – Verify that policies have been revised to reflect changes in operations.	N/A
108	6.1	FACILITY ACTION ITEM – Verify the use of the state mandated testing schedule through observation and interviews. Through student interviews and file reviews, verify access of eligible students to the state mandated exam.	N/A
109	6.2	FACILITY ACTION ITEM – The CYA will provide written verification that the content of its curriculum guides in English-language arts and mathematics is related to items on the California Graduation Test.	N/A
110	6.3	FACILITY ACTION ITEM – Through student interviews and file reviews, verify that eligible students have appropriate opportunities to pass the state mandated exam.	N/A

Audit Items in Substantial Compliance Two Years or Longer

Due to improved compliance tracking methods, DJJ is now able to identify all of the Education Services audit items that have achieved a Substantial Compliance rating for two or more years and can identify whether or not that audit item has been formally relieved from further monitoring by the Education Experts.

The chart below identifies the overall status of the Education Services' audit items that have been in Substantial Compliance for two years or longer at each of the seven facilities audited since 2005.

Number of Audit Items in Substantial Compliance for Two Years or Longer								
EDUCATION SERVICES	OHC	NAC	HGS	Preston	Ventura	SYCRCC	DWN	Total
Number of Audit Items	115	115	115	115	115	115	115	805
Number of Audit Items in Substantial Compliance for two years or longer	33	26	20	42	23	46	33	223
Percentage of Audit Items in Substantial Compliance for two years or longer	29%	23%	17%	36%	20%	40%	29%	28%
Number of Audit Items that have been relieved by the experts	11	11	11	11	11	11	11	77
Number of Audit Items in Substantial Compliance for two years or Longer that have not been relieved by the Experts	22	15	9	31	12	35	22	146
Percentage of Audit Items that have been in Substantial Compliance for two years or longer that have been relieved by the Experts	33%	42%	55%	26%	48%	24%	33%	34%
Percentage of Audit Items in Substantial Compliance for two years or longer that have not been relieved by the Experts	67%	58%	45%	74%	52%	76%	67%	66%

Of the 223 audit items that have met the two year Substantial Compliance threshold, 77 (34%) have been relieved from future monitoring by the Education Experts. The Education Experts are still monitoring the remaining 146 (66%) audit items that have been in Substantial Compliance for two years or longer.

Items Removed from Relieved Status

The Education Experts have not rescinded any audit item that they have previously identified as being relieved from future audits.

Statewide Compliance Items

In addition to the 11 relieved action items, there are also 21 action items for which the Education Experts have provided Substantial Compliance ratings for each of the seven facilities audited during the last round of audits. When an action item receives a Substantial Compliance rating for every applicable site, this is referred to as being in "Statewide Compliance." Items that are found to be in "Statewide Compliance" should not be confused with audit items that have been formally relieved from future expert monitoring.

The chart below lists the 21 action items in which every facility received a Substantial Compliance rating during the last round of audits.

Education Services Action Items in Statewide Compliance – Round Three (Relieved Items not Included)			
DJJ #	Item #	Action Item	Deadline
1	1.1	FACILITY ACTION ITEM – Verify WASC accreditation status at all school sites. Review WASC records at each site.	N/A
10	2.3	FACILITY ACTION ITEM – Review and evaluate the written recruitment plan and the qualifications and use of the 2 recruiters.	N/A
17	2.10	FACILITY ACTION ITEM – Use a sample of 10 or 10%, whichever is greater, of special education students referred for related services during the monitoring period; determine how long it was from referral to provision of services.	N/A
18	2.11	FACILITY ACTION ITEM – Verify employment of 2 school psychologists at schools with restricted programs.	N/A
19	3.1	FACILITY ACTION ITEM – Verify the existence and implementation of a Standardized 220 day Academic Calendar which provides for at least 240 minutes of instruction each day for each eligible student.	N/A
20	3.2	FACILITY ACTION ITEM – Verify the existence and implementation of a Standardized 220 day Academic Calendar which provides for at least 240 minutes of instruction each day for each eligible student.	N/A
22	3.4	FACILITY ACTION ITEM – Verify that high school registrars request transcripts from any prior school within 4 school days of the student's arrival at the facility for students entering during the monitoring period.	N/A
48	3.30	FACILITY ACTION ITEM – Review and evaluate annual school calendar.	N/A
49	3.31	FACILITY ACTION ITEM – Review scheduling and utilization of the 44 student advising/case conference days per year.	N/A
71	4.13	FACILITY ACTION ITEM – Verify the use of annual surveys to provide vocational course planning by July 2005.	7/1/05
72	4.14	FACILITY ACTION ITEM – Verify the use of annual Career Technical job studies to determine the effectiveness of CTE programs.	N/A
80	4.22	FACILITY ACTION ITEM – Verify that the strategic plan and reading initiative are being implemented at each site.	N/A
82	4.24	FACILITY ACTION ITEM – Verify that policies are made available to staff electronically by June 2006.	6/1/06
83	5.1	FACILITY ACTION ITEM – Verify that the manual is complete and made available to staff by September 2005. Verify that Special Education Manual meets all relevant state and federal rules and guidelines.	9/1/05
92	5.10	FACILITY ACTION ITEM – Verify that the revised standards are established and that the timelines are being met.	N/A
102	5.20	FACILITY ACTION ITEM – Verify in-service training schedule including dates and outline of topics. Verify staff attendance through inspection of in-service roll information and review of Principal's Monthly Report.	N/A
106	5.24	FACILITY ACTION ITEM – Verify in-services schedule including date and topics. Verify staff attendance through inspection of in-service roll information and review of Principal's Monthly Report. Verify schedule using CYA Master Calendar.	N/A
107	5.25	FACILITY ACTION ITEM – Review quarterly site review reports.	N/A
111	6.4	FACILITY ACTION ITEM – Verify by records review of students taking state mandated exams that appropriate accommodations, modifications or variations were provided as a part of testing procedures (in accord with CDE guidelines).	N/A
112	6.5	FACILITY ACTION ITEM – Review the cooperative agreements to ensure students' access and attendance in the school program. Interview staff and students to verify implementation of the agreements.	N/A
113	6.6	FACILITY ACTION ITEM – Verify by records review of students taking the test that students failing at least one part of the exam were provided specific remediation related to test items.	N/A

Action Items with Majority Ratings of Non-compliance

In addition to identifying areas of progress, the Education Experts' audit reports also provide valuable information on the action items that require more attention and work before they will be deemed to satisfy the mandates of the Education Services Remedial Plan. Generally, these types of items require a higher level of inter-departmental coordination and are sometimes dependent on action items from other Remedial Plans being implemented. These make them more challenging to implement in a timely manner.

The chart below identifies 17 action items which received a majority of Non-compliance ratings at the different facilities.

Education Services Action Items with Majority of Ratings of Non-compliance			
DJJ #	Item#	Action Item	Deadline
13	2.6	FACILITY ACTION ITEM – Document class cancellations due to teacher absences that are not covered by substitute teachers.	N/A
33	3.15	FACILITY ACTION ITEM – Review 10 or 10%, whichever is greater, student files to document school attendance for the last 30 school days.	N/A
34	3.16	FACILITY ACTION ITEM – Review the cooperative agreements to ensure students' access and attendance in the school program. Interview staff and students to verify implementation of the agreements.	N/A
37	3.19	FACILITY ACTION ITEM – Review and evaluate quarterly corrective action plans for sites that have an absence rate of more than 7%.	N/A
38	3.20	FACILITY ACTION ITEM – Review school schedules for the last 30 days. Review WIN Data and verify individual class cancellations at each site. Interview teachers, other staff and students.	N/A
52	3.34	FACILITY ACTION ITEM – Verify the use of the alternative behavior management classroom at each site.	N/A
55	3.37	FACILITY ACTION ITEM – Verify existence of classrooms in restricted settings. Verify that all classrooms meet minimum CDOE size standards. Report the number of students in restricted settings served in small classrooms and the number not being served.	N/A
56	3.38	FACILITY ACTION ITEM – Review current and previous 30 school days class rolls for all restricted school programs to determine staffing pattern. Verify teachers' credentials. Review high school graduation plans, IEPs and other documents to document assignment/instructional match.	N/A
57	3.39	FACILITY ACTION ITEM – Verify instructional program on restricted units by reviewing school schedule, education progress reports and school transcripts. Conduct direct observation of instructional program. Interview site administrators. Interview teachers, custodial staff and students.	N/A
75	4.17	FACILITY ACTION ITEM – Verify implementation and use of Global Classrooms distance learning.	6/1/2006
76	4.18	FACILITY ACTION ITEM – Verify use of distance learning in restricted settings by direct observation, lesson plan and transcript review.	N/A
79	4.21	FACILITY ACTION ITEM – Verify the practice of quarterly teacher observations by administrators using the revised rubric for Classroom Observation.	N/A
88	5.6	FACILITY ACTION ITEM – During site visits and staff interviews, determine whether each CYA facility provides a continuum of placement options, including the full range of time, frequency and duration within each option.	N/A
89	5.7	FACILITY ACTION ITEM – During site visits and through staff interviews, determine whether the continuum of available special education services is provided to all eligible students including those assigned to restricted settings.	N/A
90	5.8	FACILITY ACTION ITEM – Review 10 or 10% whichever is greater, of special education student files at each site to verify that eligible students are receiving the required number of segments and full instructional day. Interview special education students to verify that services listed in IEPs are being provided.	N/A

Education Services Action Items with Majority of Ratings of Non-compliance			
DJJ #	Item#	Action Item	Deadline
95	5.13	FACILITY ACTION ITEM – Verify existence of collaborative agreements.	N/A
96	5.14	FACILITY ACTION ITEM – Verify established procedures that enforce requirements.	N/A

2.1.6 Proof of Practice

The following chart identifies the Proof of Practice documents relating to the Education Services Remedial Plan that have been sent to the Education Experts and the Special Master during the last quarter. The Proof of Practice documents are evidence of the progress DJJ makes toward full implementation of the audit item. Submission of these documents to the Experts does not necessarily mean that the audit item for which the Proof of Practice documents are submitted has been completed; rather, it merely demonstrates DJJ's efforts to come into compliance with and the progress being made on a given action item.

Education Services Proof of Practice Documents Submitted During the Last Quarter				
Log #	Section	Audit Item Description	Documents Submitted	Date Sent
277	1	"All school sites meet WASC Accreditation Standards"	<p>1 – Memorandum, dated October 30, 2008, issued by Doug P. McKeever, Director, Division of Juvenile Programs, to all Principals, Superintendents, Chief Medical Officers, and DJJ Headquarters Staff, subject: "Superintendent of Education," which announces the appointment of Leda Medearis as Acting Superintendent of Education (1 page). The position of Superintendent of Education is mandated under the Education Services Remedial Plan and also pursuant to State law (Welfare & Institutions Code § 1120.1).</p> <p>DJJ has been attempting to recruit to fill the position of Superintendent of Education but has been unsuccessful in its efforts thus far. DJJ will continue to recruit to fill the position with a more focused effort, but in the meantime, an Acting Superintendent of Education has been appointed to oversee the management of education programs throughout the Department: Leda Medearis.</p>	11/05/08
284	N/A	N/A	<p>1 – Document entitled "Key Audit Items for Expert's Verification" (31 pages). This document is being submitted to the Education Experts to allow them the opportunity to review it and ensure that the document correctly identifies the items that were submitted.</p> <p>This constitutes DJJ's second submission of the reporting tool to the Experts. This submission also contains additional information that DJJ relied upon in drafting the reporting tool, including information provided by and/or derived from consultations with the Experts.</p>	11/20/08

Education Services Proof of Practice Documents Submitted During the Last Quarter				
Log #	Section	Audit Item Description	Documents Submitted	Date Sent
294	V-1	<p><i>"The Special education Policy Manual will be approved and available to staff by September 2005.</i></p> <p><i>"The Special Education Manual will meet all state and federal regulations."</i></p>	<p>1 – California Department of Corrections and Rehabilitation, Juvenile Justice Division's Special Education Manual (154 pages). This Special Education Manual is being submitted to the Education Services Experts pursuant to the requirements of Section V, Item 1, of the Education Services Remedial Plan, which requires DJJ to make available a Special Education Policy Manual and ensure that the Manual meets all applicable state and federal regulations.</p> <p>The Special Education Manual submitted with this Proof of Practice was originally finalized in July of 2002 and underwent revisions in October 2008 to conform to applicable State and federal laws.</p>	11/20/08

2.1.7 Summary and Application of Audit Findings

Although the two recent audit reports received by DJJ continues to demonstrate an objective pattern of progress, DJJ is aware that work still remains in order for it to attain full compliance for all the mandates within the Education Services Remedial Plan. The Program Service Day will help alleviate the issue of students being absent from school as well as ensuring that students remain in education classes without numerous pull-outs. Further, Education will ensure that there is consistent access for the mandated 240-minute educational services day for all students in restricted programs.

2.2 Sex Behavior Treatment Program Remedial Plan Compliance Status

2.2.1 Historical Audit Perspective

Court Filings

The Sexual Behavior Treatment Program (SBTP) Remedial Plan was filed with the Court on May 16, 2005. The SBTP audit tool was included with the filing of the SBTP Remedial Plan.

Audit Tool

The SBTP audit tool has approximately 53 action items. It is difficult to ascertain the exact number of action items and audit items as the audit tool is not clear or consistent in identifying both the audit criteria and its corresponding compliance rating. Associated with the 53 action items are 212 audit items. The number of audit items refers to the total number of compliance ratings that DJJ will receive within a given audit cycle or, in other words, the number of things that DJJ has to "get right" in order to come into full compliance for a given round of auditing.

In the latest SBTP Annual Report, the SBTP Expert provided compliance ratings on 53 action items instead of the previously identified 52. Also, the number of 212 audit items is greater than the previously reported 208. The 208 number was derived from the assumption that the SBTP Expert was just going to audit the four formal SBTP Programs within DJJ. However, in her last Annual Report, the SBTP Expert began to provide compliance ratings on informal programs as well as "DJJ Administration" specific audit items. Because these two new categories were added for the first time in her latest report and that the number of action items has increased by one since her last report, DJJ is unclear as to the exact number of SBTP audit items it is responsible for being in compliance with.

None of the approximately 53 SBTP action items within the audit tool have a specific deadline for implementation.

Audit Tool Breakdown

Audit Item Numbers Based on Six Facilities	Filing Dates		"Action Items"			"Audit Items"		
	Remedial Plan	Audit Tool	# of Action Items with a Deadline	# of Action Items without a Deadline	Total # of Action Items	# of Audit Items with a Deadline	# of Audit Items without a Deadline	Total # of Audit Items
Sexual Behavior Treatment Program	5/16/05	5/16/05	0	53*	53*	0	212**	212**

* Originally in past Reports this number was listed as 52 but since receiving the SBTP Expert's most recent Annual Report she is now providing compliance ratings on 53 action items.

** This number is based on the four Formal SBTP Programs within DJJ. However, there is an informal program at Preston in which the SBTP Expert has since provided compliance ratings for in her most recent Annual Report. In addition, the SBTP Expert has now included a "DJJ Administration" section in her Annual Report. Because of these occurrences the number of audit items will be greater than 212 but DJJ does not have a clear understanding of the exact number of audit items it is responsible to be in compliance with at this time.

Audit History

The SBTP Expert conducted her first round of visits in October 2005 at each of the four facilities that have a residential Sex Behavior Treatment Program: O.H. Close Youth Correctional Facility, N.A. Chaderjian Youth Correctional Facility, Heman G. Stark Youth Correctional Facility, and the Southern Youth Correctional Reception Center-Clinic. In January 2006, the SBTP Expert provided DJJ with her first comprehensive report addressing all four programs. This report was in a narrative format and did not use the matrix/spreadsheet audit tool that was filed with the Court. Although the SBTP Expert did supply approximately 26 compliance ratings in this report, it was difficult, due to the narrative nature of the report, for DJJ to align many of the compliance ratings to a specific action item. Also, the SBTP Expert's report provided a singular compliance rating for each audit item for all four facilities. Of the 26 compliance ratings provided in this initial report, approximately nine were given Partial Compliance (35%), and 17 were found to be in Non-compliance (65%).

Because the SBTP Expert did not use an audit tool during the first round, DJJ is considering the audits to have actually started when the SBTP Expert began using the audit tool, which occurred during her second round of visits. The SBTP Expert's second round of visits incorporated the use of the Court-filed audit tool and provided specific compliance ratings for each of the audit items. However, the Expert did not provide site-specific compliance ratings but, rather, a single compliance rating for every facility for each of the different audit items. This resulted in all four facilities having identical compliance percentages. For compliance tracking purposes, this second round of visits, in which specific audit items received a specific compliance rating, is referred to as "Round One" of the audits.

The SBTP Expert's most recent Annual Report provided DJJ with site-specific information for the four formal SBTP Programs as well as the Preston informal program and a section identified as "DJJ Administration." DJJ appreciates that the SBTP Expert provided site-specific compliance ratings and comments in her most recent Annual Report. This level of detail allows DJJ to objectively assess the progress of each facility's SBTP program and to identify the issues that need further attention.

The chart below provides a more detailed listing of all of the SBTP audits by facility to date:

SBTP	Initial Visit	ROUND ONE		ROUND TWO	
Facility	Date Audited	Date Audited	Time Since Last Audit	Date Audited	Time Since Last Audit
SYCRCC	Oct. 25, 2005	July 26, 2007	21 months	May 21, 2008	10 months
Heman G. Stark	Oct. 24, 2005	July 27, 2007	21 months	May 22, 2008	10 months
N.A. Chaderjian	Oct. 21, 2005	May 25, 2007	19 months	April 29, 2008	11 months
O.H. Close	Oct. 20, 2005	May 24, 2007	19 months	Feb. 21, 2008	9 months

Future Audit Schedule

During this last reporting period, the SBTP Expert provided DJJ with the following schedule for her next round of audits:

- O.H. Close Youth Correctional Facility — March 9, 2009
- N.A. Chaderjian Youth Correctional Facility – March 10, 2009
- Heman G. Stark Youth Correctional Facility – March 26, 2009
- Southern Youth Correctional Reception Center and Clinic — March 27, 2009
- Preston Youth Correctional Facility — April 20, 2009
- DJJ Headquarters – May 8, 2008

2.2.2 Most Recent Audit Findings

Audit Reports Received During Last Quarter

The SBTP Expert has not started her next round of audits. Therefore, DJJ has not received an audit report during this last quarter.

2.2.3 Sexual Behavior Treatment Program Audit Results

Audit Results Introduction

The Sexual Behavior Treatment Program charts on the following pages document the most up-to-date compliance ratings for each site audited by the SBTP Expert. The compliance percentages are derived from the SBTP Expert's Annual Report. These charts also include the cumulative results of the most recent round of audits as well as the comparison of a facility's prior audit results in previous rounds. Attached at the bottom of these charts are the statistical data for each audit performed for the identified site.

The percentages identified in the following charts have been rounded off and therefore, may have a slight variance of no more than 1% of either less than or greater than 100%. For example, in adding up the different compliance percentages, the sum total for a given site could either be 99%, 100%, or 101% due to rounding.

To help fully understand the charts on the following pages, the abbreviations, color code, and terms below are more clearly defined:

- **SC** = Substantial Compliance and is shaded in green.
- **PC** = Partial Compliance and is shaded in yellow.
- **NC** = Non-compliance and is shaded in red.
- **N/A** = Not Applicable and is shaded in gray.
- **Numbers in red font** = A negative number denoting a decrease in a compliance percentage.
- **Raw %** = The compliance percentages with the number of N/A items included in the calculations.
- **Adjusted %** = The compliance percentages with the number of N/A items excluded from the calculations. This is the number used by DJJ to identify the compliance percentage for a given site.
- ***UPDATED THIS QUARTER:** = Identifies charts and graphs that have been updated since the last Quarterly Report.

CUMULATIVE RESULTS

The pie chart below identifies the cumulative averages for all of the compliance data received during the SBTP Expert's most recent round of audits. The bar graph on the right provides a side-by-side comparison of the cumulative data from the previous round of audits. Below these diagrams are the statistical data from these audits.

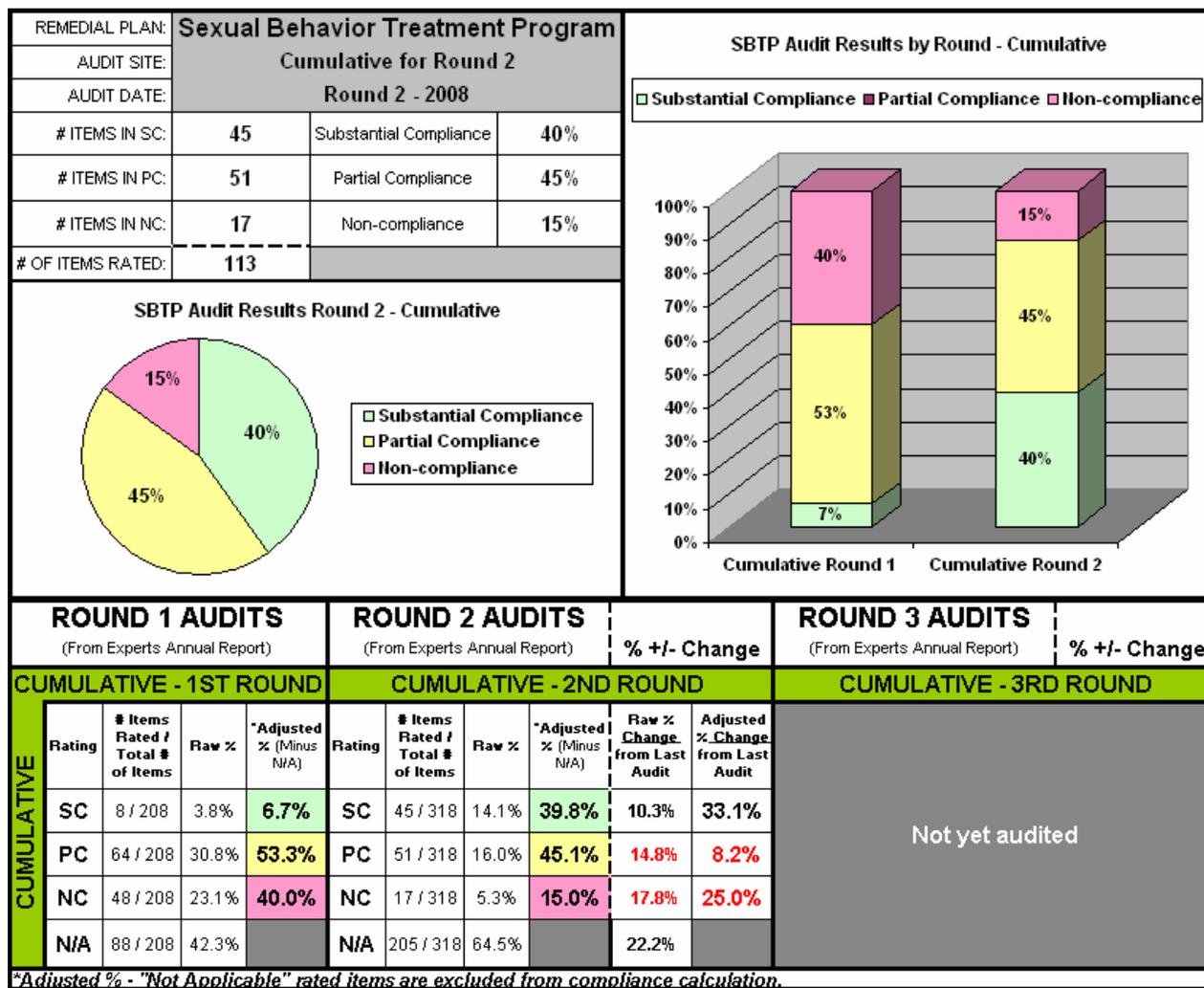


Figure 13: SBTP Audit Results – Cumulative

- DJJ increased its cumulative Substantial Compliance percentage from Round One to Round Two and also correspondingly decreased its Non-compliance percentage.
- DJJ's cumulative Substantial Compliance percentage increased by 33% from Round One to Round Two and is now at 40%.
- DJJ's cumulative Non-compliance percentage decreased by 25% from Round One to Round Two and is now at 15%.
- DJJ's cumulative combined Substantial Compliance and Partial Compliance percentages total 85%.

N.A. CHADERJIAN YOUTH CORRECTIONAL FACILITY

The SBTP Expert last audited the N.A. Chaderjian Youth Correctional Facility on April 29, 2008. The pie chart below identifies the results from this audit, and the bar graph on the right provides a side-by-side comparison from the facility's previous audit. Below these diagrams are the statistical data from those audits.

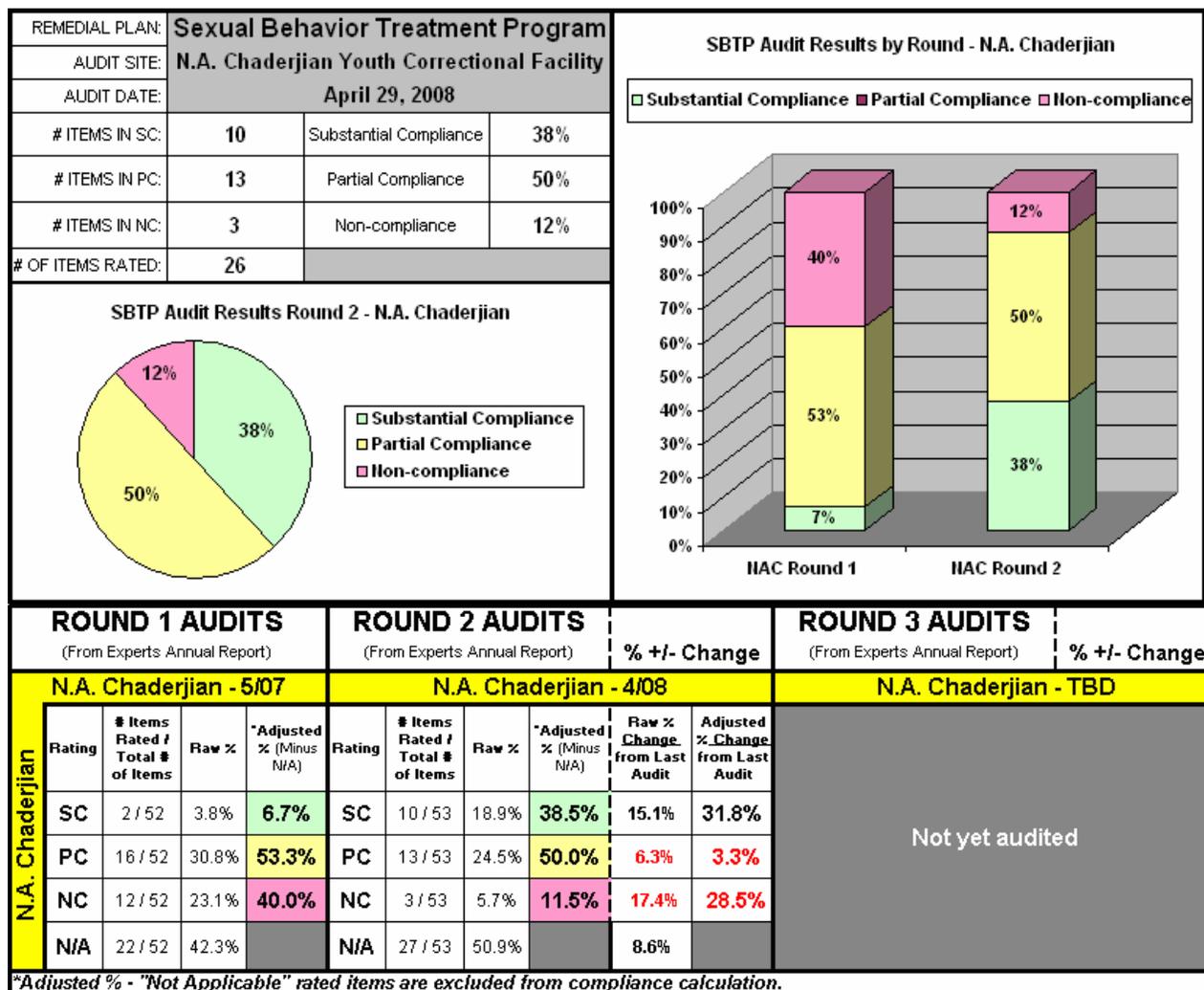
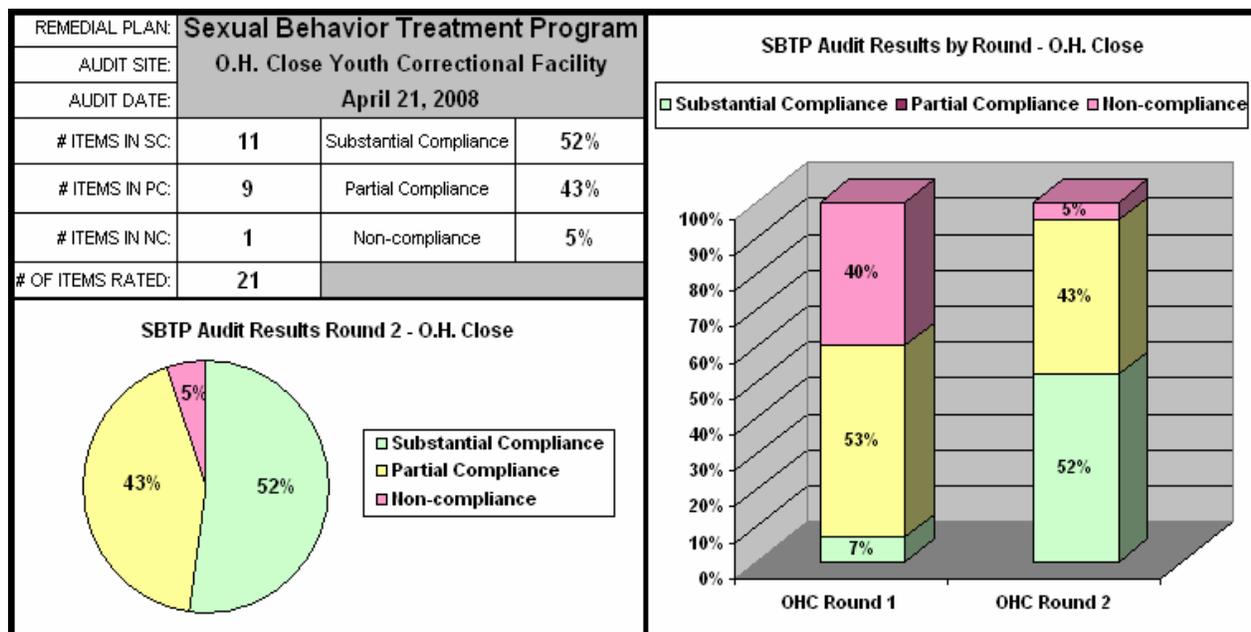


Figure 14: SBTP Audit Results – N.A. Chaderjian Youth Correctional Facility

- The facility increased its Substantial Compliance from Round One to Round Two and correspondingly decreased its Non-compliance percentage.
- The facility's Substantial Compliance percentage increased by 31% from Round One to Round Two and is now at 38%
- The facility's Non-compliance percentage decreased by 28% from Round One to Round Two and is now at 12%.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 88%.

O.H. CLOSE YOUTH CORRECTIONAL FACILITY

The SBTP Expert last audited the O.H. Close Youth Correctional Facility on April 21, 2008. The pie chart below identifies the results from this audit, and the bar graph on the right provides a side-by-side comparison from the facility's previous audit. Below these diagrams are the statistical data from each of those audits.



ROUND 1 AUDITS <small>(From Experts Annual Report)</small>				ROUND 2 AUDITS <small>(From Experts Annual Report)</small>				% +/- Change		ROUND 3 AUDITS <small>(From Experts Annual Report)</small>		% +/- Change	
O.H. Close - 5/07				O.H. Close - 2/08						O.H. Close - TBD			
Rating	# Items Rated / Total # of Items	Raw %	*Adjusted % (Minus N/A)	Rating	# Items Rated / Total # of Items	Raw %	*Adjusted % (Minus N/A)	Raw % Change from Last Audit	Adjusted % Change from Last Audit	Not yet audited			
SC	2 / 52	3.8%	6.7%	SC	11 / 53	20.7%	52.4%	16.9%	45.7%				
PC	16 / 52	30.8%	53.3%	PC	9 / 53	17.0%	42.9%	13.8%	10.4%				
NC	12 / 52	23.1%	40.0%	NC	1 / 53	1.9%	4.8%	21.2%	35.2%				
N/A	22 / 52	42.3%		N/A	32 / 53	60.4%		18.1%					

*Adjusted % - "N/A" rated items are excluded from compliance calculation.

Figure 15: SBTP Audit Results - O.H. Close Youth Correctional Facility

- The facility increased its Substantial Compliance from Round One to Round Two as well as decreasing its Non-compliance percentage.
- The facility's Substantial Compliance percentage increased by 45% from Round One to Round Two and is now at 52%.
- The facility's Non-compliance percentage decreased by 35% from Round One to Round Two and is now at 5%.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 95%.

HEMAN G. STARK YOUTH CORRECTIONAL FACILITY

The SBTP Expert last audited the Heman G. Stark Youth Correctional Facility on May 22, 2008. The pie chart below identifies the results from this audit, and the bar graph on the right provides a side-by-side comparison from the facility's previous audit. Below these diagrams are the statistical data from each of those audits.

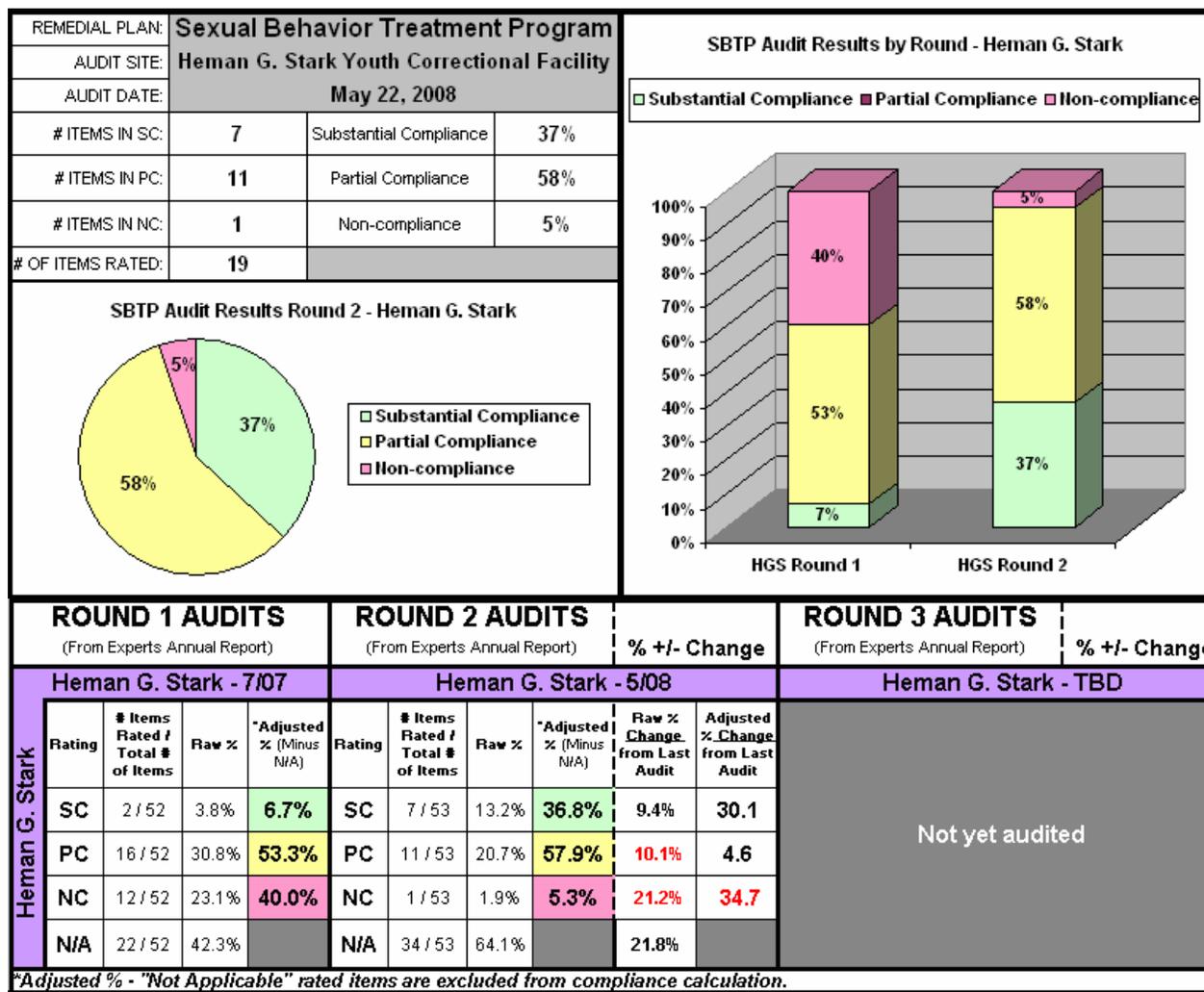


Figure 16: SBTP Audit Results – Heman G. Stark Youth Correctional Facility

- The facility increased its Substantial Compliance from Round One to Round Two and correspondingly decreased its Non-compliance percentage.
- The facility's Substantial Compliance percentage increased by 30% from Round One to Round Two and is now at 37%.
- The facility's Non-compliance percentage decreased by 35% from Round One to Round Two and is now at 5%
- The facility's combined Substantial Compliance and Partial Compliance percentages total 95%.

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER-CLINIC

The SBTP Expert last audited the Southern Youth Correctional Reception Center-Clinic on May 21, 2008. The pie chart below identifies the results from this audit, and the bar graph on the right provides a side-by-side comparison from the facility's previous audit. Below these diagrams are the statistical data from each of those audits.

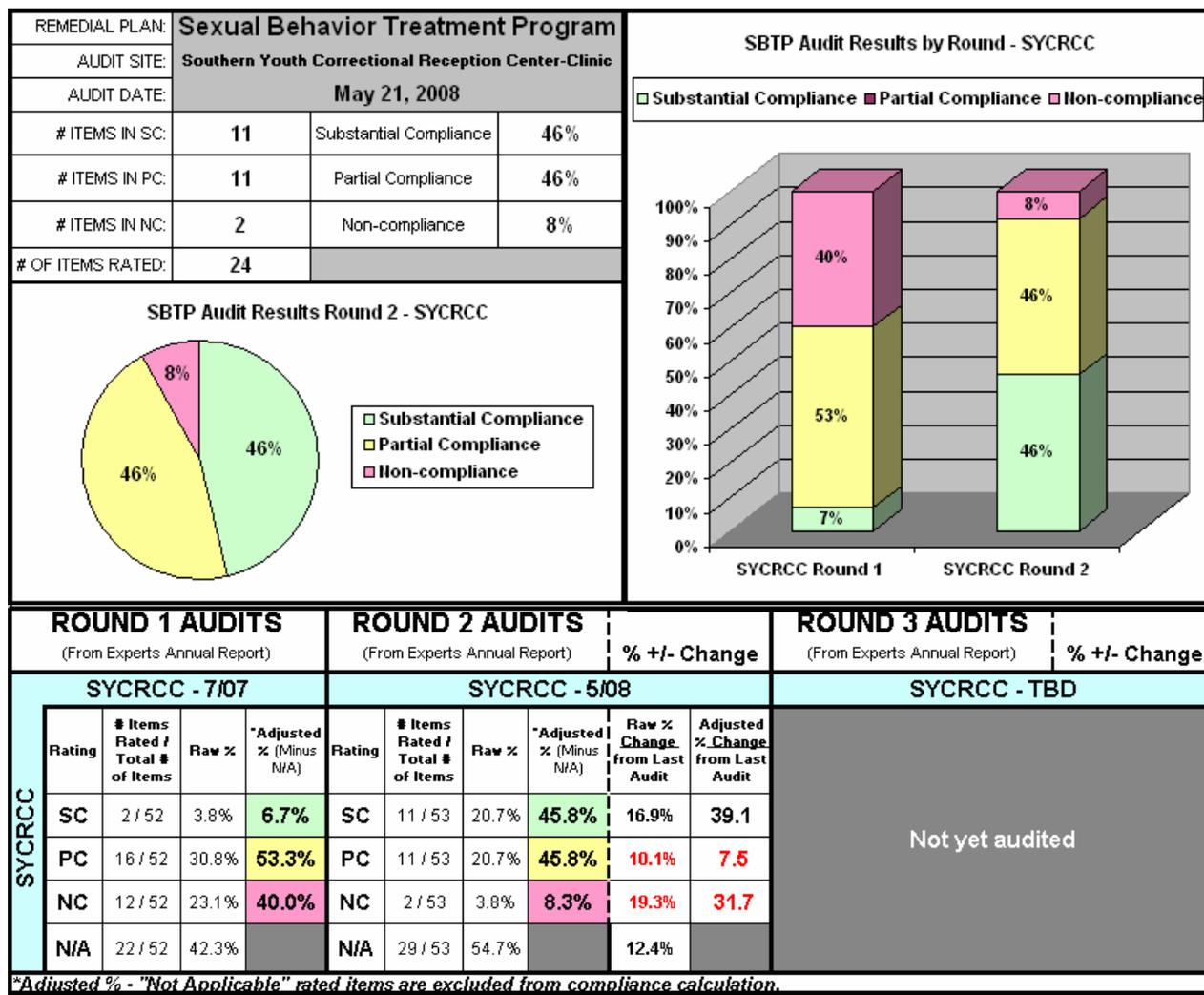


Figure 17: SBTP Audit Results – Southern Youth Correctional Reception Center-Clinic

- The facility increased its Substantial Compliance from Round One to Round Two and correspondingly decreased its Non-compliance percentage.
- The facility's Substantial Compliance percentage increased by 39% from Round One to Round Two and is now at 46%.
- The facility's Non-compliance percentage decreased by 32% from Round One to Round Two and is now at 8%.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 92%.

PRESTON YOUTH CORRECTIONAL FACILITY

The SBTP Expert last audited the Preston Youth Correctional Facility on April 28, 2008. The pie chart below identifies the results from this audit, and the bar graph on the right would have provided a side-by-side comparison from the facility's previous audit if it would have applied. Below these diagrams are the statistical data from this initial audit.

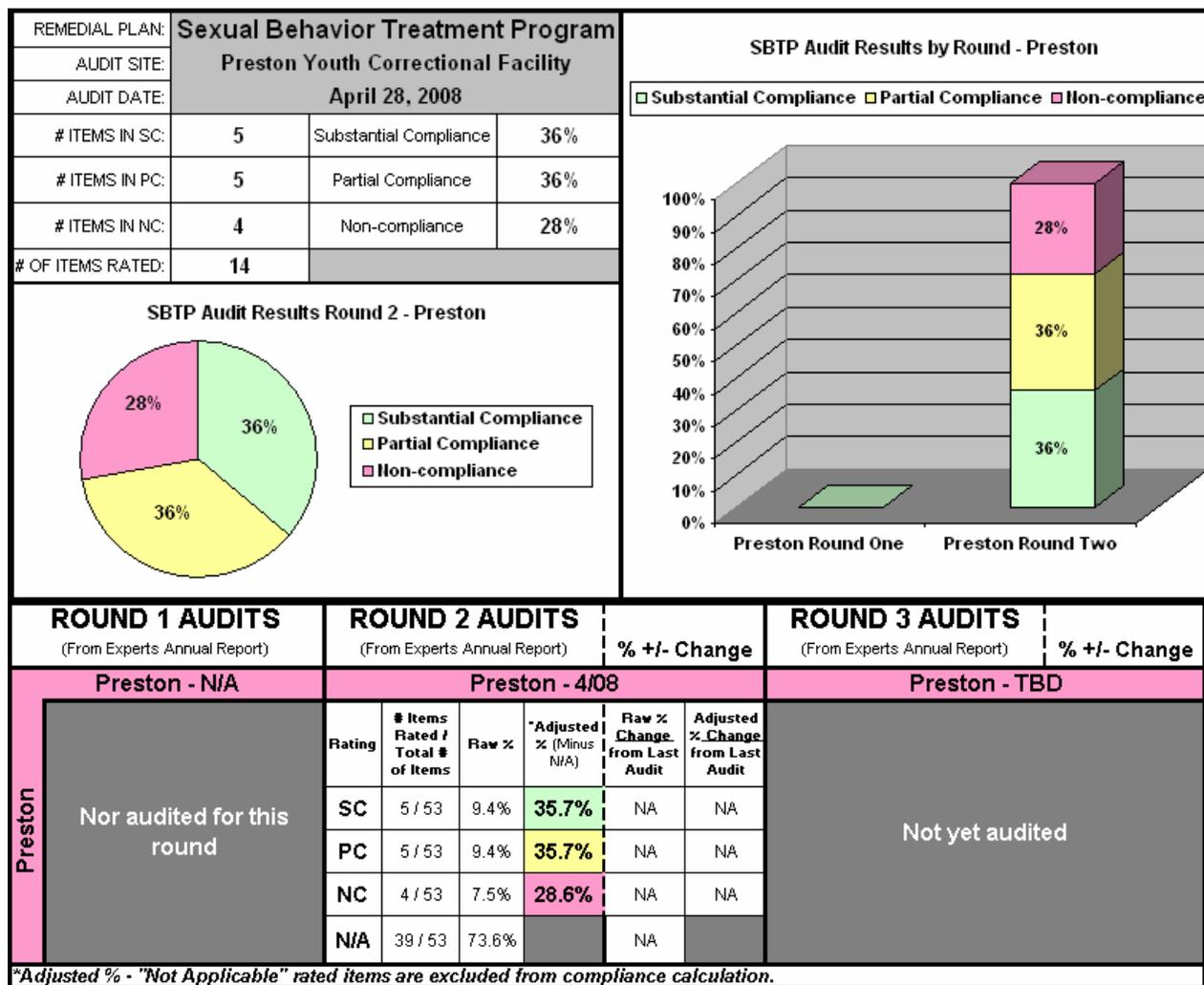


Figure 18: SBTP Audit Results - Preston Youth Correctional Facility

- This was the facility's first SBTP audit. Even though the Preston Youth Correctional Facility does not have a formal SBTP Program, it does have an informal program that the SBTP Expert assessed during her site visit. Not all of the action items in the SBTP audit tool apply to the informal program, and so the Expert assessed only those audit items that she deemed appropriate.
- The facility's Substantial Compliance percentage is 36%.
- The facility's Non-compliance percentage is 29%.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 71%.

DJJ "ADMINISTRATION"

Through several visits to DJJ Headquarters during the last round of audits, the SBTP Expert was able to assess audit items that she has now identified as "Administration"-specific. This was the first time that the SBTP Expert provided DJJ with Administration-specific compliance ratings.

The pie chart below identifies the results from this audit, and the bar graph would have provided a side-by-side comparison from the facility's previous audit if it would have applied. Below these diagrams are the statistical data from this initial audit.

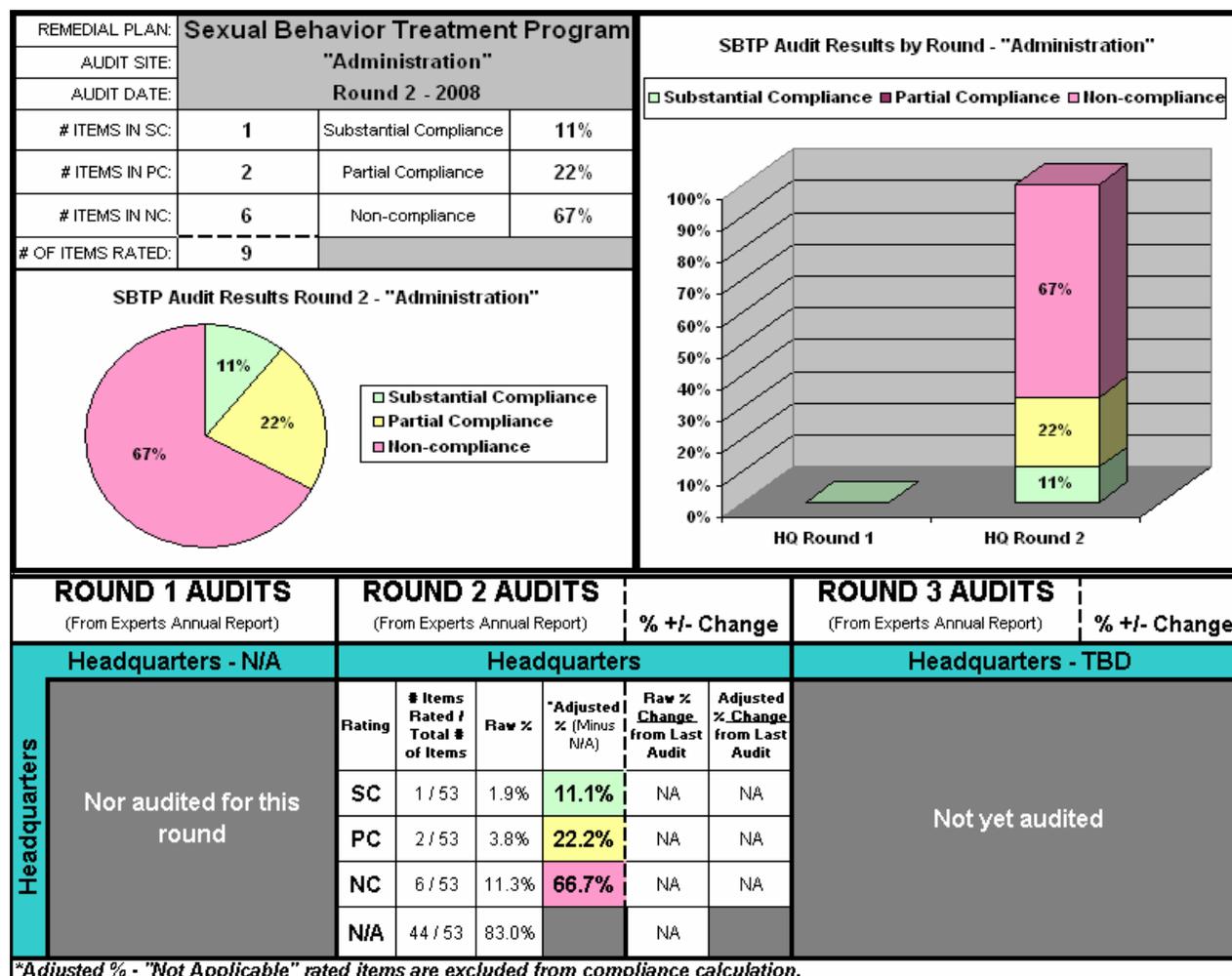


Figure 19: SBTP Audit Results – DJJ Administration

- This was the first SBTP audit of DJJ Headquarters-specific audit items, and there were a total of nine Administration-specific audit items that received a compliance rating.
- DJJ Headquarters' Substantial Compliance percentage was 11%.
- DJJ Headquarters' Non-compliance percentage was 67%.
- DJJ Headquarters' combined Substantial Compliance and Partial Compliance percentages total 33%.

SITE COMPARISON FOR ROUND TWO

The graph below illustrates the cumulative average compliance ratings for the SBTP's Round Two audit as well as compliance percentages for each of the six sites.

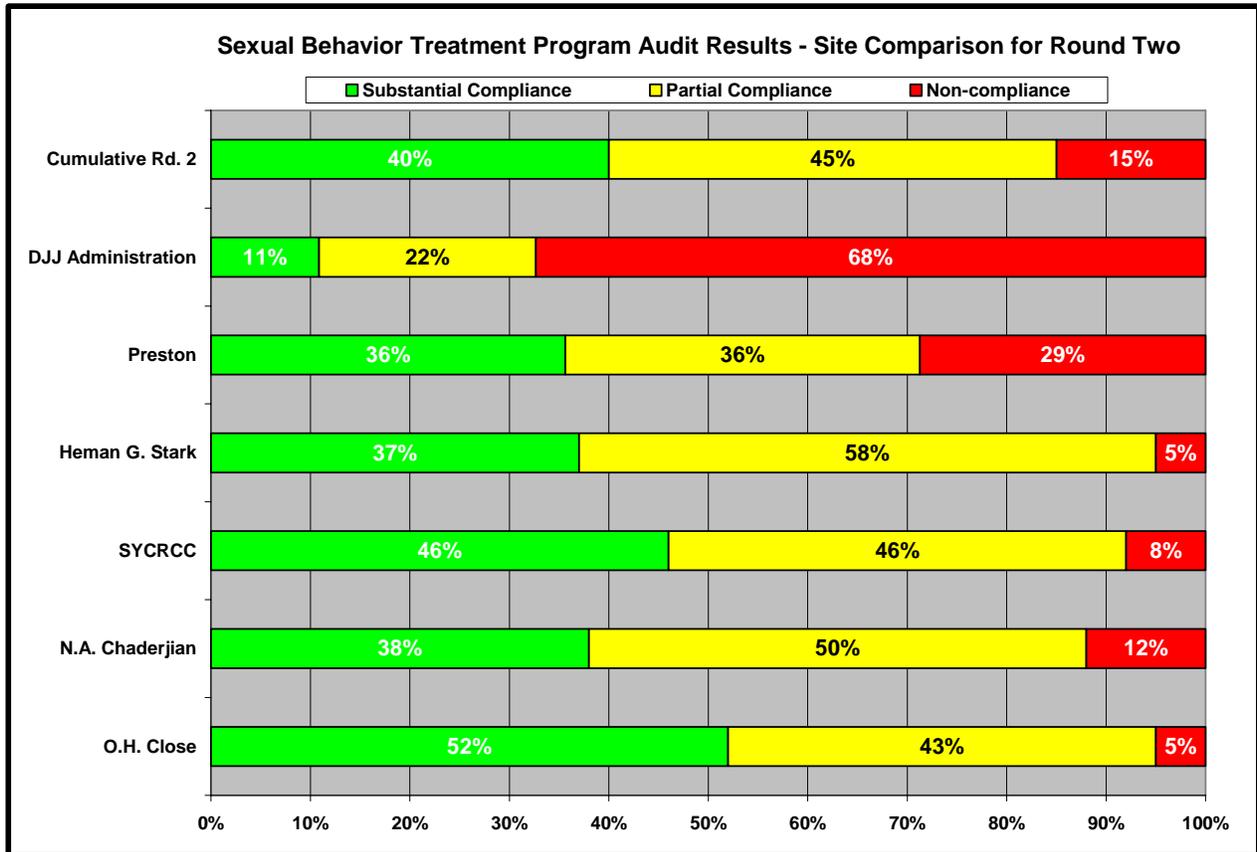


Figure 20: SBTP Audit Results – Site Comparison for Round Two

- Substantial Compliance for Round Two ranged from a high of 52% to a low of 11%.
- For the two sites with the lowest Substantial Compliance percentages, DJJ Administration (11%) and Preston Youth Correctional Facility (36%), this was the first time these two sites were audited.
- Partial Compliance for Round Two ranged from a high of 58% to a low of 22%.
- Non-compliance for Round Two ranged from a high of 68% to a low of 5%.
- The cumulative compliance averages for Round Two were:
 - Substantial Compliance at 40%
 - Partial Compliance at 45%
 - Non-compliance at 15%

SUBSTANTIAL COMPLIANCE COMPARISON

The graph below compares the Substantial Compliance percentages of the sites audited from Round One to Round Two. Please note that the Preston Youth Correctional Facility and DJJ Administration were not previously audited in Round One.

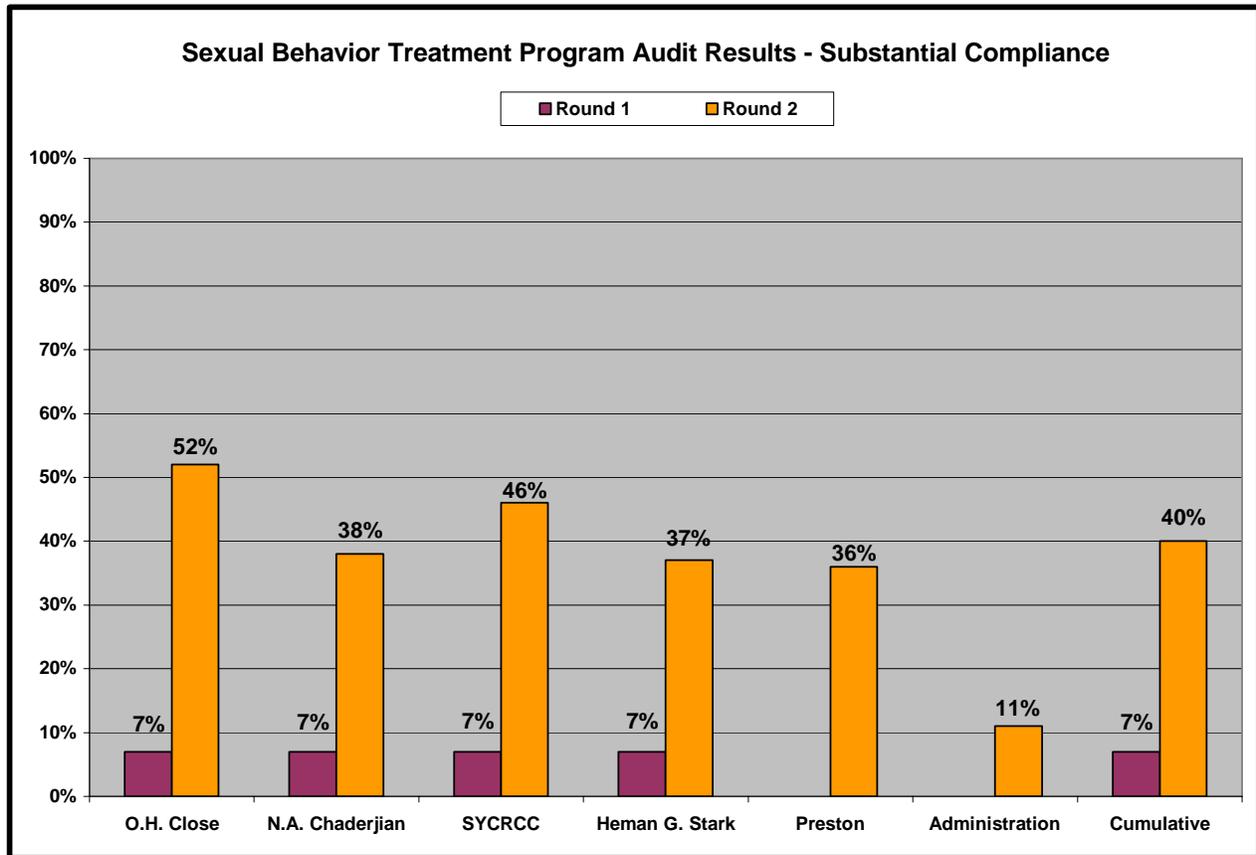


Figure 21: SBTP Audit Results – Substantial Compliance Comparison

- All sites that were audited in Round One increased their Substantial Compliance percentage in Round Two.
- O.H. Close Youth Correctional Facility had the largest gain in Substantial Compliance with an increase of 45% from Round One to Round Two.
- Heman G. Stark Youth Correctional Facility had the smallest increase in Substantial Compliance with an increase of 30% from Round One to Round Two.
- The cumulative average increase in Substantial Compliance from Round One to Round Two was 33%.

SUBSTANTIAL PLUS PARTIAL COMPLIANCE COMPARISON

A Partial Compliance rating, while not at the same high level as Substantial Compliance, does demonstrate that progress and work effort have been realized to move a particular audit item towards Substantial Compliance. The graph below combines the Substantial Compliance and Partial Compliance percentages for each site for each round of audits to demonstrate the amount of work that has been put forth in working toward Substantial Compliance. A percentage of 100% indicates that the facility does not have any audit items rated as being in Non-compliance.

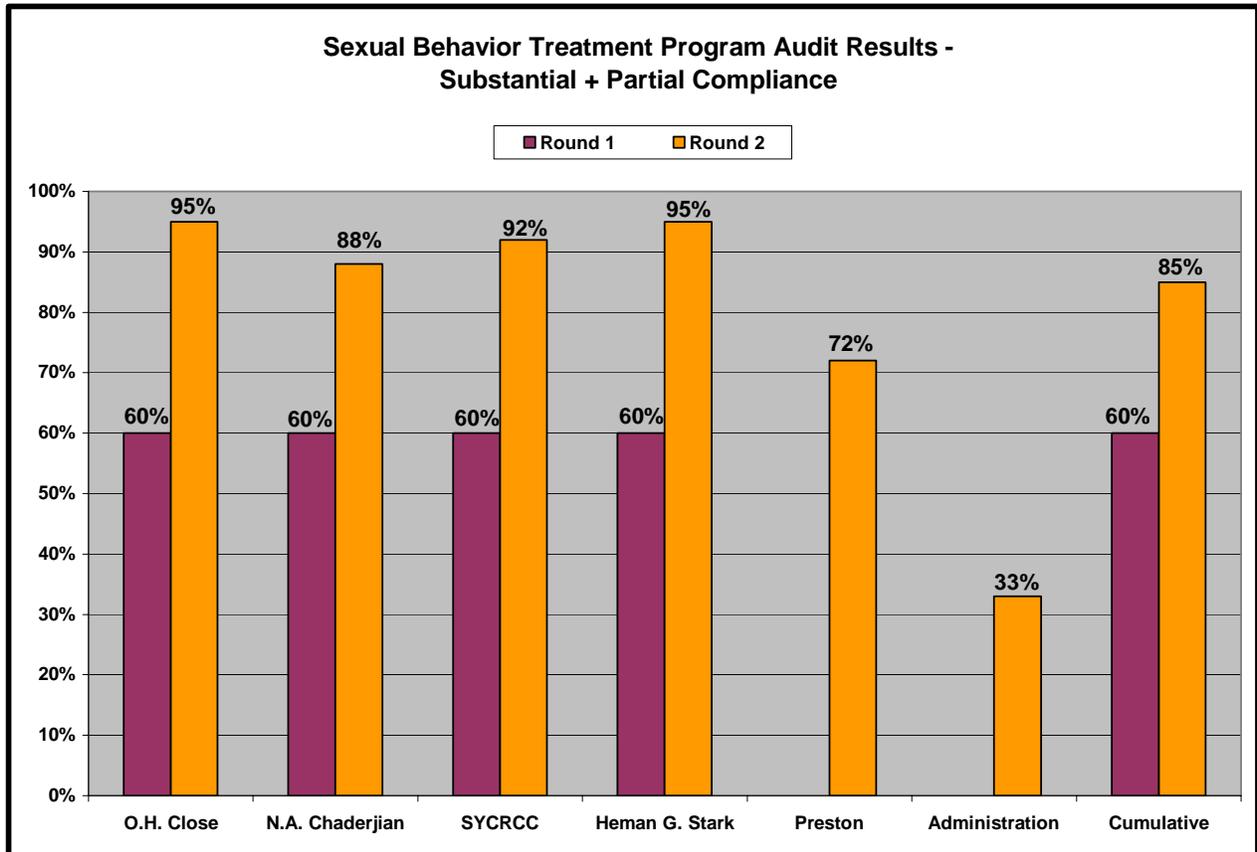


Figure 22: SBTP Audit Results – Substantial Plus Partial Compliance Comparison

- All sites audited in Round One increased their combined Substantial and Partial Compliance percentages in Round Two.
- The cumulative average in Round Two was 85%, representing an increase of 25% from Round One.

Even though progress has been made, it is important to note that DJJ still has work left to do to fully implement the SBTP Remedial Plan. The development and implementation of key policies, curriculum and training are still major benchmarks that must be achieved to make meaningful progress. DJJ is working closely with the SBTP Expert in these areas, and through this collaborative approach, DJJ will continue to improve the services provided to the youth in these programs.

2.2.4 Expert Feedback

DJJ has not received any compliance-specific feedback from the SBTP Expert during this last quarter.

2.2.5 Status of Specific Action Items

Relieved Items

Page 11, paragraph 23, of the Consent Decree states:

When a facility is found to be in substantial compliance on an issue for one full year, and is found to remain in substantial compliance after review by the relevant expert(s) one year later, expert tours regarding that issue at that facility shall end.

A “relieved” audit item is one that has met or exceeded the two-year Substantial Compliance threshold and for which the appropriate Expert has formally noted will be removed from that Expert’s future monitoring.

Currently, none of the SBTP audit items meet the time criteria identified in the Consent Decree to be deemed relieved.

Audit Items in Substantial Compliance Two Years or Longer

This is the SBTP Expert’s second round of audits, and there are no audit items that have met this time threshold.

Items Removed from Relieved Status

Since this is only the SBTP Expert’s second round of audits, there are no audit items that have met the time threshold, as identified in the Consent Decree, to be eligible to be relieved from future monitoring at this time.

Statewide Compliance Items

For Round Two, the SBTP Expert identified two action items being in Substantial Compliance at all applicable sites. When an action item receives a Substantial Compliance rating for every applicable site during a round of audits, this is referred to as being in “Statewide Compliance.” Items that are found to be in Statewide Compliance should not be confused with audit items that have been formally relieved from future Expert monitoring.

The chart below lists the two action items in which every site received a Substantial Compliance rating during the last round of audits.

SBTP Action Items in Statewide Compliance – Round Two			
DJJ #	Standard #	Action Item	Deadline
TBD	13a	The program uses multidisciplinary teams which conduct quarterly treatment reviews regarding client information.	N/A
TBD	21	CYA will retain a full time program coordinator of the SBTP who will orchestrate the establishment and ongoing operation of all facets of the SBTP.	N/A

Action Items with Majority Ratings of Non-compliance

In addition to identifying areas of progress, the SBTP Expert’s Annual Report also provides valuable information on the action items that require more attention and work before they will be deemed to satisfy the mandates of the SBTP Remedial Plan. Generally, these types of items require a higher level of inter-departmental coordination and are sometimes dependent on action items from other remedial plans being implemented, thus making them more challenging to implement in a timely manner.

The chart below identifies 12 SBTP action items which received a majority of Non-compliance ratings at the different facilities.

SBTP Action Items with Majority Ratings of Non-compliance – Round Two			
DJJ #	Standard #	Action Item	Deadline
TBD	1a	The expert will review the Program Manual and all policies and procedures to insure adequacy.	N/A
TBD	3a	Expert will review the instruments and protocol for the development and/or selection and administration of appropriate screening and assessment tools.	N/A
TBD	4g	The expert will review 10% of records for presence and appropriate-ness of group notes on maintenance groups for all program participants having completed Stage 10 documenting at least one hour of treatment a week following completion of residential treatment.	N/A
TBD	5a	The expert will review 10% of records for presence and adequacy of group notes documenting individual progress in at least two hours of group therapy per week.	N/A
TBD	6a	The expert will review for presence and adequacy the notes of residential large group minutes documenting that such two groups are held per week for a total of four hours per week.	N/A
TBD	6b	The expert will review committee and large group notes to ascertain whether program participants are participating in a variety of committees related to the operation of the residential treatment program.	N/A
TBD	9b	The expert will review documentation of outreach to victims’ agencies.	N/A
TBD	14a	The expert will review written procedures regarding confidentiality and informed consent.	N/A
TBD	14b	Audit will review 10% of randomly selected files for documents signed by program participants informing them of these policies.	N/A
TBD	15a	The expert will review 10% of clinical files of program completers for evidence that program completion was based on the completion of competency-based goals.	N/A
TBD	16a	The expert will review 10% of clinical records for documents reflecting program participants’ understanding of program rules related to suspension and termination.	N/A
TBD	26b	The expert will review the content of training materials to insure that quality training is being provided is suitable.	N/A

2.2.6 Proof of Practice

The following chart identifies the Proof of Practice documents relating to the SBTP Remedial Plan that have been sent to both the SBTP Expert and the Special Master during the last quarter. The Proof of Practice documents provide evidence of DJJ's efforts to come into Substantial Compliance with the specific audit items.

SBTP Proof of Practice Documents Submitted During the Last Quarter				
POP #	Sect. #	Audit Item Description	Documents Submitted	Date Submitted
278	N/A	N/A	<p>1 – Organizational chart depicting the formal structure of DJJ's Sexual Behavior Treatment Program (SBTP) and the relationships between management staff at DJJ Headquarters and staff at the facility level (1 page).</p> <p>This organizational chart is being provided to the SBTP Expert to demonstrate the linkages and chain of command among and between SBTP staff at the Headquarters level and the facility level.</p>	11/05/08
283	1	<p>Policies and Procedures Which Establish and Govern the Administration of the Sexual Behavior Treatment Program</p> <p><i>"Written and officially approved policies and procedures will be included in a Program Manual that describes in detail the implementation of the Sexual Behavior Treatment Program"</i></p>	<p>1 – Policy draft of the Sexual Behavior Treatment Program Overview (10 pages). This draft of the Sexual Behavior Treatment Program (SBTP) Overview is being submitted to the SBTP Expert for her review. This policy draft provides a description of the treatment services, programs, and models that DJJ's SBTP will encompass and utilize. This draft, when finalized, will fulfill the requirements of the SBTP Audit Tool, Standard No. 1.</p> <p>As such, DJJ respectfully requests that the SBTP Expert review this Program Overview policy draft and provide feedback on this document. DJJ would like to receive the Expert's feedback by Friday, December 5, 2008, by the close of business.</p>	11/20/08
286	N/A	N/A	<p>1 – Document entitled "Key Audit Items for Expert's Verification" (31 pages). This document is being submitted to the Sex Behavior Treatment Program Expert to allow her the opportunity to review it and ensure that the document correctly identifies the items that were submitted.</p> <p>This constitutes DJJ's second submission of the reporting tool to the Expert. This submission also contains additional information that DJJ relied upon in drafting the reporting tool, including information provided by and/or derived from consultations with the Expert.</p>	11/20/08

SBTP Proof of Practice Documents Submitted During the Last Quarter				
POP #	Sect. #	Audit Item Description	Documents Submitted	Date Submitted
291	4	<p>Multi-Modal Treatment Model-Residential Component</p> <p><i>"The treatment program provides a multi-modal, multi-disciplinary and offense-specific model which is responsive to the evolving research on treatment efficacy in the field of treating youths with sexual behavior."</i></p>	<p>1 – "The Good Lives Model" (5 pages);</p> <p>2 – G-MAP comprehensive assessment sample (12 pages);</p> <p>3 – Good Lives Case Formulation training Example (2 pages);</p> <p>4 – "Interpreting Primary Needs from Behaviours," a document containing questions from G-MAP (1 page);</p> <p>5 – The Good Lives Model training summary (22 pages);</p> <p>6 – The Good Lives Model Treatment Plan Instructions (10 pages);</p> <p>7 – Lerversee's list of "Primary Human Goods/Protective Factors" (2 pages); and</p> <p>8 – Lerversee hand-out entitled, "Exploring a Holistic Model that Addresses Decreased Risk and Increased Health" (4 pages).</p> <p>These materials are being used in the juvenile sex offender residential treatment programs in the United Kingdom and include materials for the G-MAP Project (documents 1 through 6 above) as well as those developed for the Colorado Division of Youth Corrections (documents number 7 and 8 above). These documents were gathered as part of DJJ's efforts in researching the residential treatment programs utilized in treating juvenile sex offenders.</p>	11/19/08

2.2.7 Summary and Application of Audit Findings

Much of the SBTP's progress is dependent on the development and implementation of a program curriculum which has been delayed by contractual issues. DJJ is currently working closely with the SBTP Expert to review the appropriate steps and materials to remedy this situation. DJJ is very grateful for the SBTP Expert's input and willingness to work with DJJ and for any assistance she can provide in helping DJJ overcome the current barriers that prevent the SBTP from achieving full implementation.

2.3 Wards with Disabilities Program

2.3.1 Historical Audit Perspective

Court Filings

The Wards with Disabilities Program (WDP) Remedial Plan filed with the Court on May 31, 2005, was the third *Farrell* Remedial Plan to be filed. The audit tool, also referred to as the Standards and Criteria, was filed simultaneously with the Remedial Plan.

Audit Tool

The Wards with Disabilities Program audit tool contains 122 different action items. Associated with those 122 action items are approximately 566 individual audit items. This number has decreased due to the recent closure of two facilities. These 566 audit items are the total number of compliance ratings that DJJ is responsible for achieving compliance with during a complete round of auditing.

Of the 122 action items within the Wards with Disabilities Program audit tool, 25 of the action items have a specific deadline for implementation.

Audit Tool Breakdown

Audit Item Numbers Based on Six Facilities	Filing Dates		"Action Items"			"Audit Items"		
	Remedial Plan	Audit Tool	# of Action Items with a Deadline	# of Action Items without a Deadline	Total # of Action Items	# of Audit Items with a Deadline	# of Audit Items without a Deadline	Total # of Audit Items
Wards with Disabilities Program	5/31/05	5/31/05	25	97	122	81	485	566

Audit History

The time-spans for each of the three rounds of Wards with Disabilities Program monitoring, conducted at the facility level, are as follows:

- Round One: September 2005 to April 2006;
- Round Two: October 2006 to April 2007; and
- Round Three: September 2007 to May 2008.

The following chart provides a more detailed listing of all the Wards with Disabilities Program facility audits to date:

WDP	ROUND ONE	ROUND TWO		ROUND THREE	
Facility	Date Audited	Date Audited	Time Since Last Audit	Date Audited	Time Since Last Audit
DeWitt Nelson	Sep. 2005	Feb. 2007	17 months	Oct. 2007	8 months
El Paso de Robles	Oct. 2005	Dec. 2006	14 months	Apr. 2008	16 months
Ventura	Nov. 2005	Mar. 2007	16 months	Nov. 2007 & Mar. 2008	8 & 4 months
SYCRCC	Feb. 2006	April 2007	14 months	Jan. 2008 & May 2008	8 & 5 months
Heman G. Stark	Dec. 2005	Jan. 2007	13 months	Dec. 2007 & Mar. 2008	11 & 3 months
N.A. Chaderjian	Feb. 2006	Oct. 2006	8 months	Jan. 2008 & Apr. 2008	14 & 4 months
O.H. Close	Mar. 2006	Oct. 2006	7 months	Jan. 2008 & Apr. 2008	14 & 4 months
Preston	April 2006	Feb. 2007	10 months	Sept. 2007 & Apr. 2008	7 & 7 months

Future Audit Schedule

The schedule below is the Wards with Disabilities Program Expert’s audit schedule for his Round Four audits. Unlike the other *Farrell* Experts, the Wards with Disabilities Program Expert visits each facility twice during a round of audits before providing DJJ with facility-specific compliance ratings.

- Preston Youth Correctional Facility — October 21, 2008, and January 8, 2009
- O.H. Close Youth Correctional Facility — October 22, 2008, and February 19, 2009
- N.A. Chaderjian Youth Correctional Facility — October 23, 2008, and February 18, 2009
- Southern Youth Correctional Reception Center-Clinic — November 14, 2008, and April 9, 2009
- Heman G. Stark Youth Correctional Facility — December 9, 2008, and March 18, 2009
- Ventura Youth Correctional Facility — December 10, 2008, and March 19, 2009
- DJJ Headquarters — April 24, 2009

2.3.2 Most Recent Audit Findings

Audit Reports Received During Last Quarter

DJJ has received four informal facility reports from the Wards with Disabilities Program Expert during this last quarter. These reports were for Preston Youth Correctional Facility, O.H. Close Youth Correctional Facility, N.A. Chaderjian Youth Correctional Facility, and the Southern Youth Correctional Reception Center-Clinic. These reports do not contain compliance ratings but do contain information on areas that are progressing well and areas which are not – hence, while DJJ considers these reports to be helpful, for the purpose of recording compliance data, it regards those initial facility reports to be informal.

These informal reports help DJJ identify areas that it must improve upon and provides DJJ with time to address some of these deficiencies prior to the Expert's second audit of the facility in which that audit is more structured on providing specific compliance ratings. The Expert's compliance ratings are then provided to DJJ for all of the facilities and Headquarters in the Expert's Annual Report which is provided to DJJ sometime around the end of the fiscal year.

2.3.3 Wards with Disabilities Program Audit Results

Audit Results Introduction

The Wards with Disabilities Program charts on the following pages document the most up-to-date compliance ratings for each site audited by the Wards with Disabilities Program Expert. The compliance percentages are derived from the compliance data provided by the Wards with Disabilities Program Expert in his Annual Report. These charts also include the cumulative results of the most recent round of audits as well as a comparison of a facility's prior audit results in previous rounds with the most recent one. Attached at the bottom of these charts are the statistical data for each audit performed for the identified site.

The percentages identified in the following charts have been rounded off and therefore, may have a slight variance of no more than 1% of either less than or greater than 100%. For example, in adding up the different compliance percentages, the sum total for a given site could either be 99%, 100%, or 101% due to rounding.

To fully help understand the charts on the following pages, the abbreviations, color codes, and terms below are more clearly defined:

- **SC** = Substantial Compliance and is shaded in green.
- **PC** = Partial Compliance and is shaded in yellow.
- **NC** = Non-compliance and is shaded in red.
- **N/A** = Not Applicable and is shaded in gray.
- **Numbers in red font** = A negative number denoting a decrease in a compliance percentage.
- **Raw %** = The compliance percentages with the number of N/A items included in the calculations.
- **Adjusted %** = The compliance percentages with the number of N/A items excluded from the calculations. This is the number used by DJJ to identify the compliance percentage for a given site.
- ***UPDATED THIS QUARTER:** = Identifies charts and graphs that have been updated since the last Quarterly Report.

CUMULATIVE RESULTS

The pie chart below identifies the cumulative average for all of the compliance data received during the Wards with Disabilities Program Expert's last round of audits. The bar graph on the right provides a side-by-side comparison of the cumulative data from the previous round of audits. Below these diagrams are the statistical data from each of those audits.

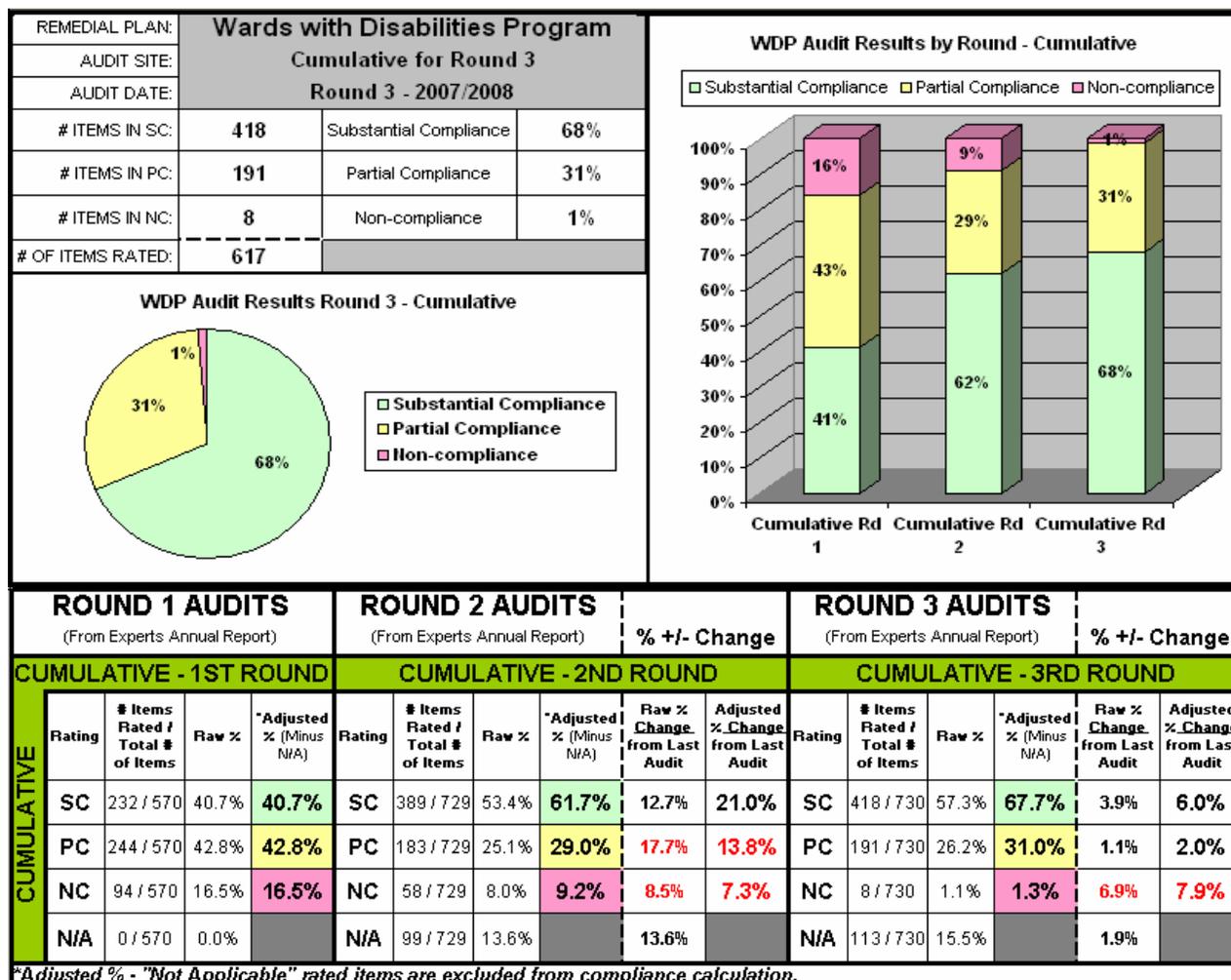


Figure 23: Wards with Disabilities Program Audit Results – Cumulative

- DJJ has increased its cumulative Substantial Compliance percentage after every round of audits and correspondingly decreased its Non-compliance percentage after each round.
- DJJ's cumulative Substantial Compliance percentage has increased by an average of 13% after each round of audits.
- DJJ's cumulative Non-compliance percentage has decreased by an average of 8% after each round of audits.
- DJJ's cumulative combined Substantial Compliance and Partial Compliance percentages total 99%.

N.A. CHADERJIAN YOUTH CORRECTIONAL FACILITY

The Wards with Disabilities Program Expert last audited the N.A. Chaderjian Youth Correctional Facility on January 24, 2008, and on April 22, 2008. The pie chart below identifies the results from this audit and the bar graph on the right provides a side-by-side comparison from the facility's previous audits. Below these diagrams are the statistical data from each of those audits.

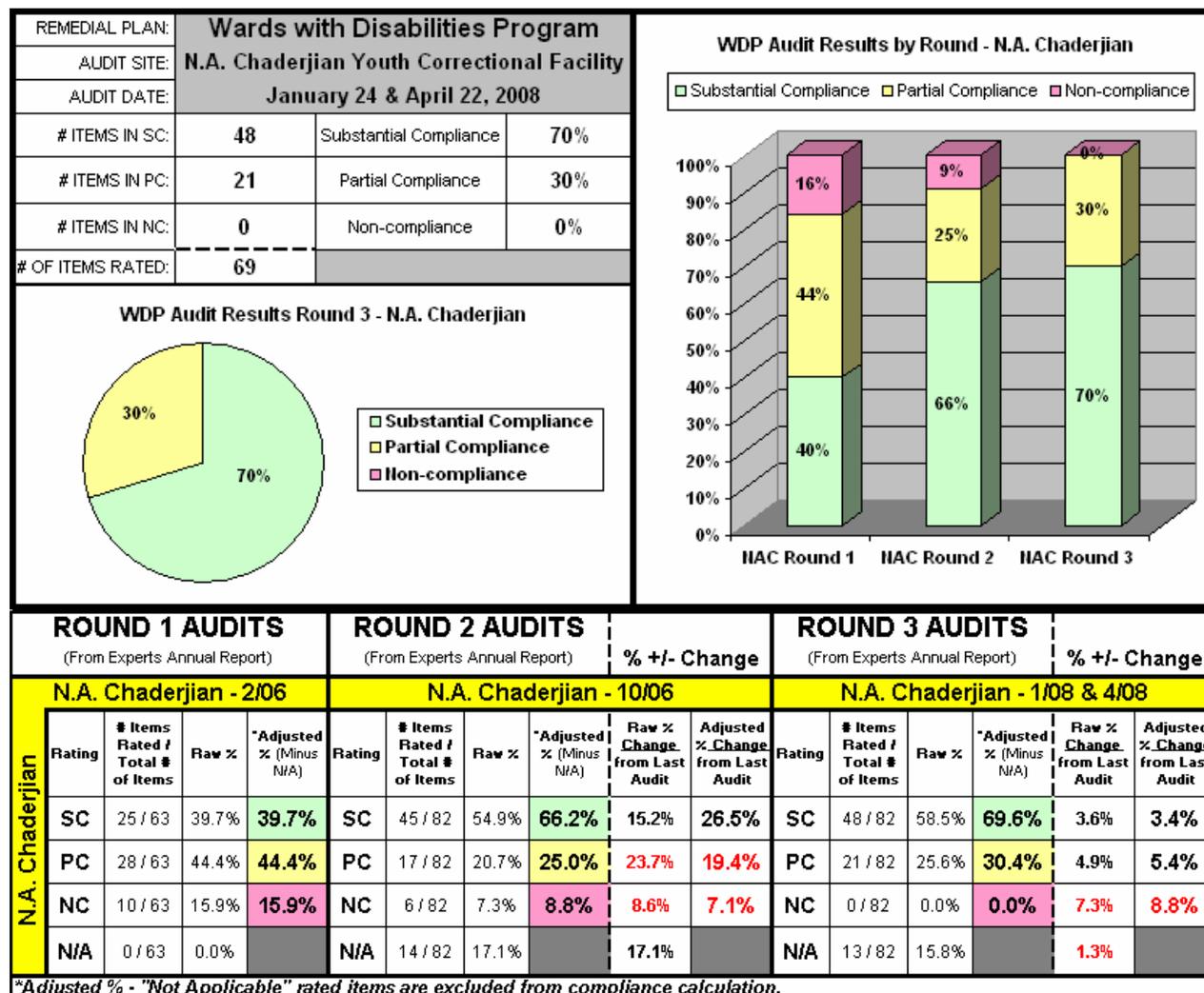


Figure 24: Wards with Disabilities Program Audit Results – N.A. Chaderjian Youth Correctional Facility

- The facility has increased its Substantial Compliance percentage after every round of audits and correspondingly decreased its Non-compliance percentage after each round.
- The facility's Substantial Compliance percentage has increased by an average of 15% after each round of audits.
- The facility's Non-compliance percentage has decreased by an average of 8% after each round of audits.
- The facility's cumulative Substantial Compliance and Partial Compliance percentages total 100%.

O.H. CLOSE YOUTH CORRECTIONAL FACILITY

The Wards with Disabilities Program Expert last audited the O.H. Close Youth Correctional Facility on January 23, 2008, and on April 23, 2008. The pie chart below identifies the results from this audit and the bar graph on the right provides a side-by-side comparison from the facility's previous audits. Below these diagrams are the statistical data from each of these audits.

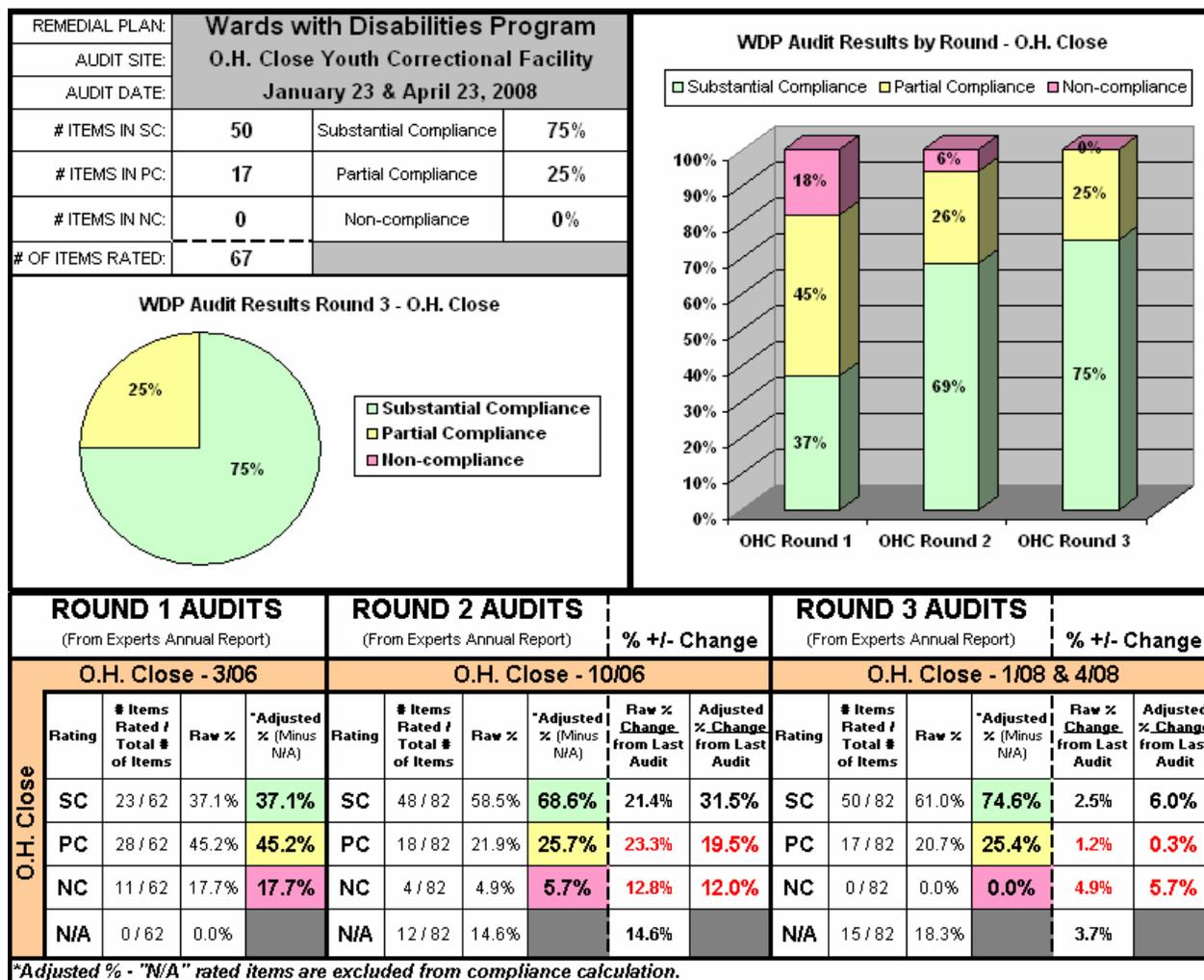


Figure 25: Wards with Disabilities Program Audit Results – O.H. Close Youth Correctional Facility

- The facility has increased its Substantial Compliance percentage after every round of audits and correspondingly decreased its Non-compliance percentage after each round.
- The facility's Substantial Compliance percentage has increased by an average of 19% after each round of audits.
- The facility's Non-compliance percentage has decreased by an average of 9% after each round of audits.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 100%.

HEMAN G. STARK YOUTH CORRECTIONAL FACILITY

The Wards with Disabilities Program Expert last audited the Heman G. Stark Youth Correctional Facility on December 11, 2007, and on March 11, 2008. The pie chart below identifies the results from this audit and the bar graph on the right provides a side-by-side comparison from the facility's previous audits. Below these diagrams are the statistical data from each of these audits.

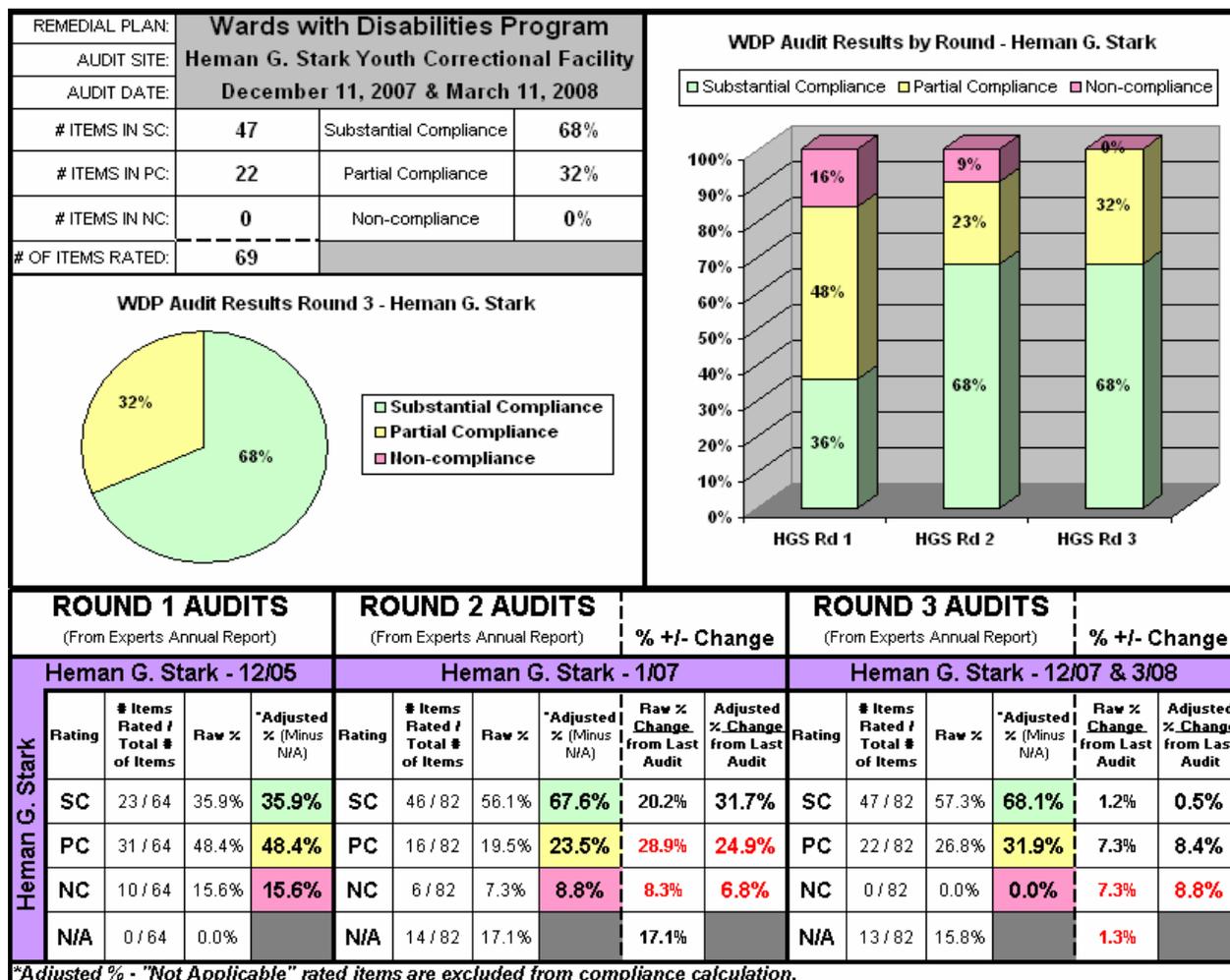


Figure 26: Wards with Disabilities Program Audit Results – Heman G. Stark Youth Correctional Facility

- The facility has increased its Substantial Compliance percentage after every round of audits and correspondingly decreased its Non-compliance percentage after each round.
- The facility's Substantial Compliance percentage has increased by an average of 16% after each round of audits.
- The facility's Non-compliance percentage has decreased by an average of 8% after each round of audits.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 100%.

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER-CLINIC

The Wards with Disabilities Program Expert last audited the Southern Youth Correctional Reception Center-Clinic on January 10, 2008, and May 20, 2008. The pie chart below identifies the results from this audit and the bar graph on the right provides a side-by-side comparison from the facility's previous audits. Below these diagrams are the statistical data from each of these audits.

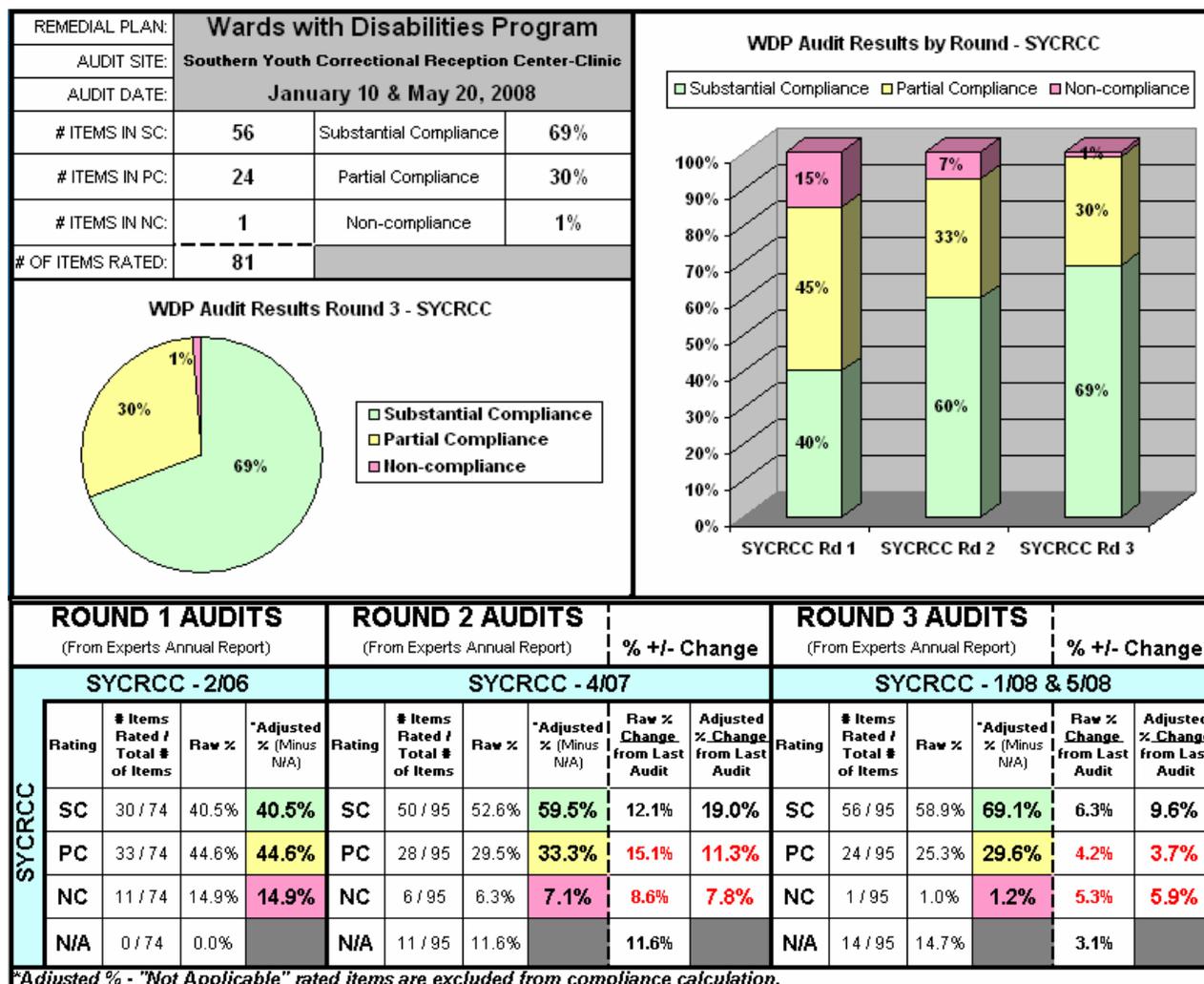


Figure 27: Wards with Disabilities Program Audit Results – Southern Youth Correctional Reception Center-Clinic

- The facility has increased its Substantial Compliance percentage after every round of audits and correspondingly decreased its Non-compliance percentage after each round.
- The facility's Substantial Compliance percentage has increased by an average of 14% after each round of audits.
- The facility's Non-compliance percentage has decreased by an average of 7% after each round of audits.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 99%.

PRESTON YOUTH CORRECTIONAL FACILITY

The Wards with Disabilities Program Expert last audited the Preston Youth Correctional Facility on September 20, 2007, and April 1, 2008. The pie chart below identifies the results from this audit and the bar graph on the right provides a side-by-side comparison from the facility's previous audits. Below these diagrams are the statistical data from each of these audits.

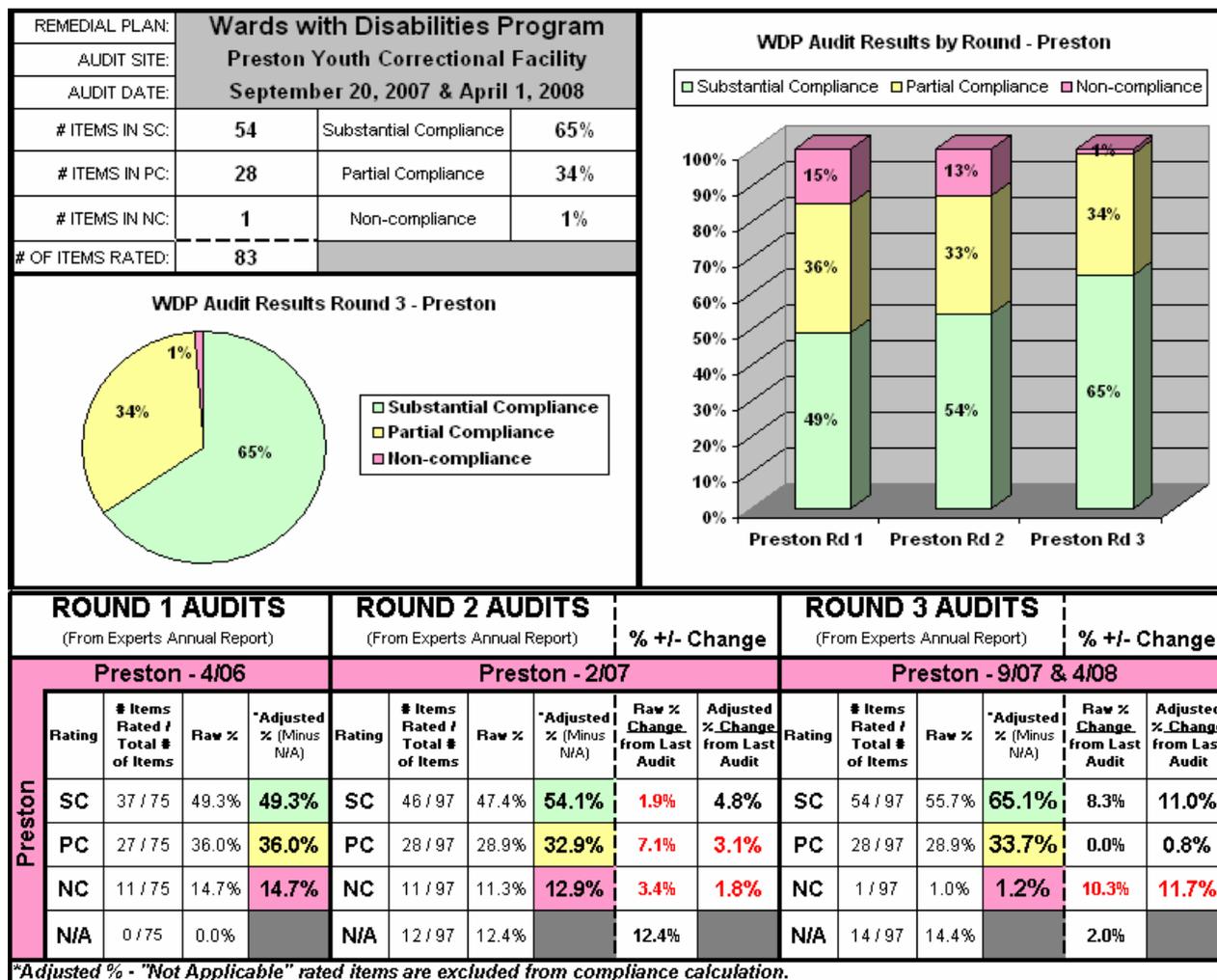


Figure 28: Wards with Disabilities Program Audit Results – Preston Youth Correctional Facility

- The facility has increased its Substantial Compliance percentage after every round of audits and correspondingly decreased its Non-compliance percentage after each round.
- The facility's Substantial Compliance percentage has increased by an average of 8% after each round of audits.
- The facility's Non-compliance percentage has decreased by an average of 7% after each round of audits.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 99%.

VENTURA YOUTH CORRECTIONAL FACILITY

The Wards with Disabilities Program Expert last audited the Ventura Youth Correctional Facility on November 20, 2007, and March 12, 2008. The pie chart below identifies the results from this audit and the bar graph on the right provides a side-by-side comparison from the facility's previous audits. Below these diagrams are the statistical data from each of these audits.

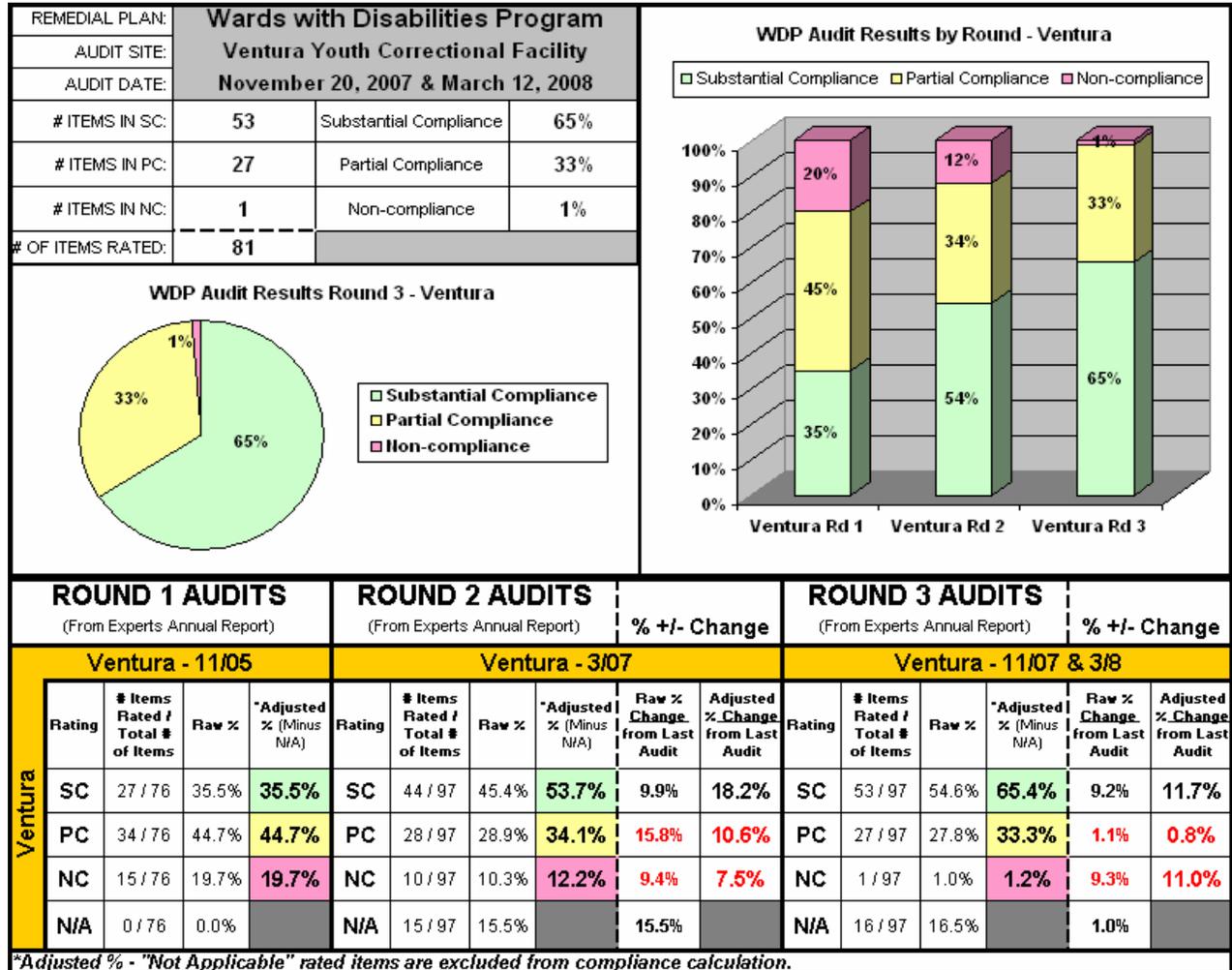


Figure 29: Wards with Disabilities Program Audit Results – Ventura Youth Correctional Facility

- The facility has increased its Substantial Compliance percentage after every round of audits and correspondingly decreased its Non-compliance percentage after each round.
- The facility's Substantial Compliance percentage has increased by an average of 15% after each round of audits.
- The facility's Non-compliance percentage has decreased by an average of 9% after each round of audits.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 99%.

EL PASO DE ROBLES YOUTH CORRECTIONAL FACILITY

The Wards with Disabilities Program Expert last audited the El Paso de Robles Youth Correctional Facility on April 29, 2008. The pie chart below identifies the results from this audit, and the bar graph on the right provides a side-by-side comparison from the facility's previous audits. Below these diagrams are the statistical data from each of these audits. It is important to note that this facility has since been closed and will no longer be audited in the future.

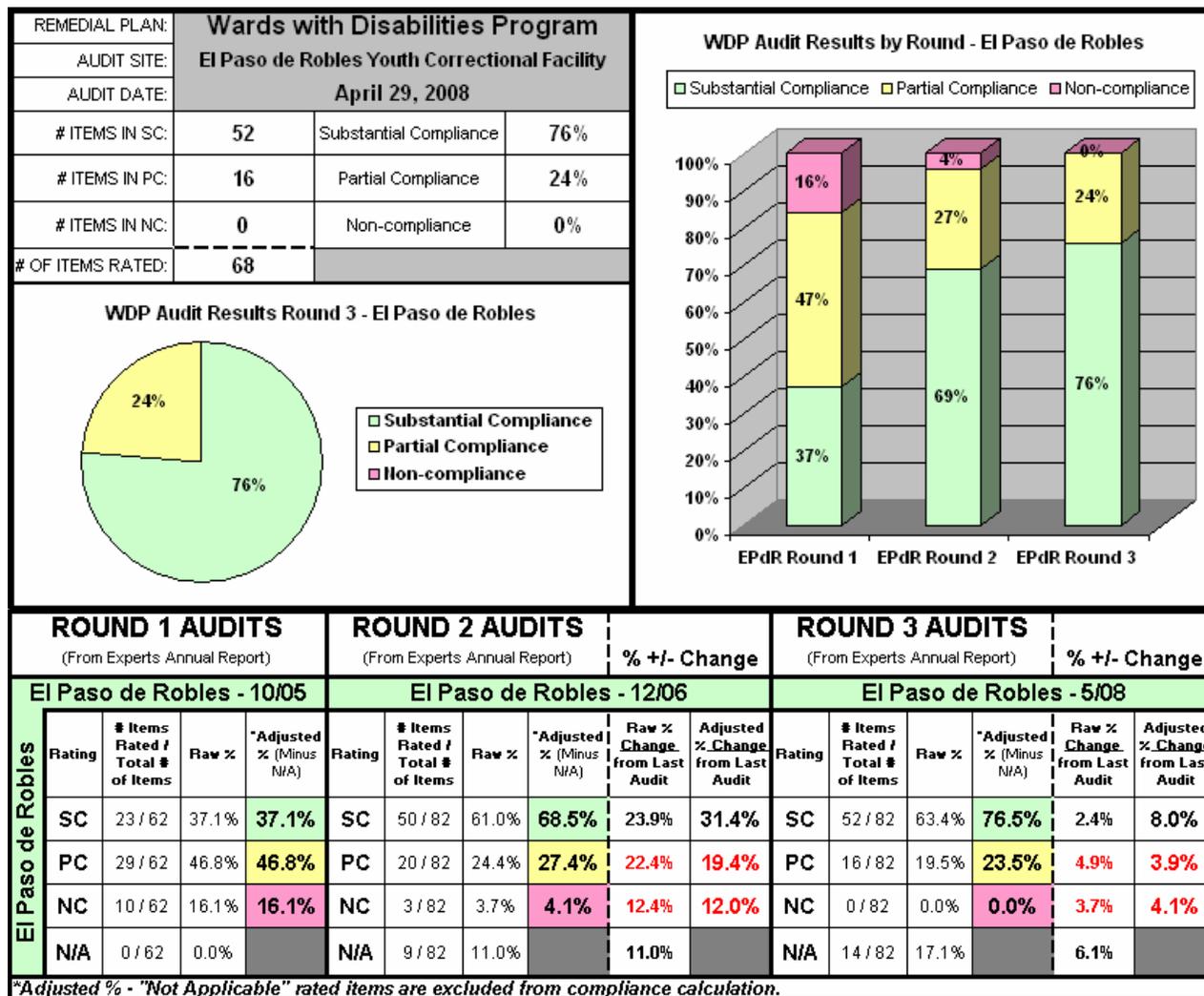


Figure 30: Wards with Disabilities Program Audit Results – El Paso de Robles Youth Correctional Facility

- The facility has increased its Substantial Compliance percentage after every round of audits and correspondingly decreased its Non-compliance percentage after each round.
- The facility's Substantial Compliance percentage has increased by an average of 20% after each round of audits.
- The facility's Non-compliance percentage has decreased by an average of 8% after each round of audits.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 100%.

DEWITT NELSON YOUTH CORRECTIONAL FACILITY

The Wards with Disabilities Program Expert last audited the DeWitt Nelson Youth Correctional Facility on October 30, 2008. The pie chart below identifies the results from this audit, and the bar graph on the right provides a side-by-side comparison from the facility's previous audits. Below these diagrams are the statistical data from each of these audits. It is important to note that this facility has since been closed and will no longer be audited in the future.

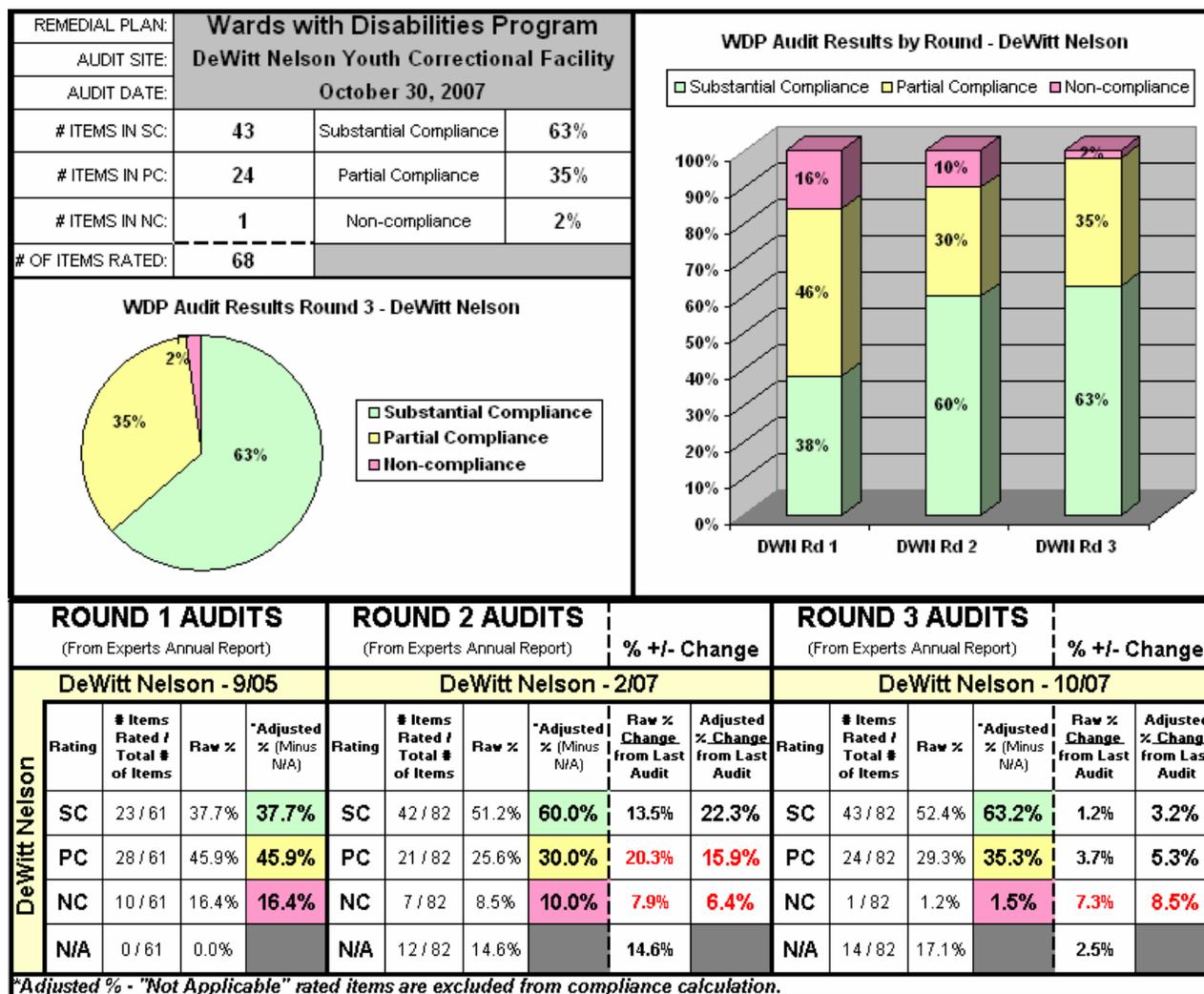


Figure 31: Wards with Disabilities Program Audit Results – DeWitt Nelson Youth Correctional Facility

- The facility has increased its Substantial Compliance percentage after every round of audits and correspondingly decreased its Non-compliance percentage after each round.
- The facility's Substantial Compliance percentage has increased by an average of 13% after each round of audits.
- The facility's Non-compliance percentage has decreased by an average of 7% after each round of audits.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 98%.

DJJ HEADQUARTERS

The Wards with Disabilities Program Expert last audited DJJ Headquarters on June 3, 2008. The pie chart below identifies the results from this audit, and the bar graph on the right provides a side-by-side comparison from previous audits of Headquarters. Below these diagrams are the statistical data from each of these audits.

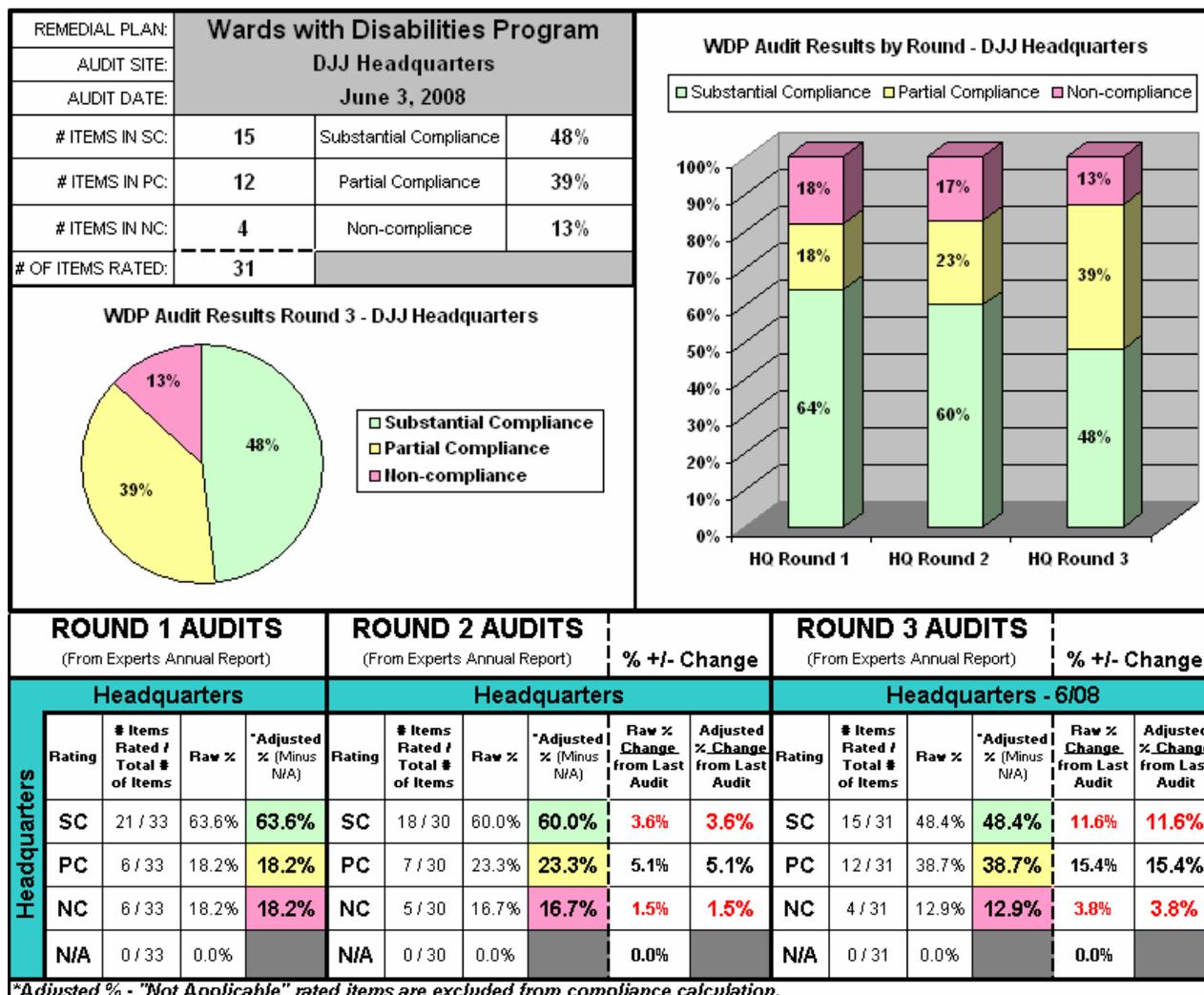


Figure 32: Wards with Disabilities Program Audit Results – DJJ Headquarters

- DJJ Headquarters has decreased its Substantial Compliance percentage after every round of audits but has also been able to decrease its Non-compliance percentage after each round.
- DJJ Headquarters' Substantial Compliance percentage has decreased by an average of 8% after each round of audits.
- DJJ Headquarters' Non-compliance percentage has decreased by an average of 3% after each round of audits.
- DJJ Headquarters' combined Substantial Compliance and Partial Compliance percentages total 87%.

SITE COMPARISON FOR ROUND THREE

The graph below illustrates the compliance percentages for the eight facilities audited by the Wards with Disabilities Program Expert during the last round of audits as well as the cumulative average of those audits.

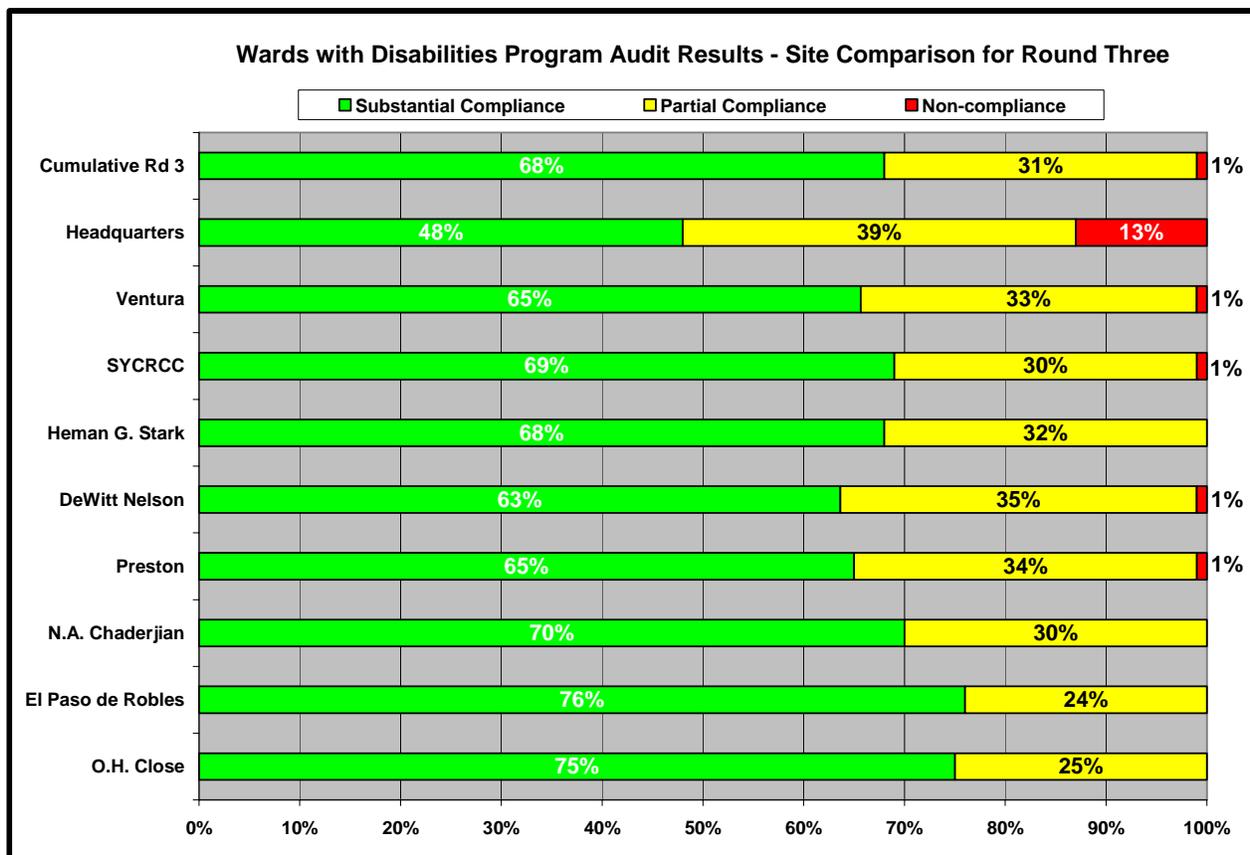


Figure 33: Wards with Disabilities Program Audit Results – Site Comparison for Round Three

- For Round Three, the Wards with Disabilities Program Expert assessed DJJ to be 68% in Substantial Compliance, 31% in Partial Compliance, and 1% in Non-compliance.
- A total of 617 audit items received a compliance rating for Round Three. Of these 617 audited items, 418 received a Substantial Compliance rating, 191 received a Partial Compliance rating, and 8 received a Non-compliance rating.
- Two facilities had an 11% increase or more in their Substantial Compliance percentage: Preston Youth Correctional Facility with 11.0% and Ventura Youth Correctional Facility with 11.7%.
- Two facilities are at or above 75% in Substantial Compliance: O.H. Close Youth Correctional Facility and El Paso de Robles Youth Correctional Facility.
- Four facilities did not have any item rated as being in Non-compliance: O.H. Close Youth Correctional Facility, El Paso de Robles Youth Correctional Facility, N.A. Chaderjian Youth Correctional Facility, and Heman G. Stark Youth Correctional Facility. The other four remaining facilities had just a single item each that was rated as being in Non-compliance.

SUBSTANTIAL COMPLIANCE COMPARISON

The graph below identifies the Substantial Compliance percentage for each audited site by the Wards with Disabilities Program Expert for each of the three rounds of audits to date.

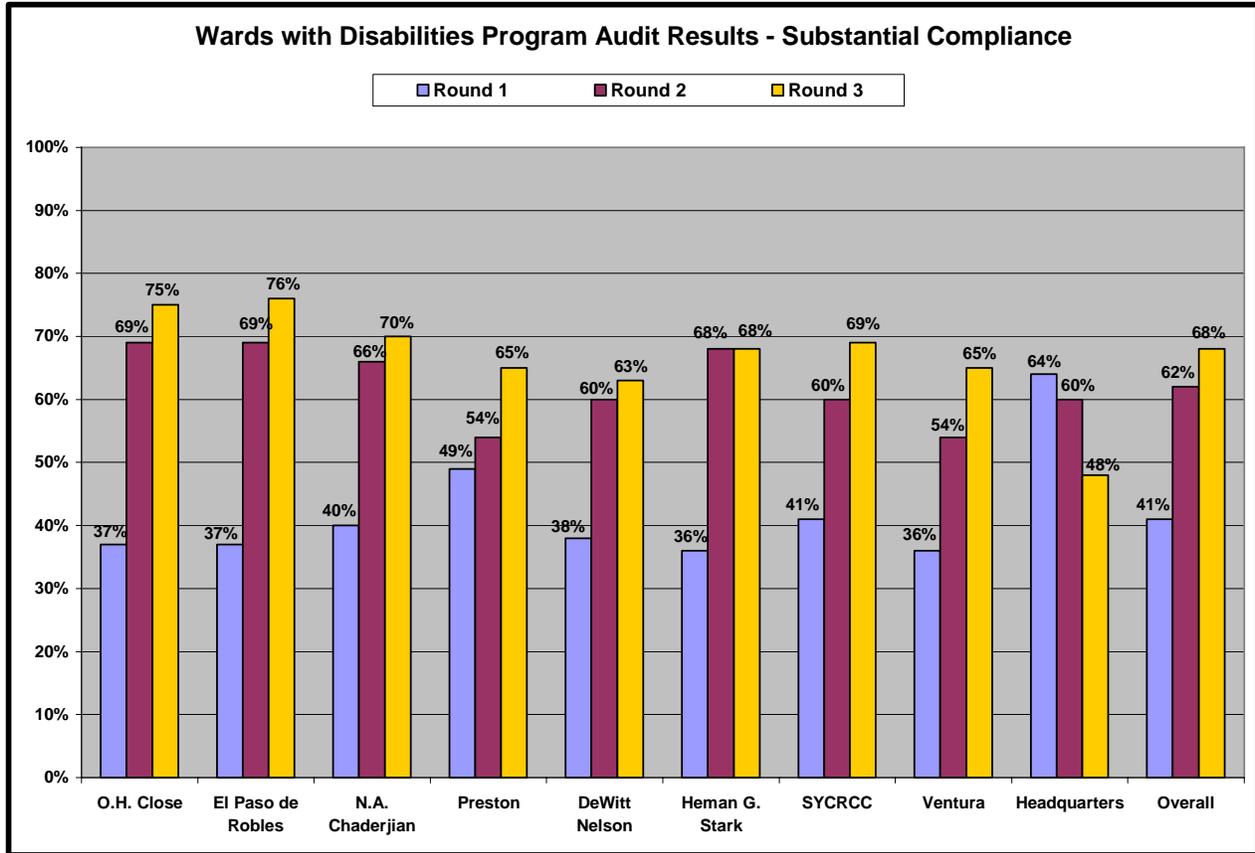


Figure 34: Wards with Disabilities Program Audit Results – Substantial Compliance Comparison

- Every facility increased its Substantial Compliance percentage after each round of auditing (Please note that Heman G. Stark Youth Correctional Facility increased its Substantial Compliance percentage by 0.5% in Round Three).
- The facility with the highest Substantial Compliance percentage, El Paso de Robles Youth Correctional Facility with 76%, and the facility with the lowest Substantial Compliance percentage, DeWitt Nelson Youth Correctional Facility with 63%, have since been closed and therefore will not be audited in future rounds.
- An area of concern for DJJ is the pattern of decline in the Substantial Compliance percentage for DJJ Headquarters from Round One (64%) to Round Three (48%).

SUBSTANTIAL PLUS PARTIAL COMPLIANCE COMPARISON

A Partial Compliance rating, while not at the same high level as Substantial Compliance, does demonstrate that progress and work effort have been achieved to move a given audit item towards Substantial Compliance. The graph below combines the Substantial Compliance and Partial Compliance percentages for each site for each round of audits to demonstrate the amount of work that has been put forth in working site toward Substantial Compliance. A percentage of 100% indicates that the facility does not have any audit items rated as being in Non-compliance.

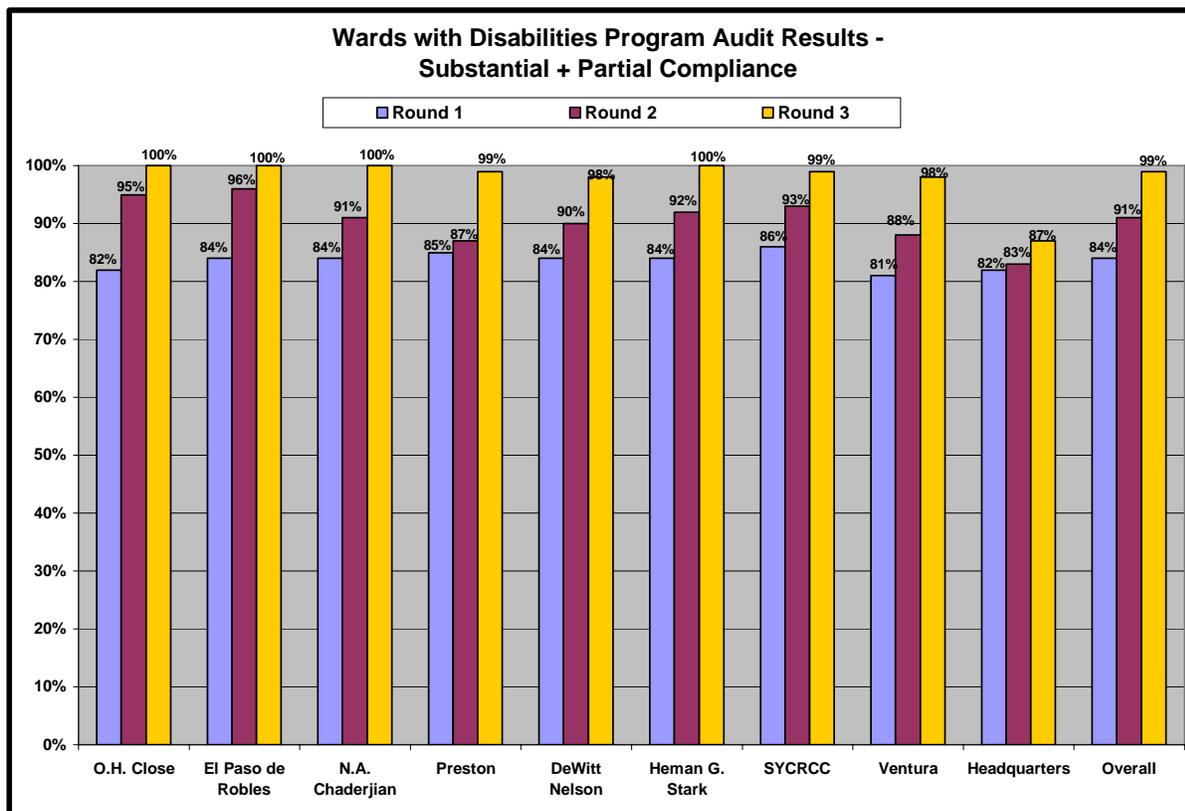


Figure 35: Wards with Disabilities Program Audit Results – Substantial Plus Partial Compliance Comparison

- Every site increased their combined Substantial and Partial compliance percentages after every round of audits.
- When combining the Substantial and Partial compliance percentages together for each facility, the totals range from a high of 100% (four facilities) to a low of 98%.
- Four facilities are at 100% in Substantial Compliance, two facilities are at 99%, and the remaining two facilities are at 98%.
- The Headquarters' combined Substantial and Partial compliance percentage is 87%.
- The cumulative combined Substantial and Partial compliance percentage for all the sites is 99%.

DJJ still has work left to do to fully implement all the reforms in the Wards with Disabilities Program Remedial Plan. However, DJJ believes that these percentages demonstrate an objective pattern of progress that speaks to DJJ's efforts to fully implement the Wards with Disabilities Program Remedial Plan. It is clear that a major focus for DJJ for the next round of audits will be to work to move items currently rated as Partial Compliance into Substantial Compliance and to demonstrate increased compliance at DJJ Headquarters.

2.3.4 Expert Feedback

DJJ has received four informal facility audits from the Wards with Disabilities Program Expert during the last quarter. Although these reports do not contain specific compliance ratings, they do contain valuable information on the implementation status of the Wards with Disabilities Program reforms. The comments below are a sampling from the Wards with Disabilities Program Expert's recent audit reports that DJJ found to be valuable feedback.

WDP Expert's Comments - Preston Youth Correctional Facility

- *"The facility WDP Coordinator, Sherri Lowe, who was the first facility coordinator appointed under the WDP Remedial Plan in 2005, continues to be actively involved in the on-going efforts of WDP Remedial Plan documentation and implementation. She is believed to be committed to the program's goals and a valuable asset to the facility. She continues to have the support of the Superintendent and high-level administrators. She continues to be receptive to recommendations from the Disabilities Expert on ways to improve services to wards with disabilities."*
- *"Efforts to identify wards with educational disabilities, including initial screenings and assessments, self-referrals, and staff-referrals, were previously rated as partially compliant, and there appeared to be no significant improvements in these areas. In fact, the process of identifying incoming wards with IEP's or requiring evaluation for IEP's appeared to be less effective than was previously reported, sometimes requiring wards to self-refer in order to be evaluated. There were several records of formal staff or self-referrals for evaluating wards with disabilities. Of these, the time periods allowed by the WDP Remedial Plan were exceeded in all cases."*
- *"There appeared to be significant improvements in the areas of medical and mental health identifications. While these records will require some augmentation and more detailed review before and during the next audit date, it was clear that the heads of each discipline were aware that identifications were necessary and were proceeding to make the appropriate professional determinations."*
- *"Other documentation provided showed that the average time required for a formal educational evaluation was 140 days (please see above for the time limits required by the WDP Remedial Plan). The actual forms prepared by DJJ for this purpose contain irregularities, and while it may be possible that WIN computerized records were entered for these wards, that would not remove the need to complete referral forms appropriately (the only way currently available to show valid dates and signatures). It is believed that issues involving the specific wards described above have since been resolved, but with an obvious long-term effect on their educational advancement."*
- *"In the area of mental health evaluations, a significant effort was recently undertaken to provide comprehensive screenings, and where appropriate, further detailed assessments. There were commendable efforts made to identify wards with mental and emotional, and potentially developmental, disabilities, with a substantial amount of documentation provided in this area. Due to the extensive nature of this activity, there were some preliminary misunderstandings and confusion among the mental health staff, but our review indicated that these were more procedural and personnel-related in nature, and the considerable positive efforts undertaken and results achieved should be acknowledged."*

- *“While a productive meeting was held with security staff to review alternate use of force procedures and the type of appropriate documentation that would be necessary, no conclusive procedures on ways to provide proof of practice were resolved during the audit. (It should be noted that at other facilities visited recently, similar discussions were held with security staff, with fairly conclusive agreements on the type of documentation that would be prepared and provided at future audits.) It is recommended that security staff meet again with the departmental WDP Manager, who is familiar with the appropriate documentation techniques, prior to the next audit date so that this information can be reviewed in detail during the next audit date.”*
- *“It was also evident that improved lines of communication between the WDP Coordinator and medical staff were bringing about substantial improvements in health care services for wards with physical disabilities.”*
- *“It is evident that most wards receive a packet of information regarding the Wards with Disabilities Program as they arrive at the living unit (in combination with twenty-one other orientation packets related to various programs). However, it is not clear that the computerized, standardized WDP orientation module, as developed by DJJ and approved by the Disabilities Expert, is actually being presented, and the effectiveness of the individual orientation, when combined with so much other information and given in random formats, is questionable. While it is known that most wards receive some type of orientation, documentation was provided for only five wards. It is known that Headquarters is in the process of developing and coordinating the WDP orientation process, and it is hoped that the Disabilities Expert will be consulted early in this process to assure future compliance. It is also our understanding that the WDP orientation process being developed is intended for use at all facilities, but it is our opinion that doing so is excessive, since the WDP Remedial Plan only requires that the standardized orientation module be presented at the three reception centers.”*
- *“In the past, special case conferences convened due to disability referrals and subsequent determinations were almost non-existent at all facilities. It is quite encouraging to see that a number of these were held at Preston within the past four months.”*
- *“Monthly reports continue to be filed by the facility WDP Coordinator in a timely manner. These reports are sent to Headquarters and the Superintendent. The Facility WDP Coordinator also utilizes an expanded report format as recommended by the Disabilities Expert.”*
- *“Education received the only substantial compliance rating among all facilities during last fiscal year for discussing the IEP process with wards and surrogates prior to IEP meetings and encouraging active ward participation. IEP documents consistently (though not always) provided adequate documentation that this WDP Remedial Plan requirement was understood and followed. Other facilities have been quite remiss in attempting to either provide or document this activity, and Preston could again be used as an example that such documentation is not onerous.”*

- *“While not specifically a part of this facility, the Transportation Department demonstrated the new wheelchair accessible bus delivered since the last audit. The bus is truly state-of-the-art, with a full size wheelchair lift and a secure holding area specially designed for wheelchair anchorage and safe transport for wards with disabilities. The Auditor reviewed all aspects of the operation and verified that this previously non-compliant audit item was now in substantial compliance.”*

WDP Expert’s Comments - O.H. Close Youth Correctional Facility

- *“A detailed review of the School Consultation Team's binder and a brief meeting with the newly-appointed SCT Coordinator raised expectations for increased compliance with the WDP Remedial Plan's requirements for using the SCT process in referring, screening, and assessing wards with educational disabilities, for possible inclusion in special education programs.”*
- *“While Sandi Becker's and Maria Correa's (her assistant) efforts to dedicate substantial time and effort to fill in and fulfill the facility WDP coordinator's duties and to assist with the facility's documentation for the audit are commendable, it is still evident that the departure of the previous WDP coordinator at the end of August has caused some slowdown and decreased reporting in WDP activity, although not as much as one might expect, since systems seems to have been set up very well at the facility. Nevertheless, it is important that interviews for this position, which are scheduled for next month, should proceed expeditiously so that a new facility WDP coordinator can begin soon and follow through with the many new policies and procedures, particularly continuing implementation of the WIN system.”*
- *“Efforts to identify wards with mental and emotional disabilities, including screenings and assessments based upon self-referrals or staff referrals, were previously rated as substantially compliant (the only current facility to be so rated) in the area of initial identifications, but only partially compliant in the area of subsequent referrals (rated so primarily due to the previous lack of consistent guidance from headquarters). Even considering the previous positive aspects, there appeared to be significant improvements in both areas.”*
- *“Efforts to identify wards with disabilities, including self-referrals, staff-referrals, screenings, and assessments, were previously rated as partially compliant in several areas, and there appeared to be few significant improvements in the areas of educational and medical identifications.”*
- *“A very productive meeting with the Chief of Security, Captain Sandra Huyg yielded a basic agreement in ways to effectively provide documentation within the various types of reports prepared by security staff showing alternate use of force techniques for wards with disabilities, as well as documentation of why alternate techniques could not be utilized in specific situations.”*

- *“As with the last audit, Education provided no written response or documentation to the seven audit items contained in the Audit Instrument and the special detailed list prepared in August by the Disabilities Auditor, a relatively small task. Areas with no records included documentation of training for wards with disabilities on how to use electronic equipment effectively, CAHSEE results, waiver requests, staff consultations with wards and surrogates prior to IEP meetings, and surrogate training. While it was apparent from the file reviews that some strides have been made in IEP policy development and high school graduation plan preparation since the last audit, little written documentation was provided.”*
- *“The Staff Assistant program continues to be active and very effective at the facility.”*
- *“Case Report Transmittal Forms are being generated and placed in field files, as required by the WDP Remedial Plan, for review by Parole Board members prior to hearings. The use of ward signature forms used in conjunction with Board activities may have had some irregularities, and this aspect will be reviewed in more detail during the second round of audits.”*

WDP Expert’s Comments – N.A. Chaderjian Youth Correctional Facility

- *“The facility WDP Coordinator, Velia Quesada, was one of the first facility coordinators appointed under the WDP Remedial Plan in 2005, and she continues to be actively involved in the on-going efforts of WDP Remedial Plan documentation and implementation. She is believed to be committed to the program’s goals and a valuable asset to the facility. She continues to have the support of the Superintendent and high-level administrators and to be receptive to recommendations from the Disabilities Expert on ways to improve services to wards with disabilities.”*
- *“Efforts to identify wards with medical disabilities, including self-referrals, staff-referrals, screenings, and assessments, were previously rated as partially compliant in several areas, and there appeared to be little significant improvement in the medical identification process. There were few records of any formal staff or self-referrals regarding wards with disabilities, which may not be a problem given the reduced ward population, but nevertheless a situation that will require further examination during the next audit date. Those records that were provided did not provide complete documentation of medical determinations or follow-up procedures.”*

- *“While these records will require some augmentation and more detailed review during the next audit date, it was clear that clinical psychologists were aware that identifications were necessary and were proceeding to make the appropriate professional determinations. As at other facilities, a significant effort was recently undertaken to update the WIN system by providing comprehensive screening, and where appropriate, further detailed assessments for wards with potential mental health disabilities. While there were some preliminary misunderstandings and confusion among the mental health staff at other facilities (believed to be more procedural and personnel-related in nature), psychologists at Chad appeared to do an exceptional job in achieving the necessary results effectively with few problems. This serves as an example of how the recent increase in psychological staffing (believed to be too great by some) allowed for a proper and effective program to resolve some long-standing compliance issues with respect to WDP Remedial Plan requirements. While it is believed that psychologists used reasonable professional criteria to make the appropriate identifications, the need for improved guidance from Headquarters became obvious during the interview.”*
- *“Copies of parole consideration reports typically contained a copy of the Case Report Transmittal Form, which shows very basic listing of a ward's disability status and necessary accommodations. However, they typically did not include the type of detailed disability information or referrals to appropriate community service agencies, as required by the WDP Remedial Plan.”*
- *“Educational documentation provided by the department was extensive and showed considerable improvements in the number of self-referrals and staff referrals being provided through the School Consultation Team, and the variety of SCT forms provided appeared to be consistent and filled out properly.”*
- *“Procedures for WDP orientation, usually given at this facility in group sessions along with other orientation activities, appeared to be provided appropriately. It is the Auditor's opinion that orientation at the three non-reception centers should be less focused than at the reception centers (where the WDP Remedial Plan requires a higher degree of formal orientation), and the program at Chad was in line with this concept and appeared to be effective.”*
- *“The facility WDP Coordinator reviews placements into special and restricted settings, including temporary detentions and placements into special management programs and medical settings, on a regular basis and notifies via e-mail the Superintendent, Headquarters staff, and other appropriate parties concerning wards with disabilities involved in these placements. These e-mails are different from the standard format used in the past in that they contain a "reminder" of WDP Remedial Plan requirements regarding procedures affecting these wards, a very positive addition. Also, records provided to the Auditor showed that such placements and the conditions surrounding them are being entered into WIN.”*
- *“In the past, special case conferences convened due to disability referrals and subsequent determinations were almost non-existent at all facilities. It is quite encouraging to see that a number of these were held at Chad within the past few months.”*

WDP Expert's Comments – Southern Youth Correctional Reception Center-Clinic

- *“The facility WDP Coordinator, Carlos DeLeon, continues to be actively involved in the on-going efforts of WDP Remedial Plan documentation and implementation. He is believed to be committed to the program's goals and a valuable asset to the facility, and he continues to have the support of the Superintendent and high-level administrators. He has always been receptive to recommendations from the Disabilities Expert on ways to improve services to wards with disabilities.”*
- *“The facility still uses the interim Disability Evaluation/Referral Form DJJ 8.288 to provide the appropriate staff referrals to Education, Health Care, and Mental Health (in the case of Education, in lieu of the SCT Referral Form prescribed by the WDP Remedial Plan). The use of this form was discussed by DJJ staff during the audit, and it appears there may still be some lack of clarity about whether this form or the WIN system should currently be used to document initial intake referrals. Irrespective of this, there was no follow-up documentation provided by the facility WDP Coordinator or any of the three disciplines listed above to demonstrate a full evaluation of a potential ward disability. These procedures still need some clarification and direction from headquarters, and documentation needs to be completed appropriately by all parties.”*
- *“There appeared to be significant improvements in the areas of initial identification and referral as provided by the intake and reception staff. The comprehensive nature of the documents package provided to the Auditor indicated a systematic process and utilized the proper forms intended for these purposes. While these records will require some augmentation and more detailed review before and during the next audit date, it was clear that reception center staff were aware that such identifications were necessary and were proceeding to make the appropriate referrals.”*
- *“In the area of mental health evaluations, a significant effort was recently undertaken to provide comprehensive screenings, and where appropriate, further detailed assessments. There were commendable efforts made to identify wards with mental and emotional, and potentially developmental, disabilities, with a substantial amount of documentation provided in this area.”*
- *“The Staff Assistant program continues to be active and effective at the facility. Currently, 25 staff members from various departments have been listed as participants. Most if not all of these staff members have been trained by the facility WDP coordinator. Records provided for various activities (orientation, initial case conferences, Board hearings, etc.) indicated an effective system for providing staff assistants, although a detailed tracking log would help to document all Staff Assistant usage.”*
- *“The documentation of disability-related data, as included in the WIN system, was in use at the facility and staff has been recently trained on how to use the system. Identification and evaluation data is in the process of being input into the system, and full utilization is close to implementation.”*
- *“Audit items related to equal access to services, CAHSEE waivers, education staff assistance to wards related to IEP's, and IEP preparation showed little progress since the last audit.”*

- “However, it is not clear that the computerized, standardized WDP orientation module, as developed by DJJ and approved by the Disabilities Expert, is actually being presented, and the effectiveness of the individual orientation, when combined with so much other information and given in random formats, is questionable.”

2.3.5 Status of Specific Action Items

Relieved Items

Page 11, paragraph 23, of the Consent Decree states:

When a facility is found to be in substantial compliance on an issue for one full year, and is found to remain in substantial compliance after review by the relevant expert(s) one year later, expert tours regarding that issue at that facility shall end.

A “relieved” audit item is one that has met or exceeded the two-year Substantial Compliance threshold and which the appropriate Expert has formally noted that the audit item is to be removed from that Expert’s future monitoring.

In the Wards with Disabilities Program Expert’s latest Annual Report, he identifies a total of 22 action items that he has relieved from future independent monitoring. As stated in the Wards with Disabilities Program audit tool, these 22 action items meet the criteria of “a second consecutive ‘substantial compliance’ rating; the Auditor recommends no further independent auditing, but rather continuing auditing by the Department WDP Coordinator.”

These 22 relieved action items represent an increase of 13 additional relieved action items from that which had been relieved during the previous round of auditing.

The following chart identifies the 22 relieved action items.

WDP Action Items Relieved from Future Independent Monitoring			
DJJ #	Section	Action Item	Deadline
1	Directorate	HQ ACTION ITEM – Maintain a current copy of the Wards with Disabilities Program Remedial Plan in the Director’s Office.	N/A
3	Departmental Ward Disability Coordinator & Functions	HQ ACTION ITEM – Ensure duty statement encompasses all Departmental WDP Coordinator duties as defined in the WDP Remedial Plan.	N/A
5		FACILITY ACTION ITEM –Establish and maintain full-time WDP Coordinators at each facility by February 2006.	2/1/06
18	Headquarters Policies	HQ ACTION ITEM – By December 2005, the Education Branch shall establish a working committee consisting of the Disability Expert, one Education Expert, the SELPA Director and the Manager of Special Education to study and make recommendations to improve the adult ward’s and parents’ meaningful participation during IEP meetings, to encourage more active participation, and to provide informational materials for parents and/or surrogates.	12/1/05
19		HQ ACTION ITEM – The Education Branch working committee shall also study the need for and evaluate the ability for the various public or private groups or agencies to assist with the means of attending IEP meetings for parents. (This is not being interpreted as requiring the Department to provide such means).	N/A

WDP Action Items Relieved from Future Independent Monitoring			
DJJ #	Section	Action Item	Deadline
20		HQ ACTION ITEM – The Education Branch working committee shall also study the need to include a wider variety of individualized accommodations in IEP's.	N/A
27	Headquarters Policy	HQ & RECEPTION CENTER ACTION ITEM – The CYA shall develop a provisional form that contains a written advisement of ADA Rights Notification in simple English and Spanish by August 2005.	8/1/05
28	Headquarters Programs / Screening	HQ & FACILITIES ACTION ITEM – Maintain a contract for sign language interpreter services, as well as a record of the use of this service.	N/A
30		HQ ACTION ITEM – The CYA will revise the Referral Document, YA 1.411 by replacing the term "handicap" with "disability" within 30 days of the filing date of this plan.	12/19/04
32	Superintendent	FACILITY ACTION ITEM – Maintain a current copy of the Wards with Disabilities Program Remedial Plan in the Superintendent's Office.	N/A
44	Facility Policies	FACILITY ACTION ITEM – Wards with hearing impairments shall have access to at least one facility television located in their assigned living unit that utilizes the closed captioning function at all times while the television is in use.	N/A
45		FACILITY ACTION ITEM – Distribute and post reports, brochures, treatment, and education materials in a manner that is accessible to wards with disabilities.	N/A
66		FACILITY ACTION ITEM – The Department shall ensure that aid is provided to all wards with disabilities who request assistance in requesting accommodations during YAB hearings.	N/A
67	Disciplinary Decision Making System	FACILITY ACTION ITEM – To assure a fair and just proceeding, if the rule violation is recorded as a Level 3 (Serious Misconduct), all wards with disabilities who require an accommodation shall be assigned a Staff Assistant (SA) from the facility SA team.	N/A
68		FACILITY ACTION ITEM – Each facility shall have a SA team with at least one representative from each of the following disciplines: mental health, healthcare, and education.	N/A
74	Grievance Procedures	FACILITY ACTION ITEM – The SA shall complete a course to become a staff assistant that contains modules that define SA roles and responsibilities, describe cognitive and emotional disabilities and present an overview of the DDMS process.	N/A
75		FACILITY ACTION ITEM – The WDP Coordinator shall review all grievances forms at least monthly to identify any patterns of repetitive involvement that may be related to mental and physical disabilities and refer such cases to the appropriate supervisory staff.	N/A
87	Reception Center and Clinic Functions	RECEPTION CENTER ACTION ITEM – During the initial ward interviews, advise wards of their rights under the ADA and section 504, and receive formal documentation that they have received and understood this advisement.	NA
116	Removal of Architectural Barriers	FACILITY ACTION ITEM – The Department committed to the renovation of one room at each facility, as a minimum, to ensure the provision of accessible housing for wards with disabilities. The total completion of this project is scheduled for June 30, 2006.	6/30/06
117		FACILITY ACTION ITEM – The Department committed, at a minimum, to have one fully accessible shower and/or lavatory areas must be in close proximity to the renovated accessible cells due to be completed by June 30, 2006.	6/30/06
119		FACILITY ACTION ITEM – The Department committed to analyze the 3000 additional barriers identified in the report prepared by Access Unlimited and provide a report that would categorize the barriers into three distinct areas. The three categories would be: 1) Projects that could be fixed in a short period of time with minimum cost; 2) Projects that will require substantial funding, and 3) Projects that have been identified but are not specifically required for ward programmatic access and are not part of the plan. This report is due July 15, 2005 and will be filed as Appendix C to the Disability Remedial Plan.	7/15/05
120		FACILITY ACTION ITEM – Construction of the first category of projects, which involves projects that can be fixed in a short period of time with minimum costs, shall be completed by September 30, 2006.	9/30/06

Items Removed from Relieved Status

Of the nine previously relieved action items from Round Two, the Wards with Disabilities Program Expert decided that two of those items should no longer be considered relieved and are once again subject to his independent monitoring. It is important to note that both of these action items maintained their Substantial Compliance ratings during this last round of audits.

The Expert’s rationale for removing these two items from relieved status, as well as other items that have met the two-year Substantial Compliance standard, is that these action items are staff-dependent; that is, there will always be a possibility that staff will one day leave the position. Because of this possibility, the Expert has decided to keep these and other action items open to his continued monitoring, despite the fact that they have been in Substantial Compliance for two years or longer. Because turnover in personnel is unavoidable and DJJ has continued to actively recruit for Wards with Disabilities Program positions as they become vacant, DJJ informed the Wards with Disabilities Program Expert of its objection to this auditing methodology.

The chart below identifies the two action items that the Wards with Disabilities Program Expert has recently removed from relieved status and will once again be monitored during his next round of audits.

WDP Action Items Removed from Relieved Status					
DJJ #	Section	Action Item	Deadline	Current Rating	Expert Comments
4	Departmental Ward Disability Coordinator & Functions	HQ ACTION ITEM – The WDP Coordinator shall perform the oversight functions as set forth in the WDP Remedial Plan.	N/A	SC	Sandi Becker is believed to be performing the required oversight functions.
36	Facility Wards with Disabilities Coordinator	FACILITY ACTION ITEM – Maintain WDP Coordinators at each facility.	2/1/06	SC	Each facility had an active WDP Coordinator in place at the time of each site visit. Since this situation could change at any point in time (e.g., a coordinator could resign or be promoted), it is felt that this item should remain in the audit instrument despite the two concurrent “SC” compliance ratings (as with the four items directly below).

Statewide Compliance Items

In addition to the 22 relieved action items, there are also 37 action items for which the Wards with Disabilities Program Expert has provided Substantial Compliance ratings to each of the applicable sites audited during the last round of audits. When an action item receives a Substantial Compliance rating for every applicable site during a round of audits, this is referred to as being in “Statewide Compliance.” Items that are found to be in Statewide Compliance should not be confused with audit items that have been formally relieved from future Expert monitoring.

The following chart lists the 37 action items in the Wards with Disabilities Program audit tool for which every applicable site received a Substantial Compliance rating during the last round of audits.

WDP Action Items in Statewide Compliance – Round Three (Relieved Items not Included)			
DJJ #	Section	Action Item	Deadline
2	Departmental Ward Disability Coordinator & Functions	HQ ACTION ITEM – By October 2005, establish and maintain a full-time Departmental Wards with Disabilities Program (WDP) Coordinator and analytical staff to develop, support, lead and manage a quality program.	10/1/05
4		HQ ACTION ITEM – The WDP Coordinator shall perform the oversight functions as set forth in the WDP Remedial Plan.	N/A
5		FACILITY ACTION ITEM – Establish and maintain full-time WDP Coordinators at each facility by February 2006.	2/1/06
11		HQ ACTION ITEM – Within six months of the court approval and adoption of this plan, the Department's Ward Disability Program Coordinator will receive a higher level of training provided by qualified trainers/consultants from outside the Department as recommended in Section 5.1 of the Expert's report.	11/30/05
13	Headquarter Policies	HQ ACTION ITEM – The CYA shall procure two wheelchair assessable vans to transport wards with disabilities by July 2006.	7/1/06
15		HQ ACTION ITEM – The Department shall ensure that wards with disabilities have access equal to non-disabled wards in all levels of care within the youth correctional system.	N/A
16		HQ ACTION ITEM – All wards under the jurisdiction of the CYA shall be given equal access to all programs, services and activities offered by the Department. Programs, services, and activities shall be offered in the least restrictive environment, with or without accommodations.	N/A
29	Headquarters Programs / Screening	HQ ACTION ITEM – The Intake and Court Services Unit staff shall review incoming documentation from the committing courts and counties of all wards for indicators of impairments that may limit a major life activity and require accommodations or program modifications.	N/A
34	Superintendent	FACILITY ACTION ITEM – The Superintendent shall report to the Deputy Director, within twenty-four hours, when a ward with a disability that requires accommodation is placed in a restrictive setting, i.e., TD or lockdown.	N/A
36	Facility Wards with Disabilities Coordinator	FACILITY ACTION ITEM – Maintain WDP Coordinators at each facility.	2/1/06
37		FACILITY ACTION ITEM – Ensure duty statement encompasses all facility WDP Coordinator duties as defined in the WDP Remedial Plan.	N/A
38		FACILITY ACTION ITEM – The facility WDP Coordinator shall perform the oversight functions as set forth in the WDP Remedial Plan.	N/A
39		FACILITY ACTION ITEM – Within six months of the court approval and adoption of this plan, the facility Ward Disability Program Coordinators will received a higher level of training provided by qualified trainers/consultants from outside the Department as recommended in Section 5.1 of the Experts report.	11/30/05
40		FACILITY ACTION ITEM – The facility WDP Coordinators shall submit monthly reports to the Department WDP Coordinator.	N/A
42	Facility Policies	FACILITY ACTION ITEM – Assistive devices shall be taken away from a ward to ensure the safety of persons, the security of the facility or to assist in an investigation or when a Dept. physician or dentist determines that the assistive device is no longer medically necessary or appropriate	N/A
43		FACILITY ACTION ITEM – Wards with hearing disabilities shall be provided use of a Telecommunications Device for the Deaf (TDD).	N/A
47		FACILITY ACTION ITEM – The Principal shall ensure students with disabilities are trained in the proper use of electronic equipment.	N/A
50		FACILITY ACTION ITEM – Provide for and implement the four exceptions to the graduation standards for students with disabilities, as listed in the remedial plan.	N/A
52		FACILITY ACTION ITEM – Non-emergency verbal announcements, in living units where wards with hearing and other impairments reside, shall be done on the public address system and by flicking the lights on and off several times to notify wards with disabilities of impending information. Verbal announcements may be effectively communicated in writing, on a chalkboard, or by personal notification.	N/A

WDP Action Items in Statewide Compliance – Round Three (Relieved Items not Included)			
DJJ #	Section	Action Item	Deadline
54		FACILITY ACTION ITEM – Prior to placing a ward with a disability into a restricted setting, the Superintendent shall review the referral form and ensure that any accommodation required by a ward has been documented.	N/A
61		FACILITY ACTION ITEM – The Department shall ensure that wards with disabilities have access to all Youth Authority Board (YAB) proceedings. To this end, the Department shall provide reasonable accommodations to wards with disabilities preparing for parole and YAB proceedings.	N/A
62		FACILITY ACTION ITEM – Department staff shall ensure that wards with disabilities are provided staff assistance in understanding regulations and procedures related to parole plans and in the completion of required forms.	N/A
69	Disciplinary Decision Making System	FACILITY ACTION ITEM – Disposition chairperson shall be trained to communicate with wards that have disabilities.	N/A
70		FACILITY ACTION ITEM – The SA shall complete a course to become a staff assistant that contains modules that define SA roles and responsibilities, describe cognitive and emotional disabilities and present an overview of the DDMS process.	N/A
71		FACILITY ACTION ITEM – The facility WDP Coordinators shall review all DDMS/grievance forms at least monthly to identify any patterns of misbehavior that may be related to cognitive and emotional disabilities.	N/A
76		FACILITY ACTION ITEM – Completed grievance forms should be randomly monitored by the facility WDP Coordinator to determine if indeed disability is an issue, even though the ward filing the grievance may not have specifically cited it.	N/A
78	Grievance Procedures	FACILITY ACTION ITEM – The Wards Rights Coordinator, within 24 hours of receipt, shall review grievances, with attached documentation, that request accommodations or allege discrimination to determine whether the grievance meets one or more of the following criteria for review and response: (1) Allegation of non-compliance with department WDP policy. (2) Allegation of discrimination based on a disability under WDP. (3) Denial of access to a program, service, or activity based on disability.	N/A
79		FACILITY ACTION ITEM – The Wards Rights Coordinator shall forward to the facility WDP Coordinator or designee all grievances that meet the criteria for review and response within 48 hours of receipt.	N/A
83		FACILITY ACTION ITEM – The Ward's Rights Coordinator shall refer a grievance to the facility WDP Coordinator when verification of a non-medical disability is required and ensure it is handled as defined within the remedial plan and within timeframes.	N/A
88	Reception Center-Clinic Functions	RECEPTION CENTER ACTION ITEM – Assigned Casework Specialist shall refer a ward to a mental health professional on a Mental Health Referral Form when indicators of a mental impairment exists that may limit a major life activity.	N/A
89		RECEPTION CENTER ACTION ITEM – Assigned Casework Specialist shall refer a ward to a medical professional on a Disability Health Services Referral form when indicators of a physical impairment exists that may limit a major life activity.	N/A
94		RECEPTION CENTER ACTION ITEM – Credentialed education staff shall complete educational assessment within 50 calendar days.	N/A
111	Residential Programs	FACILITY ACTION ITEM – The Program Manager shall ensure that the presentation, the curriculum, and any supplemental materials used for individual and small group counseling, large group meetings, and resource groups are modified to ensure equal access to the information by wards with disabilities.	N/A
112		FACILITY ACTION ITEM – The Program Manager shall ensure that a Staff Assistant (SA) is assigned to a ward with a disability when individualized assistance in the completion of mandated or necessary functions.	N/A
113		FACILITY ACTION ITEM – The facilities shall ensure equal access to services, such as medical and religious, and activities, such as visiting and recreation, to wards with disabilities as to those provided to wards without disabilities.	N/A

WDP Action Items in Statewide Compliance – Round Three (Relieved Items not Included)			
DJJ #	Section	Action Item	Deadline
114	Developmental Disabilities	FACILITY ACTION ITEM – No outward signs of identification or labeling will be posted for wards involved in the developmental disabilities program.	N/A
118	Removal of Architectural Barriers	FACILITY ACTION ITEM – The Department committed to the removal of critical disability related structural barriers projects that will be completed by FY 2008/09. These projects are part of the barriers that were identified by the survey completed by Access Unlimited and are identified in Appendix B to the Disability Remedial Plan.	7/1/08

Action Items with Majority Ratings of Non-compliance

In addition to identifying areas of progress, the Wards with Disabilities Program Expert's audit reports also provide valuable information on the action items that require more attention and work before they will be deemed to satisfy the mandates of the Wards with Disabilities Remedial Plan. Generally, these types of items require a higher level of inter-departmental coordination and are sometimes dependent on action items from other remedial plans being implemented, thus making them more challenging to implement in a timely manner.

The chart below identifies four action items which received a majority of Non-compliance ratings at the different facilities.

WDP Action Items with Majority Ratings of Non-compliance – Round Three			
DJJ #	Section	Action Item	Deadline
9	Departmental Ward Disability Coordinator & Functions	FACILITY ACTION ITEM – In conjunction with the Health Care Transition Team, the Mental Health and Medical Experts, and Disabilities Expert, ensure systems are in place to monitor the use of psychotropic prescriptions and medications including SSRI's for wards under the age of 20.	N/A
21	Headquarter Policies	FACILITY ACTION ITEM – 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 six months from the date that the Disabilities Remedial Plan is filed with the court.	11/30/05
24		FACILITY ACTION ITEM – The CYA shall develop a screening tool to assess the current ward population in order to identify any developmentally disabled wards who may not have been previously identified. The CYA shall complete this assessment by December, 2006.	12/1/06
86	Reception Center-Clinic Functions	RECEPTION CENTER ACTION ITEM – 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 be determine whether they have a developmental disability, which may make them eligible under criteria set forth in the American with Disabilities Act (ADA) and/or may make them eligible to receive services from a Regional Center.	N/A

2.3.6 Proof of Practice

The following chart identifies the Wards with Disabilities Program-related Proof of Practice documents that were sent to the Wards with Disabilities Program Expert and the Special Master during the last quarter:

WDP Proof of Practice Documents Submitted During the Last Quarter				
#	Section	Audit Item Description	Documents Submitted	Date
288	N/A	N/A	<p>1 – Document entitled “Key Audit Items for Expert’s Verification” (31 pages). This document is being submitted to the Wards with Disabilities Program (WDP) Expert to allow them the opportunity to review it and ensure that the document correctly identifies the items that were submitted.</p> <p>This constitutes DJJ’s second submission of the reporting tool to the (WDP) Expert. This submission also contains additional information that DJJ relied upon in drafting the reporting tool, including information provided by and/or derived from consultations with the Expert.</p>	11/20/08
299	N/A (and S&W 8.3)	N/A	<p>1 – An electronic message from Rachel Veerman to CDCR staff that expresses thanks to CDCR on behalf of families at Ventura Youth Correctional Facility for new kitchen and camera equipment, vending machines, and games for kids (1 page). This document is being provided to the Safety & Welfare and the Wards with Disabilities Program (WDP) Experts to demonstrate the improvements DJJ has made in ensuring that quality equipment and apparatuses are in place for families that visit youths in the facilities.</p> <p>Although there is no specific audit item in either the WDP or Safety & Welfare Standards and Criteria to which this document directly applies, it is DJJ’s belief that it nonetheless does demonstrate that improvements have been made to help foster a more positive environment as families visit youths at the facilities.</p>	12/11/08

2.3.7 Summary and Application of Audit Findings

DJJ has made substantial progress thus far in implementing the requirements of the Wards with Disabilities Program Remedial Plan. Much of this progress is the result of the cooperative relationship between the Wards with Disabilities Program Expert and DJJ’s Departmental Wards with Disabilities Program Coordinator as well as the constructive feedback provided by the Wards with Disabilities Program Expert. DJJ will continue to look to the Wards with Disabilities Program Expert for his expertise and guidance as the Department continues to implement the reforms in the Wards with Disabilities Program Remedial Plan.

2.4 Health Care Services Remedial Plan Compliance Status

2.4.1 Historical Audit Perspective

Court Filings

The Health Care Services Remedial Plan was filed with the Court on June 7, 2006. The Health Care audit tool was filed with the Court on November 30, 2007.

Audit Tool

The Health Care audit tool is unique from the other *Farrell* audit tools in that it is made up of a series of questions and screens.

The questions are similar to the other *Farrell* audit tools in that they identify whether a process or task has been implemented and/or is being followed correctly. The Health Care Experts then apply a Substantial, Partial, or Non-compliance rating to that audit item.

Screens on the other hand are random file reviews that are designed to ensure that proper procedures and documentation are being followed. As per the audit tool, the Health Care Experts randomly select 10 to 20 youth health record files and provide either a Substantial Compliance or Non-compliance rating for each file based on the task the Experts are reviewing; there is no provision for a Partial Compliance rating in reviewing a screen. As a result, a single screen may have as many as 20 compliance ratings associated with it.

Because of this process, the Health Care audit tool had the potential of having as many as 10,592 audit items when it was first originally designed. Because the Experts have the flexibility to review a range of the number of files for a given screen, 10,592 would have been the maximum number of items that DJJ would have to get right in order to come into compliance with the Health Care Services Remedial Plan for any given round of auditing. However, based upon the six audits performed to date, the Health Care Experts are averaging oversight of 854 audit items per facility. With the six facilities that are being monitored, that totals approximately 5,125 audit items that DJJ is expected to be in Substantial Compliance with for Round One.

The Health Care audit tool is unique from the other *Farrell* audit tools in that it also measures compliance percentages in 20 different Health Care categories. Two of the 20 categories are exclusive to DJJ Headquarters. Due to the time involved in auditing all of the items in the Health Care Services audit tool, the Health Care Experts may not be able to complete an audit for all of the 18 facility categories at one time.

The list of 20 categories includes the following:

- Health Care Organization, Leadership, Budget, and Staffing – **HQ only category**
- Statewide Pharmacy Services – **HQ only category**
- Facility Leadership, Budget, Staffing, Orientation and Training
- Medical Reception
- Intra-system Transfer
- Nursing Sick Call
- Medical Care
- Chronic Disease Management
- Infection Control
- Pharmacy Services
- Medication Administration Process
- Medication Administration Health Record Review
- Urgent/Emergent Care Services
- Outpatient Housing Unit
- Health Records
- Preventive Services
- Consultation and Specialty Services
- Peer Review
- Credentialing
- Quality Management

There are no deadlines attached to any of the action items within the Health Care Services audit tool. However, the Health Care Services Remedial Plan itself does contain a few deadlines.

Audit Tool Breakdown

Audit Item Numbers Based on Six Facilities	Filing Dates		"Action Items"			"Audit Items"		
	Remedia l Plan	Audit Tool	# of Action Items with a Deadline	# of Action Items without a Deadline	Total # of Action Items	# of Audit Items with a Deadline	# of Audit Items without a Deadline	Total # of Audit Items
Health Care Services	6/7/06	11/30/07	0	205*	205*	0	Min – 5,612 Max – 10,592	Min – 5,612 Max – 10,592

Audit History

The Health Care Experts have completed their first round of monitoring using the recently filed audit tool but have not yet provided DJJ with all of the compliance reports for that round of audits. Due to their closures, the Health Care Experts did not audit either DeWitt Nelson Youth Correctional Facility or El Paso de Robles Youth Correctional Facility. DJJ has received audit reports for all of the facilities but is still awaiting the audit report for DJJ Headquarters and the Health Care Experts' Annual Report.

The chart below provides a detailed schedule of the Health Care Services audits to date:

Facility	ROUND ONE	ROUND TWO		ROUND THREE	
	Date Audited	Date Audited	Time Since Last Audit	Date Audited	Time Since Last Audit
DJJ Headquarters	June 2-4, 2008	*TBD	N/A	N/A	N/A
Heman G. Stark	Oct. 31-Nov. 2, 2007	*Jan. 12-15, 2009	N/A	N/A	N/A
N.A. Chaderjian/OHU	Feb. 25-29, 2008	*Feb. 17-19, 2009	N/A	N/A	N/A
O.H. Close	June 2-4, 2008	*June 2, 2009	N/A	N/A	N/A
Preston	Sept. 5-7, 2007	Aug. 25-28, 2008	Approximately 11 months	N/A	N/A
SYCRCC	Jan. 29-31, 2008	*Week of March 9 & *Week of March 30	N/A	N/A	N/A
Ventura	Dec 5-7, 2007	Dec. 2-4, 2008	Approximately 1 year	N/A	N/A

* - Denotes audits that have not yet taken place.

Future Audit Schedule

The Health Care Experts have recently provided DJJ with a schedule for their upcoming audits up to the end of this fiscal year.

- N.A. Chaderjian Youth Correctional Facility & OHU – February 17-19, 2009
- Southern Youth Correctional Reception Center-Clinic – The week of March 9, 2009, for Expert Joe Goldenson and the week of March 30, 2009, for Expert Madeleine LaMarre
- O.H. Close Youth Correctional Facility – June 2, 2009
- DJJ Headquarters – TBD

The Dental Services Expert has also provided a schedule of his audits for DJJ's southern facilities.

- Ventura Youth Correctional Facility – February 18-19, 2009
- Southern Youth Correctional Reception Center-Clinic – February 24-25, 2009
- Heman G. Stark Youth Correctional Facility – February 26-27, 2009

2.4.2 Most Recent Audit Findings

Audit Reports Received During Last Quarter

DJJ received one audit report from the Health Care Experts for this reporting period. That report was for Preston Youth Correctional Facility. The Health Care Experts found Preston Youth Correctional Facility to be 85% in Substantial Compliance, 1% in Partial Compliance, and 14% in Non-compliance. These percentages are from a draft of the Health Care Experts' report; thus these numbers are subject to change.

DJJ has recently received another audit report from the Health Care Experts for Ventura Youth Correctional Facility. However, that report was received after the reporting period for this report lapsed. Therefore, the Ventura Youth Correctional Facility audit report will be discussed in detail in the next Quarterly Report.

As for DJJ Headquarters, DJJ had expected to receive the Health Care Experts' audit report for Headquarters during this last quarter as well as their Annual Report; however, neither report was provided. The Headquarters audit took place in June 2008 and was the last site to be audited for the Health Care Experts' first round of audits. Typically, after a full round of audits have been completed, the responsible expert(s) provides DJJ with a comprehensive Annual Report summarizing the findings from that previous round of audits. What is somewhat confusing to DJJ is that it has now received two audit reports for the Health Care Experts' second round of audits, which took place in August and December 2008, and yet DJJ has not received either their audit report for the Headquarters audit that took place in June 2008 nor their Annual Report for the Round One audits, which DJJ expected to receive shortly thereafter.

The Dental Services Expert provided DJJ with an audit report during this last quarter for Preston Youth Correctional Facility. This is the third facility audit report that DJJ has received from the Dental Services Expert. The first two reports for O.H. Close and N.A. Chaderian Youth Correctional Facilities were received in July 2008, but DJJ considers these reports to be pilot audits since DJJ had not been able to provide any feedback on the Dental Services audit tool. Since that time and up until the Preston Youth Correctional Facility audit, DJJ has since provided feedback to the Dental Services Expert on the audit tool. Therefore, unless otherwise informed by the Dental Services Expert or other information becomes available, DJJ is considering the Preston Youth Correctional Facility Dental Services audit report to be the first formal Dental Services audit report that it has received from this Expert.

The chart on the following page identifies the Dental Expert's compliance ratings for Preston Youth Correctional Facility.

Dental Services Audit: Preston Youth Correctional Facility Date Of Audit: November 14, 2008				
Question #	Audit Item Description	Substantial Compliance	Partial Compliance	Non-Compliance
1	Dental policies and procedures are on file and reviewed by all dental staff-local polices are consistent with statewide polices.	X		
2	Adequate dental operatories, instruments, supplies, and dental clinic space exist to meet the needs of the patient population.	X		
3	Infection control procedures are followed in accordance with state and federal laws and guidelines.	X		
4	A review of dental appointment logs and statistics show a broken appointment rate of <10%.		X	
5	The dental Quality Assurance Monitoring Program (QAMP) subcommittee meets quarterly. A review of Dental QAMP minutes shows that meaningful content was discussed with studies conducted to improve quality and quantity of dental care.		X	
6	Floss and ADA approved toothbrushes and tooth paste are available to all wards/youth.	X		
7	All dentists and dental health care workers show evidence of immunity to or immunization against the hepatitis virus.	X		
8	Review wards/youth Orientation Brochure/Handout. Determine if wards/youth are provided adequate instruction as it relates to access to care.	X		
9	Documentation of current and appropriate credentials is on file at the facility for all dental staff.	X		
10	Documentation of initial and periodic dental peer reviews and actions taken if necessary.	X		
11	Documentation of adequate written protocols for use by registered nurses to make a determination of urgency of dental sick call requests.	X		
TOTAL		9	2	0
COMPLIANCE %		82%	18%	0%

Figure 36: Dental Services Audit Results – Preston Youth Correctional Facility

The Dental Services Expert provided eleven compliance ratings after his audit of Preston Youth Correctional Facility. Of those eleven items rated, 82% were assessed to be in Substantial Compliance, 18% in Partial Compliance, and 0% in Non-compliance. DJJ still has some questions in regard to the Dental Services audit tool and will seek clarification from the Dental Services Expert.

2.4.3 Health Care Services Audit Results

Audit Results Introduction

The Health Care Services charts on the following pages document the most up-to-date compliance ratings for each site audited by the Health Care Experts. The compliance percentages are derived from the Health Care Experts' compliance data that are contained within the various audit reports. These charts also include the cumulative results of the most recent round of audits as well as the comparison of a facility's prior audit results in previous rounds. Because this is the first round of audits, the comparison chart (bar graph) will illustrate the same compliance results as that of the pie chart. Attached at the bottom of these charts are the statistical data for each audit performed at each site.

The percentages identified in the following charts have been rounded off and therefore may have a slight variance of no more than 1% greater or less than 100%. For example, in adding up the different compliance percentages, the sum total for a given site could either be 99%, 100%, or 101% due to rounding.

To help fully understand the charts on the following pages, the abbreviations, color code and terms below are more clearly defined:

- **SC** = Substantial Compliance and is shaded in green.
- **PC** = Partial Compliance and is shaded in yellow.
- **NC** = Non-compliance and is shaded in red.
- **N/A** = Not Applicable and is shaded in gray.
- **Numbers in red font** = A negative number denoting a decrease in a compliance percentage.
- **Raw %** = The compliance percentages with the number of N/A items included in the calculations.
- **Adjusted %** = The compliance percentages with the number of N/A items excluded from the calculations. This is the number used by DJJ to identify the compliance percentage for a given site.
- ***UPDATED THIS QUARTER:** = Identifies charts and graphs that have been updated since the last Quarterly Report.

CUMULATIVE RESULTS

The pie chart on the following page identifies the cumulative averages for all of the compliance data received to date from the Health Care Experts current round of audits. The bar graph on the right side compares the cumulative percentages from the different rounds of audits if there was a previous audit. Because this is the first round of audits, the bar graph will illustrate the same compliance data as that of the pie chart. Below the graphs are the statistical data associated with these audits.

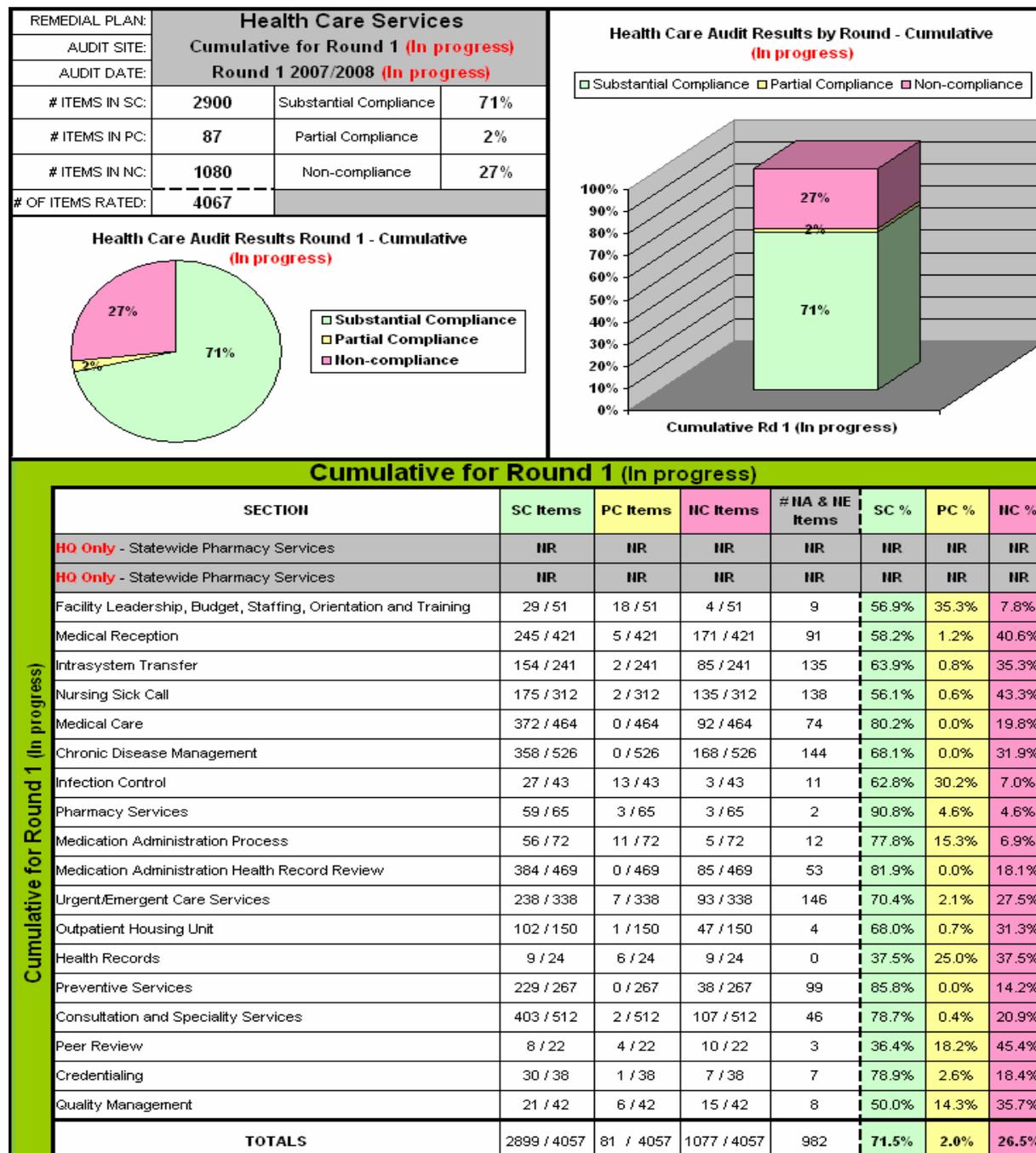


Figure 37: Health Care Services Audit Results – Cumulative

***UPDATED THIS QUARTER: PRESTON YOUTH CORRECTIONAL FACILITY**

The Health Care Experts last audited the Preston Youth Correctional Facility on August 25-28, 2008. The pie chart below identifies the results from this audit, and the bar graph on the right provides a side-by-side comparison from the facility's previous audits. Below these diagrams is the statistical data associated with this audit.

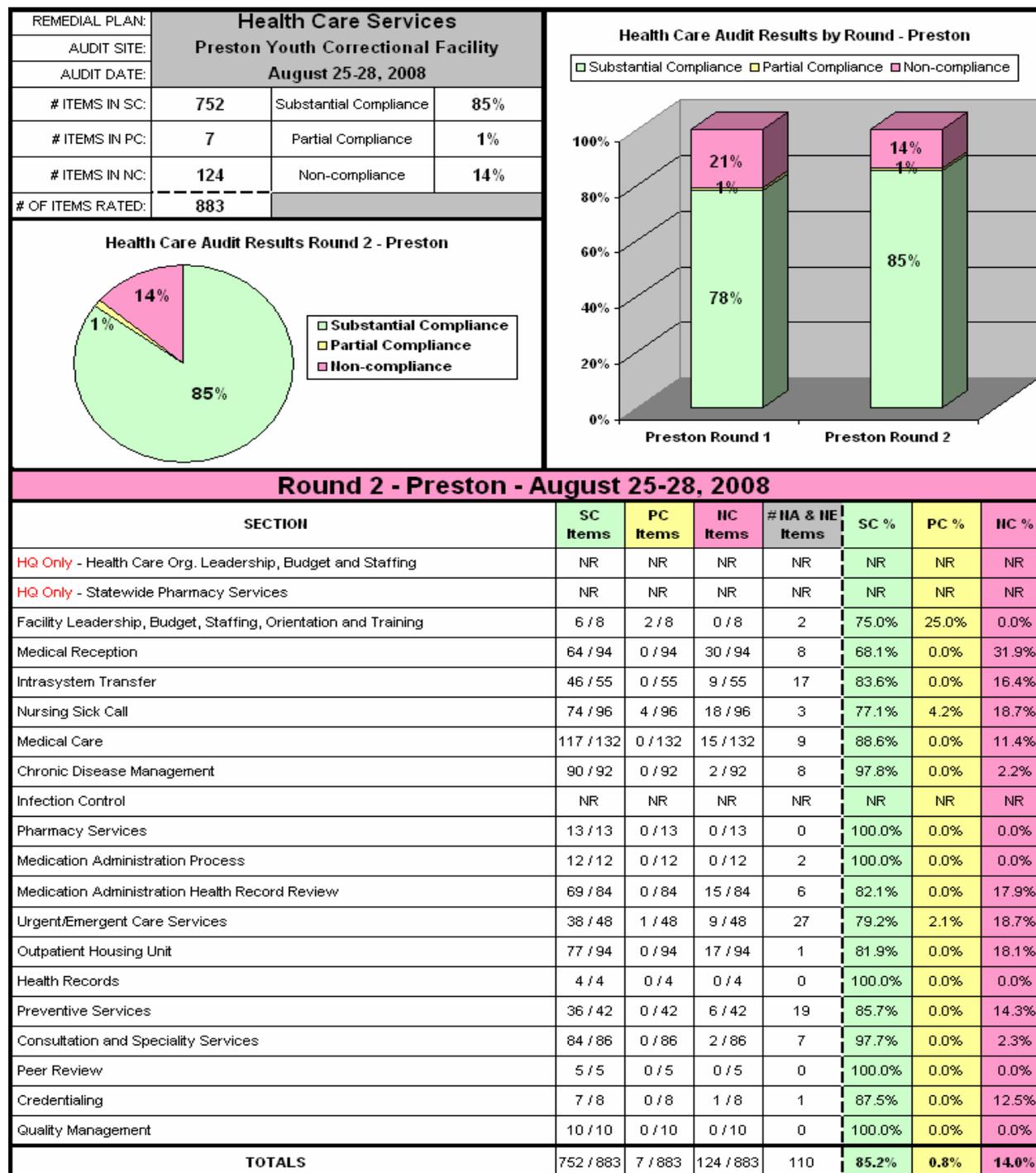
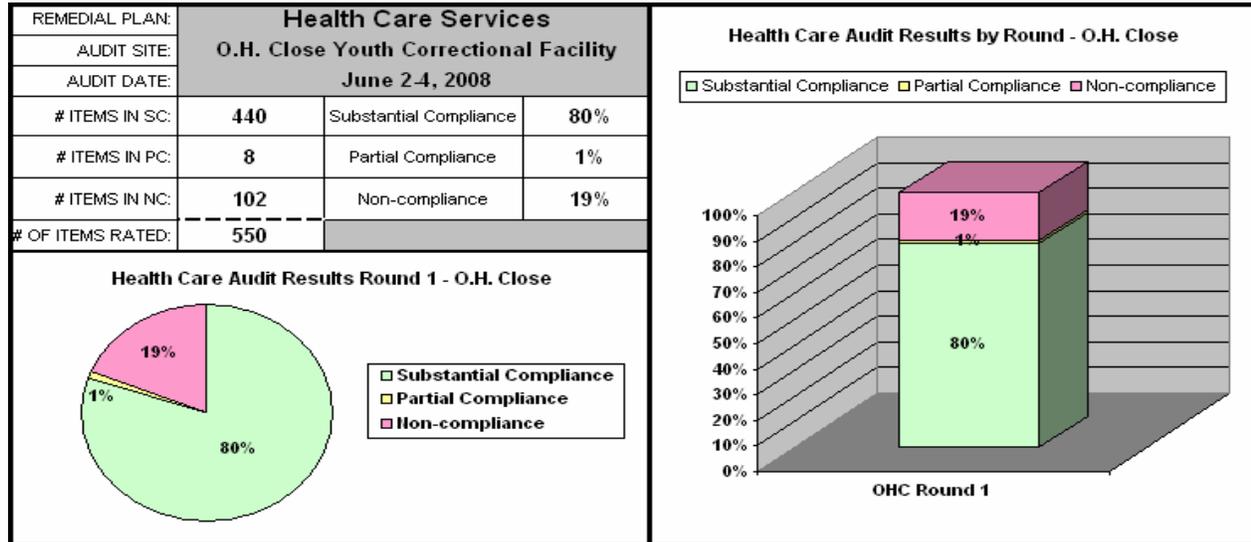


Figure 38: Health Care Services Audit Results – Preston Youth Correctional Facility

O.H. CLOSE YOUTH CORRECTIONAL FACILITY

The Health Care Experts last audited the O.H. Close Youth Correctional Facility on June 2-4, 2008. The pie chart below identifies the results from this audit, and the bar graph on the right provides a side-by-side comparison from the facility's previous audits. Because this is the first round of audits, the bar graph will illustrate the same compliance data as that of the pie chart. Below the graphs are the statistical data associated with this audit.

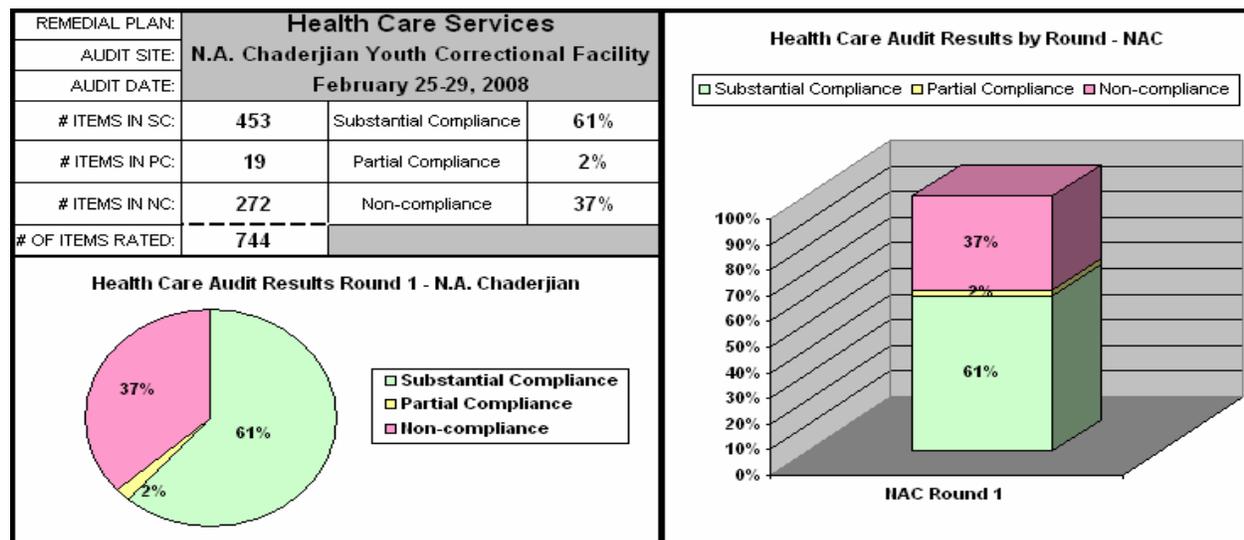


O.H. Close - June 2-4, 2008							
SECTION	SC Items	PC Items	NC Items	# IA & IE Items	SC %	PC %	NC %
HO Only - Health Care Org. Leadership, Budget and Staffing	HR	HR	HR	HR	HR	HR	HR
HO Only - Statewide Pharmacy Services	HR	HR	HR	HR	HR	HR	HR
Facility Leadership, Budget, Staffing, Orientation and Training	6 / 9	3 / 9	0 / 9	1	66.7%	33.3%	0.0%
Medical Reception	HR	HR	HR	HR	HR	HR	HR
Intrasystem Transfer	40 / 51	0 / 51	11 / 51	21	78.4%	0.0%	21.6%
Nursing Sick Call	5 / 9	0 / 9	4 / 9	90	55.6%	0.0%	44.4%
Medical Care	122 / 126	0 / 126	4 / 126	15	96.8%	0.0%	3.2%
Chronic Disease Management	71 / 86	0 / 86	15 / 86	14	82.6%	0.0%	17.4%
Infection Control	2 / 4	2 / 4	0 / 4	5	50.0%	50.0%	0.0%
Pharmacy Services	HR	HR	HR	HR	HR	HR	HR
Medication Administration Process	11 / 12	1 / 12	0 / 12	2	91.7%	8.3%	0.0%
Medication Administration Health Record Review	60 / 80	0 / 80	20 / 80	10	75.0%	0.0%	25.0%
Urgent/Emergent Care Services	26 / 48	1 / 48	21 / 48	27	54.2%	2.1%	43.7%
Outpatient Housing Unit	HR	HR	HR	HR	HR	HR	HR
Health Records	1 / 4	1 / 4	2 / 4	0	25.0%	25.0%	50.0%
Preventive Services	31 / 40	0 / 40	9 / 40	21	77.5%	0.0%	22.5%
Consultation and Speciality Services	65 / 81	0 / 81	16 / 81	12	80.2%	0.0%	19.8%
Peer Review	HR	HR	HR	HR	HR	HR	HR
Credentialing	HR	HR	HR	HR	HR	HR	HR
Quality Management	HR	HR	HR	HR	HR	HR	HR
TOTALS	440 / 550	8 / 550	102 / 550	218	80.0%	1.5%	18.5%

Figure 39: Health Care Services Audit Results – O.H. Close Youth Correctional Facility

N.A. CHADERJIAN YOUTH CORRECTIONAL FACILITY

The Health Care Experts last audited the N.A. Chaderjian Youth Correctional Facility on February 25-29, 2008. The pie chart below identifies the results from this audit, and the bar graph on the right provides a side-by-side comparison from the facility's previous audits. Because this is the first round of audits, the bar graph will illustrate the same compliance data as that of the pie chart. Below the graphs are the statistical data associated with this audit.

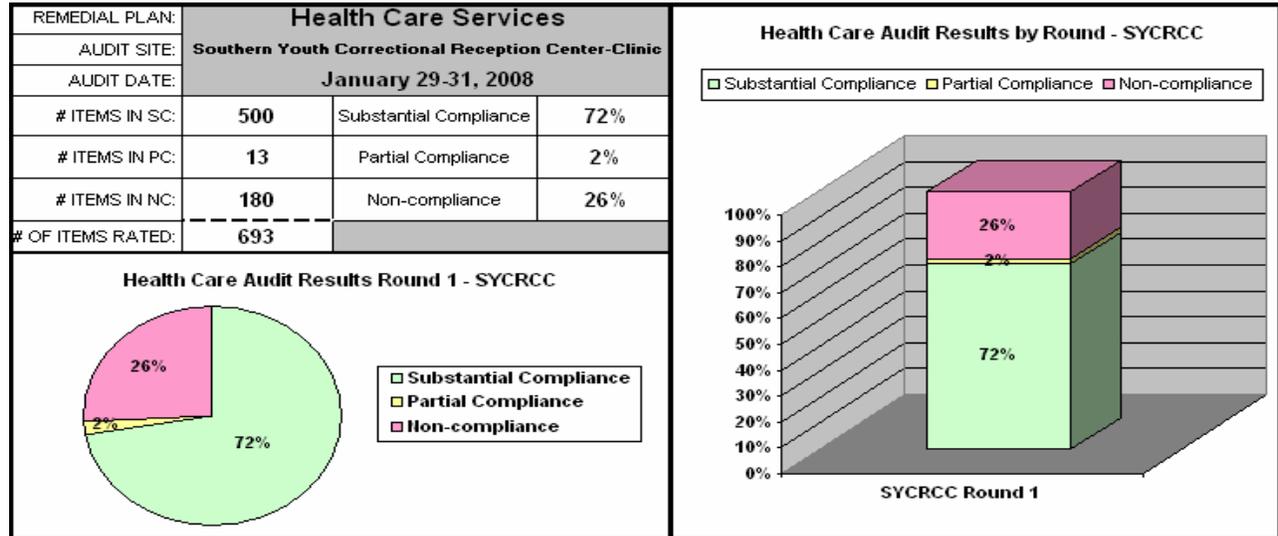


N.A. Chaderjian - February 25-29, 2008							
SECTION	SC Items	PC Items	NC Items	# NA & IE Items	SC %	PC %	NC %
HO Only - Health Care Org. Leadership, Budget and Staffing	HR	HR	HR	HR	HR	HR	HR
HO Only - Statewide Pharmacy Services	HR	HR	HR	HR	HR	HR	HR
Facility Leadership, Budget, Staffing, Orientation and Training	5 / 9	4 / 9	0 / 9	1	55.5%	44.4%	0.0%
Medical Reception	32 / 77	0 / 77	45 / 77	25	41.6%	0.0%	58.4%
Intrasystem Transfer	29 / 52	0 / 52	23 / 52	20	55.8%	0.0%	44.2%
Nursing Sick Call	HR	HR	HR	HR	HR	HR	HR
Medical Care	39 / 60	0 / 60	21 / 60	11	65.0%	0.0%	35.0%
Chronic Disease Management	81 / 134	0 / 134	53 / 134	36	60.4%	0.0%	39.5%
Infection Control	3 / 8	4 / 8	1 / 8	1	37.5%	50.0%	12.5%
Pharmacy Services	13 / 13	0 / 13	0 / 13	0	100%	0.0%	0.0%
Medication Administration Process	6 / 10	3 / 10	1 / 10	4	60.0%	30.0%	10.0%
Medication Administration Health Record Review	67 / 84	0 / 84	17 / 84	6	79.8%	0.0%	20.2%
Urgent/Emergent Care Services	42 / 73	1 / 73	30 / 73	37	57.5%	1.4%	41.1%
Outpatient Housing Unit	56 / 77	1 / 77	20 / 77	0	72.7%	1.3%	26.0%
Health Records	0 / 4	3 / 4	1 / 4	0	0.0%	75.0%	25.0%
Preventive Services	37 / 47	0 / 47	10 / 47	14	78.7%	0.0%	21.3%
Consultation and Speciality Services	27 / 72	0 / 72	45 / 72	21	37.5%	0.0%	62.5%
Peer Review	3 / 5	0 / 5	2 / 5	0	60.0%	0.0%	40.0%
Credentialing	8 / 9	0 / 9	1 / 9	0	88.9%	0.0%	11.1%
Quality Management	5 / 10	3 / 10	2 / 10	0	50.0%	30.0%	20.0%
TOTALS	453 / 744	19 / 744	272 / 744	176	60.9%	2.5%	36.6%

Figure 40: Health Care Services Audit Results – N.A. Chaderjian Youth Correctional Facility

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER-CLINIC

The Health Care Experts last audited the Southern Youth Correctional Reception Center-Clinic on January 29-31, 2008. The pie chart below identifies the results from this audit, and the bar graph on the right provides a side-by-side comparison from the facility's previous audits. Because this is the first round of audits, the bar graph will illustrate the same compliance data as that of the pie chart. Below these diagrams is the statistical data associated with this audit.



SYCRCC - January 29-31, 2008								
Southern Youth Correctional Reception Center-Clinic - January 29-31, 2008	SECTION	SC Items	PC Items	NC Items	# IIA & IIE Items	SC %	PC %	NC %
	HO Only - Health Care Org. Leadership, Budget and Staffing	11R	11R	11R	11R	11R	11R	11R
	HO Only - Statewide Pharmacy Services	11R	11R	11R	11R	11R	11R	11R
	Facility Leadership, Budget, Staffing, Orientation and Training	3 / 7	4 / 7	0 / 7	3	42.9%	57.1%	0.0%
	Medical Reception	54 / 86	2 / 86	30 / 86	16	62.8%	2.3%	34.9%
	Intrasystem Transfer	13 / 22	1 / 22	8 / 22	8	59.1%	4.5%	36.4%
	Nursing Sick Call	42 / 71	1 / 71	28 / 71	28	59.1%	1.4%	39.4%
	Medical Care	35 / 51	0 / 51	16 / 51	20	68.6%	0.0%	31.4%
	Chronic Disease Management	31 / 61	0 / 61	30 / 61	39	50.8%	0.0%	49.2%
	Infection Control	5 / 8	2 / 8	1 / 8	1	62.5%	25.0%	12.5%
	Pharmacy Services	13 / 13	0 / 13	0 / 13	0	100.0%	0.0%	0.0%
	Medication Administration Process	9 / 12	2 / 12	1 / 12	2	75.0%	16.7%	8.3%
	Medication Administration Health Record Review	73 / 83	0 / 83	10 / 83	7	87.9%	0.0%	12.0%
	Urgent/Emergent Care Services	40 / 57	1 / 57	16 / 57	18	70.2%	1.7%	28.1%
	Outpatient Housing Unit	46 / 73	0 / 73	27 / 73	4	63.0%	0.0%	37.0%
	Health Records	4 / 4	0 / 4	0 / 4	0	100.0%	0.0%	0.0%
	Preventive Services	36 / 41	0 / 41	5 / 41	20	87.8%	0.0%	12.2%
	Consultation and Speciality Services	85 / 87	0 / 87	2 / 87	6	97.7%	0.0%	2.3%
	Peer Review	2 / 3	0 / 3	1 / 3	2	66.7%	0.0%	33.3%
	Credentialing	4 / 6	0 / 6	2 / 6	3	66.7%	0.0%	33.3%
	Quality Management	5 / 8	0 / 8	3 / 8	2	62.5%	0.0%	37.5%
	TOTALS	500 / 693	13 / 693	180 / 693	179	72.1%	1.9%	26.0%

Figure 41: Health Care Services Audit Results – Southern Youth Correctional Reception Center-Clinic

HEMAN G. STARK YOUTH CORRECTIONAL FACILITY

The Health Care Experts last audited the Heman G. Stark Youth Correctional Facility on October 30 through November 2, 2007. The pie chart below identifies the results from this audit, and the bar graph on the right provides a side-by-side comparison from the facility's previous audits. Because this is the first round of audits, the bar graph will illustrate the same compliance data as that of the pie chart. Below these diagrams is the statistical data associated with this audit.

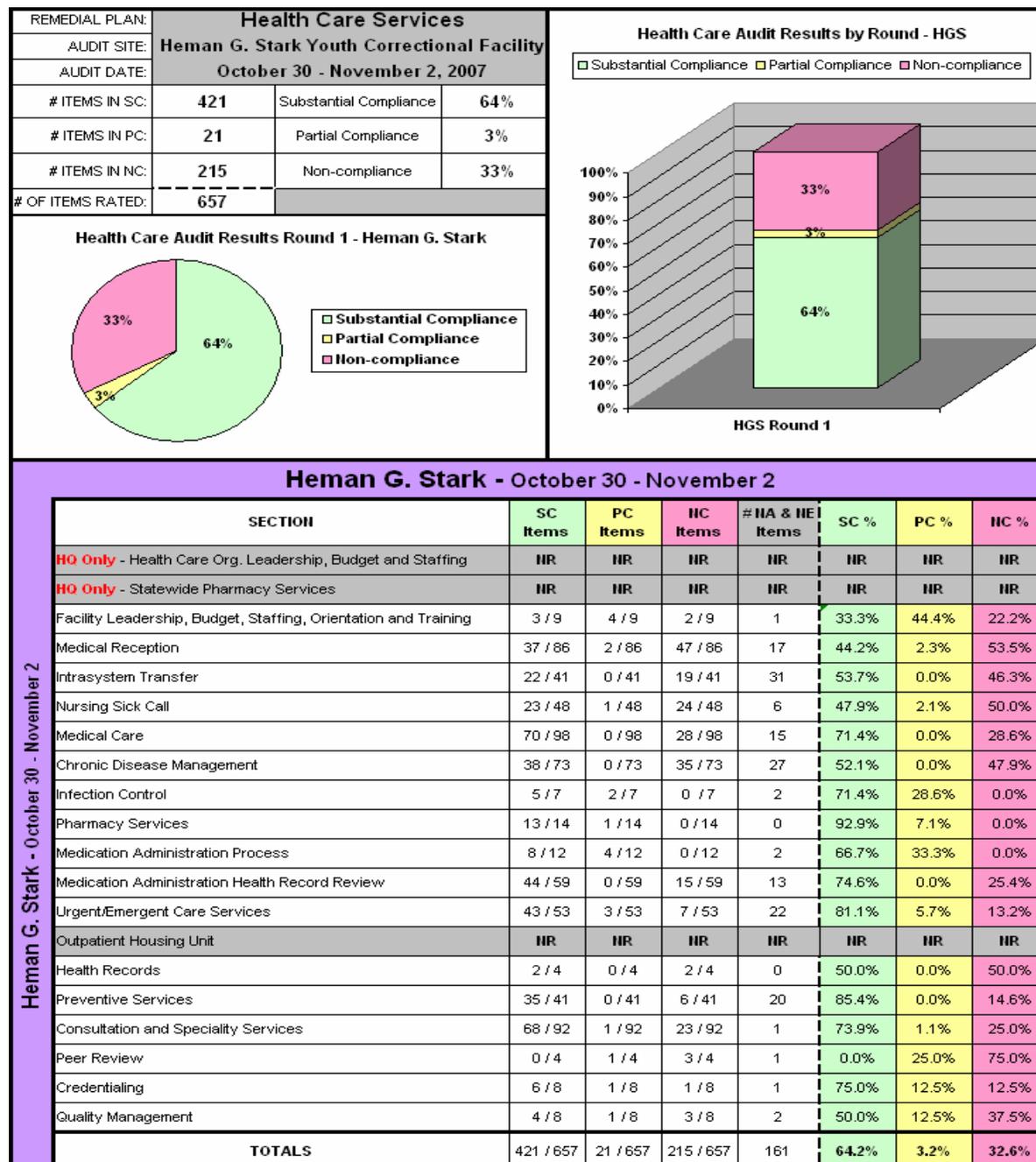


Figure 42: Health Care Services Audit Results – Heman G. Stark Youth Correctional Facility

VENTURA YOUTH CORRECTIONAL FACILITY

The Health Care Experts last audited the Ventura Youth Correctional Facility on December 5-7, 2007. The pie chart below identifies the results from this audit, and the bar graph on the right provides a side-by-side comparison from the facility's previous audits. Because this is the first round of audits, the bar graph will illustrate the same compliance data as that of the pie chart. Below these diagrams is the statistical data associated with this audit.

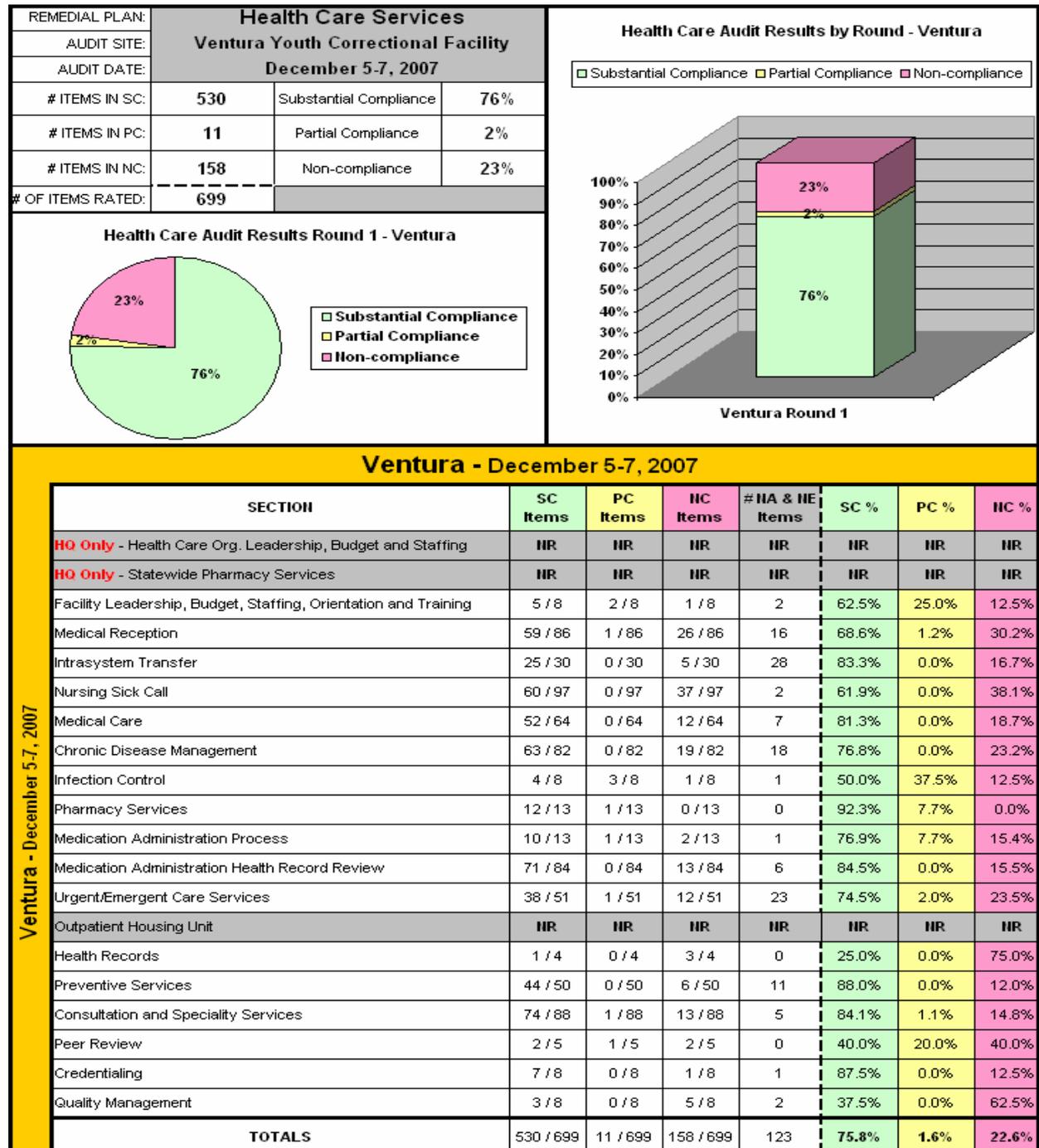


Figure 43: Health Care Services Audit Results – Ventura Youth Correctional Facility

SITE COMPARISON FOR ROUND ONE (in progress)

The chart below identifies the compliance percentages of the six facilities audited by the Health Care Experts during their Round 1 audits. Also illustrated is the cumulative average of these six audits. The only site missing from making this a complete round of audits is the Health Care Experts' audit report on DJJ Headquarters. The Headquarters audit took place in June 2008, and DJJ does not know when it will receive this report.

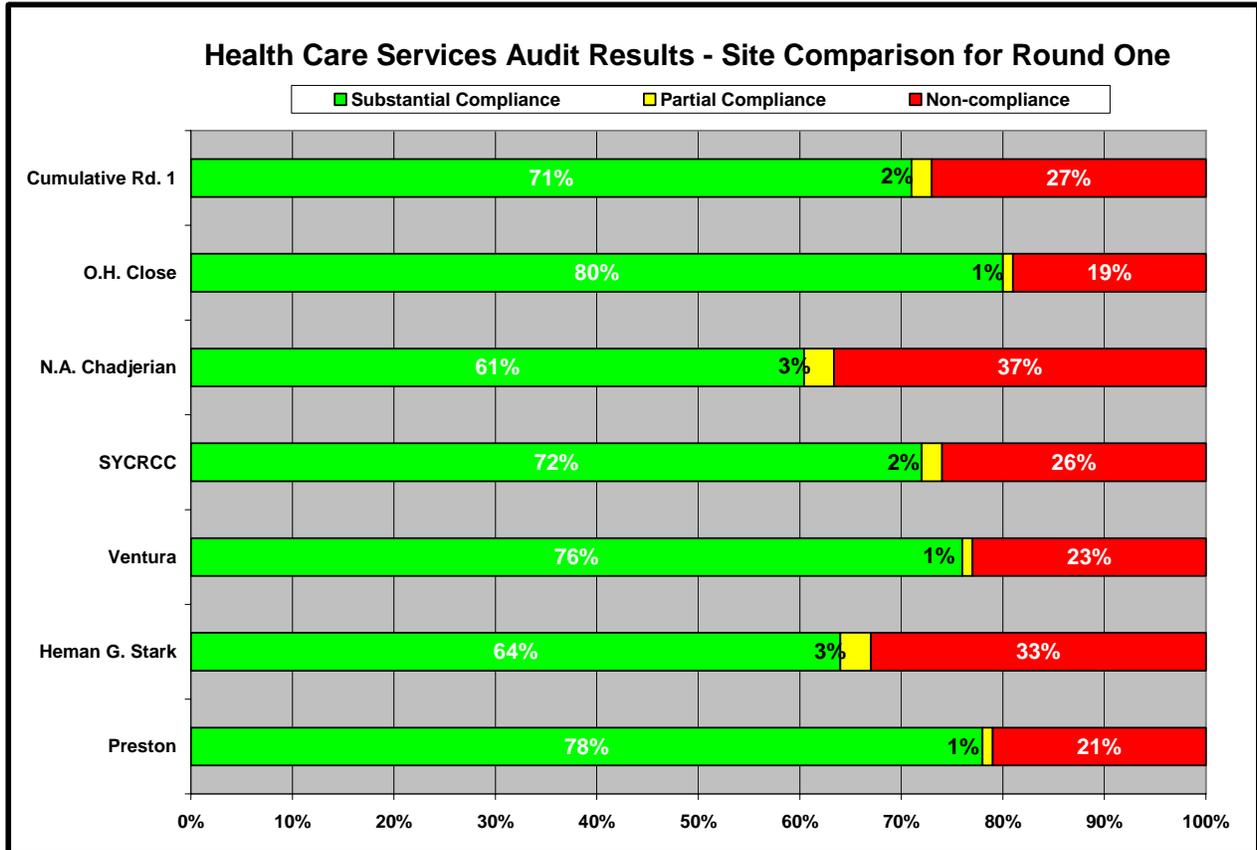


Figure 44: Health Care Services Audit Results – Site Comparison for Round One (in progress)

- Substantial Compliance percentage for the six facilities covers a range of 80% to 61%.
- Non-compliance percentage covers a range of 37% to 19%.
- Partial Compliance percentage covers a range of 3% to 1%.
- Four of the six facilities have a Substantial Compliance percentage of 72% or greater.
- The cumulative compliance averages for all six facilities are as follows:
 - 71% in Substantial Compliance
 - 2% in Partial Compliance
 - 27% in Non-compliance

CUMULATIVE COMPLIANCE BY CATEGORY FOR ROUND ONE (In progress)

The chart below identifies the cumulative compliance percentages for the 18 different categories that are audited by the Health Care Experts during a facility audit. This data is from the Health Care Experts Round One audits.

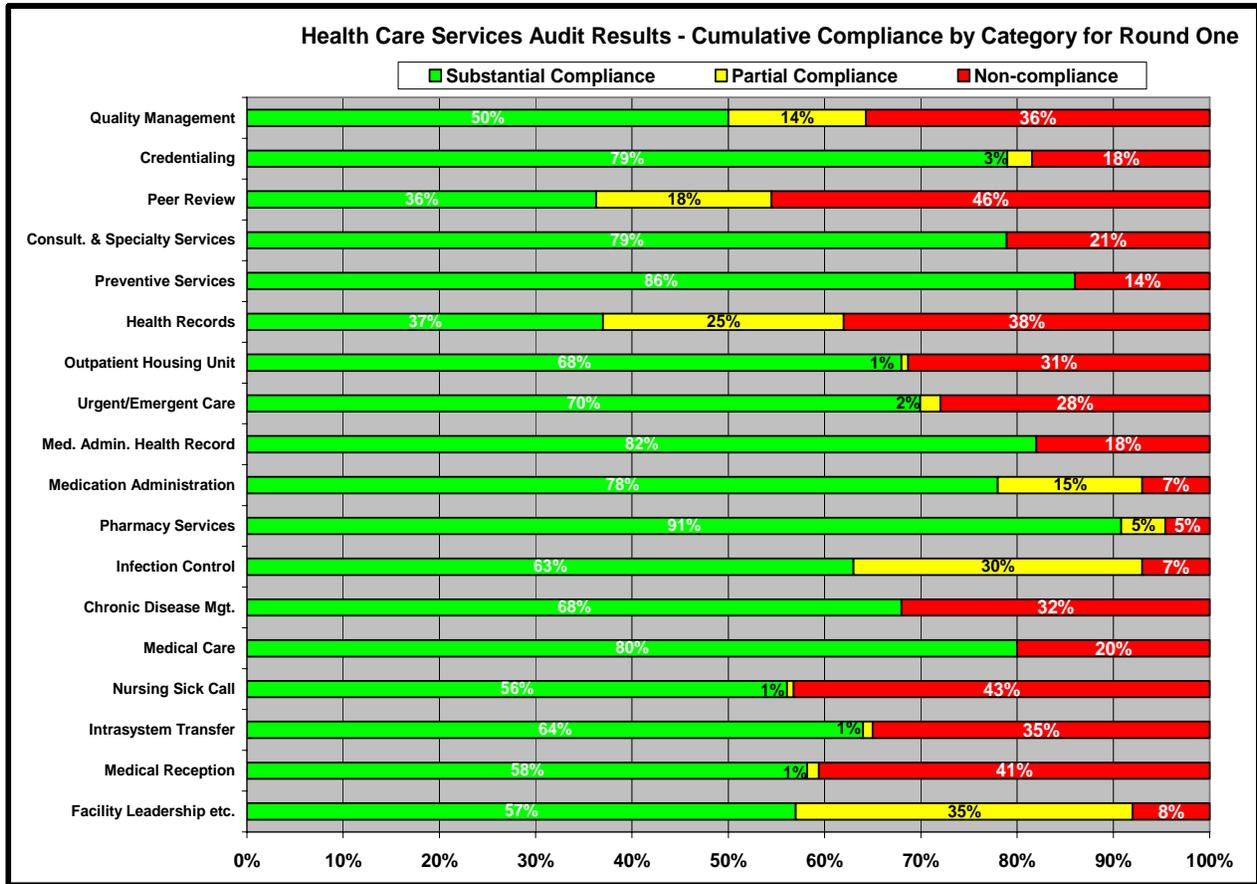


Figure 45: Health Care Services Overall Audit Results – Cumulative Compliance by Category for Round One (in progress)

- Cumulatively, DJJ is averaging 70% or more in Substantial Compliance in eight of the 18 facility categories.
- Three of the 18 facility categories are averaging 82% or more in Substantial Compliance with Pharmacy Services averaging the highest at 91%.
- Two of the 18 facility categories are averaging less than 50% in Substantial Compliance: Peer Review (36%) and Health Records (40%). DJJ anticipates that the percentages in these two areas will improve significantly for the next round of audits due to new procedures currently being put in place.
- Four of the 18 facility categories have a Non-compliance percentage of 8% or less.

2.4.4 Expert Feedback

The comments below come directly from the Health Care Experts' audit report for Preston Youth Correctional Facility. These comments represent a sampling of the comments found in the report and identify both areas of progress and areas in need of more attention and work.

- **Chronic Disease Management scored 98%.**
"This is a significant improvement from the score of 83% at our last visit. Congratulations!"
- **Medication Administration Health Record Review scored 81%.**
"This score declined from 87% at our last sight visit. Areas that need attention include clinician documentation of route of administration with each order, and accurate transcription onto the MAR and documentation of order discontinuation."
- **Health Records scored 100%.**
"This is a significant improvement from the score of 25% at our last visit. Congratulations!"
- **Preventive Services scored 86%.**
"This is a decline from the score of 96% at our last visit. Even though the facility scored greater than 85%, improvement is needed in addressing youth who are overweight."
- **Peer Review scored 100%.**
"This is a significant improvement from the score of 20% at our last visit. The medical experts auditing process reviews whether the DJJ peer review system is in place and not the accuracy/validity of individual clinician peer review. Thus we did not determine whether audit findings of physician performance were consistent with DJJs assessment of physician performance. If there are substantial differences in the audit outcomes of the medical experts and DJJ staff this should be further explored to assess the reasons. Reasons may include sampling methods and differences in interpretations of what constitutes adequate assessment, diagnosis and treatment."
- **Quality Management scored 100%.**
"This is a significant improvement from the score of 50% at our last visit. The medical experts auditing process reviews whether the DJJ quality management process is in place. We did not compare the quality management findings with our independent review. If there are substantial differences in the medical experts audit findings and those of Preston and Health Care Services staff, this should be further explored to assess the reasons. Reasons may include sampling methods and differences in interpretations of what constitutes adequate medical treatment, etc."

2.4.5 Status of Specific Action Items

Relieved Items

Page 11, paragraph 23, of the Consent Decree states:

When a facility is found to be in substantial compliance on an issue for one full year, and is found to remain in substantial compliance after review by the relevant expert(s) one year later, expert tours regarding that issue at that facility shall end.

A “relieved” audit item is one that has met or exceeded the two-year Substantial Compliance threshold and that the appropriate Expert has formally noted is to be removed from that Expert’s future monitoring.

Currently, none of the Health Care Services audit items meet the time threshold and thus have not yet been deemed relieved by the Health Care Experts.

Audit Items in Substantial Compliance Two Years or Longer

Since this is the Health Care Experts’ first round of audits, there are no audit items that have met this time threshold.

Items Removed from Relieved Status

Since this is the Health Care Experts first round of audits, there are no audit items that have met the time threshold, as identified in the Consent Decree, to be eligible to be relieved from future monitoring at this time.

Statewide Compliance Items

There are 32 action items for which the Health Care Experts have provided Substantial Compliance ratings to each of the applicable facilities audited during the last round of audits. When an action item receives a Substantial Compliance rating for every applicable site that was audited, this is referred to as being in “Statewide Compliance.”

The chart below lists the 32 action items in which every facility that was audited received a Substantial Compliance rating during the last round of audits:

Health Care Services Action Items in Statewide Compliance – Round One			
DJJ #	Item#	Action Item	Deadline
24	Facility Leadership – Question 4	Budgeted and actual physician staffing hours are sufficient to meet policy and procedures requirements, and to provide quality medical services.	N/A
26	Facility Leadership – Question 6	Medical Technical Assistant’s (MTA) primary responsibilities will be the performance of health care duties.	N/A
53	Nursing Sick Call – Question 2	Youth can confidentially submit Health Services Request forms (HSRF) daily into a locked box.	N/A
54	Nursing Sick Call – Question 3	Upon request, custody or health care staff assists youth with completion of the HSRFs.	N/A
93	Infection Control – Question 6	Compliance with work practice controls.	N/A

Health Care Services Action Items in Statewide Compliance – Round One			
DJJ #	Item#	Action Item	Deadline
97	Pharmacy Services – Question 1	Is the pharmacy currently licensed?	N/A
101	Pharmacy Services – Question 5	Does the pharmacy have computers and software programs to track medication usage, inventory, cost, drug-drug interactions, and clinical prescribing patterns?	N/A
102	Pharmacy Services – Question 6	Is there a strict accountability for all medications dispensed from the pharmacy, including medications administered from a night locker?	N/A
103	Pharmacy Services – Question 7	Is there a pharmacy system for monitoring patient adverse drug reactions and drug-drug interactions?	N/A
104	Pharmacy Services – Question 8	Does the facility have a 24-hour prescription service or other mechanism to provide essential medications 24 hours per day?	N/A
105	Pharmacy Services – Question 9	Are stock bottles of legend medications kept inside the pharmacy?	N/A
107	Pharmacy Services – Question 11	Are youth with asthma permitted to keep inhalers in their possession? Are youth permitted to keep other medications in their possession as determined by the CMO?	N/A
108	Pharmacy Services – Question 13	The pharmacist provides a monthly report detailing pharmacy utilization costs, drug stop lists, monthly lists of drugs used by class, and daily physician prescribing lists.	N/A
109	Pharmacy Services – Question 14	When a youth paroled, is medication continuity provided in accordance with the policy?	N/A
110	Med. Admin Process – Question 1	Are medications administrated from centralized medication rooms, except in specialized mental health units, SMP, TD, or BTP?	N/A
113	Med. Admin Process – Question 4	Are all medications in the Documed or night locker current and accounted for?	N/A
116	Med. Admin Process – Question 7	The medication room contains no medication that are discontinued or expired.	N/A
118	Med. Admin Process – Question 9	Does the nurse administer all legend medication from properly labeled containers and not from stock bottles?	N/A
121	Med. Admin Process – Question 12	Is the medication refrigerator clean and used only to store medications? Does staff check and log the temperature daily?	N/A
122	Med. Admin Process – Question 13	Medications are not crushed except upon a physician order and for a valid reason. Time-released medications are not crushed.	N/A
148	OHU – Question 4	There is in policy and actual practice a physician on call 24 hours per day, 7 days a week.	N/A
150	OHU – Screen 1	The clinician (MD, NP, PA, or psychologist) wrote or gave verbal order to place the youth in the OHU.	N/A
165	Preventive Services – Screen 2	Annual pap smears were performed (at a minimum) beginning 3 years after initiation of sexual intercourse and 2 consecutive years thereafter. If there are 3 consecutive normal annual pap smears, then they are performed every 3 years thereafter. Management of abnormal pap smears was appropriate, including referral.	N/A

Health Care Services Action Items in Statewide Compliance – Round One			
DJJ #	Item#	Action Item	Deadline
169	Preventive Services – Screen 6	Youth are offered Tetanus-Diphtheria Booster if not received within ten years.	N/A
188	Credentialing – Question 2	Credential files are stored in a locked cabinet with access limited to those with a legitimate need to know.	N/A
189	Credentialing – Question 3	Specific staff are assigned to maintain the credential files.	N/A
191	Credentialing – Question 5	Review of credentialing process listed in question #4 reveals no substantial problems or concerns regarding the clinician's mental fitness, clinical competence, or moral character.	N/A
192	Credentialing – Question 6	Re-credentialing occurs bi-annually. All files are current.	N/A
193	Credentialing – Question 7	Physicians, nurse practitioners, and physician assistants do not begin work until the credentialing process is completed.	N/A
195	Credentialing – Question 9	Physicians treating HIV infected youth are board certified in infectious disease (ID) or have completed a primary care residency with additional HIV related training, and are expected in the treatment of HIV patients.	N/A
198	Quality Management – Question 3	The composition of the institutional QM Committee meetings meets policy requirements.	N/A
199	Quality Management – Question 4	Minutes of the QM Committee are available for review.	N/A

Action Items with Majority Ratings of Non-compliance

The Health Care Experts have completed their facility audits for Round One, and as a result, DJJ is now able to identify the facility action items that were most frequently rated as being in Non-compliance. This information is useful to DJJ in that it identifies the areas that DJJ must continue to make improvements.

The chart on the next page identifies 27 Health Care Services action items that received a Non-compliance rating for the majority of the ratings it received:

Health Care Services Action Items with Majority of Ratings of Non-compliance – Round One			
DJJ #	Item#	Action Item	Deadline
23	Facility Leadership – Question 4	In both policy and actual practice, the facility is assigned a health care budget that is under the control of the CMO.	N/A
38	Medical Reception – Screen 6	A clinician performed a history and physical including a testicular exam for males and pelvic examination for females (if clinically indicated) within seven calendar days of arrival.	N/A
39	Medical Reception – Screen 7	A clinician (MD, NP, or PA) initiated a Problem List noting all significant medical, dental, and mental health diagnosis.	N/A
40	Medical Reception – Screen 8	A clinician documented an appropriate treatment plan on the History and Physical Exam Form or in the Progress Notes. The plan included appropriate diagnostic, therapeutic measures, patient education, and clinical monitoring (if indicated).	N/A
48	Intrasystem Transfer – Screen 4	The receiving physician reviewed the health record of each youth within one business day of arrival and legibly signed and dated the Intrasystem form. The clinician addressed any significant medical problems.	N/A

Health Care Services Action Items with Majority of Ratings of Non-compliance – Round One			
DJJ #	Item#	Action Item	Deadline
51	Intrasystem Transfer – Screen 7	The UHR shows that medical care ordered at the previous facility (e.g., vaccinations, consultations, laboratory tests) was carried out following arrival, or a clinical progress note provided an appropriate rationale for doing otherwise.	N/A
52	Nursing Sick Call – Question 1	There is a local policy and procedure that is consistent with the statewide policy.	N/A
57	Nursing Sick Call – Question 6	All registered nurses conducting sick call have been trained and demonstrate competency in health assessment and use of nursing protocols.	N/A
59	Nursing Sick Call – Question 8	Nurses conduct sick call with, at a minimum, auditory privacy, and also with visual privacy if a physical examination is performed.	N/A
63	Nursing Sick Call – Screen 3	The nursing subjective history was appropriate to the patient's complaint and included a description of onset of symptoms.	N/A
64	Nursing Sick Call – Screen 4	The nursing physical assessment and collection of objective data was appropriate to the complaint (e.g., vital signs, Snellen test, urine dipstick, etc.).	N/A
65	Nursing Sick Call – Screen 5	The nursing diagnosis/assessment was appropriate based on the clinical findings.	N/A
79	Chronic Disease Mgt – Screen 2	For the initial chronic care visit the clinician performed an appropriate medical history, physical examination pertinent to the management of the chronic disease.	N/A
131	Health Record Review – Screen 8	For discontinued medications, the nurse discontinued medications according to policy.	N/A
136	Urgent/Emergent Care – Question 4	There is documentation that health care providers have been trained regarding emergency response.	N/A
145	OHU – Question 1	There is a local policy and procedure that is consistent with the statewide policy and procedure.	N/A
147	OHU – Question 3	There is a current, standardized nursing procedure manual in the OHU at all times.	N/A
151	OHU – Screen 2	The clinician orders include the initial impression: diagnostic and therapeutic measures, the frequency of vital signs, and other monitoring (e.g., peak flow meter and capillary glucose measurements, etc.), and clinical criteria for notifying the physician (change in clinical status).	N/A
153	OHU – Screen 4	A nurse documented an appropriate initial assessment, plan of care, and patient education (including orientation to the OHU).	N/A
159	Health Records – Question 1	Local policies are consistent with statewide policies and procedures, and address all aspects of health record management.	N/A
167	Preventive Services – Screen 4	A nurse measures the youth weight annually. Obesity is addressed if clinically indicated (BMI >24 %).	N/A
182	Peer Review – Question 1	The local peer review policy and procedure, and actual practice are consistent with the statewide policy and procedure.	N/A
183	Peer Review – Question 2	The Statewide DJJ Medical Director, Health Care Director, or clinical service chief monitors the peer review process, which includes regular reporting from the facilities on peer review activities and regular quality management meetings at least annually.	N/A
187	Credentialing – Question 1	The local credential policies and procedures, and actual practice are consistent with statewide policies and procedures.	N/A
200	Quality Mgt – Question 5	QM studies for the previous 2 quarters from the date of the last audit are available for review.	N/A

Health Care Services Action Items with Majority of Ratings of Non-compliance – Round One			
DJJ #	Item#	Action Item	Deadline
203	Quality Mgt – Question 8	Physician Chart Reviews.	N/A
205	Quality Mgt – Question 10	On at least an annual basis, the Chief Medical Officer develops a Quality Management report for the Statewide Medical Director.	N/A

2.4.6 Proof of Practice

The following chart identifies Health Care-related Proof of Practice documents that have been sent to the Health Care Experts and the Special Master during the last quarter. The Proof of Practice documents provide evidence of DJJ’s efforts to come into compliance with the identified action items within each *Farrell* Remedial Plan.

Health Care Services Proof of Practice Documents Submitted During the Last Quarter				
PoP #	Section	Audit Item Description	Documents Submitted	Date
287	N/A	N/A	1 – Document entitled “Key Audit Items for Expert’s Verification” (31 pages). This document is being submitted to the Health Care Services Experts to allow them the opportunity to review it and ensure that the document correctly identifies the items that were submitted. This constitutes DJJ’s second submission of the reporting tool to the Experts. This submission also contains additional information that DJJ relied upon in drafting the reporting tool, including information provided by and/or derived from consultations with the Experts.	11/20/08

2.4.7 Summary and Application of Audit Findings

The audit reports that DJJ has received from the Health Care Services Experts thus far for their first round of audits have shown promising results, which DJJ hopes to continue to show improvement upon during the next round of audits and each successive round thereafter.

However, DJJ is still awaiting receipt of the Health Care Experts’ report for the audit they performed at DJJ Headquarters in June 2008 as well as their Annual Report. DJJ remains hopeful of receiving both of these reports soon to better enable it to gain perspective of where its strengths and its weaknesses are when it comes to implementing the goals of the Health Care Services Remedial Plan.

As for Dental Services, DJJ looks forward to continuing to work with the Dental Services Expert. The results of the Dental Services Expert’s pilot audit at Preston Youth Correctional Facility on November 14, 2008, were promising and encouraging, and DJJ remains optimistic that continued collaboration with the Dental Services Expert will enable it to progress and make improvements in providing enhanced dental services to youths.

2.5 Safety & Welfare Remedial Plan Compliance Status

2.5.1 Historical Audit Perspective

Court Filings

The Safety & Welfare Remedial Plan was filed with the Court on July 10, 2006. The audit tool was filed with the Court on October 31, 2006.

Audit Tool

The Safety & Welfare audit tool contains 227 action items, 225 of which have a deadline for implementation. The two action items that do not have a deadline are Section 8.4, Item 3, and Section 8.5, Item 13. Both of these action items read, "Assistance to youth with disabilities." To date, neither of these audit items has received a compliance rating from the Safety & Welfare Expert.

The 227 action items associated with the Safety & Welfare Remedial Plan represent the highest number for any *Farrell* audit tool. However, in terms of audit items, the Safety & Welfare Remedial Plan has only the third most, with the Health Care Services and Education Services Remedial Plans having more. With the six DJJ facilities, the Safety & Welfare audit tool has 661 audit items connected to its 227 action items.

There are two unique aspects shared by both the Safety & Welfare audit tool and the Mental Health audit tool that are not shared with the other four *Farrell* Remedial Plans' respective audit tools. Specifically, all of the Safety & Welfare and Mental Health audit items have deadlines, many of which are staggered to account for the phasing-in of reform-related tasks at each facility. The second aspect is that there are different sets of Court monitors who are responsible for auditing various audit items within these two audit tools.

In the Safety & Welfare audit tool, either the Safety & Welfare Expert, the Office of the Special Master, or the Mental Health Experts may be identified as the party responsible for providing compliance ratings to specific action items.

The Safety & Welfare audit tool is a complex document, but it clearly identifies who is required to monitor what, where, and for the most part, when. However, despite the fact that the delegation of monitoring duties is fairly clear, there still appears to be some confusion among the parties as to who monitors which audit items and where. It would be very useful to DJJ if the various parties who are required to monitor the Safety & Welfare Remedial Plan would adhere to the audit tool that was filed with the Court or, conversely, work cooperatively with DJJ to develop a more standardized and collaborative approach that will eliminate confusion and keep DJJ better apprised of what will be monitored and by whom.

Audit Tool Breakdown

Audit Item Numbers Based on Six Facilities	Filing Dates		"Action Items"			"Audit Items"		
	Remedial Plan	Audit Tool	# of Action Items with a Deadline	# of Action Items without a Deadline	Total # of Action Items	# of Audit Items with a Deadline	# of Audit Items without a Deadline	Total # of Audit Items
Safety & Welfare	7/10/06	10/31/06	225	2	227	772	18	790

Audit History

Commencing with the filing of the audit tool in October 2006 and through November 2007, the Safety & Welfare Expert made five different facility site visits to a total of three facilities: Heman G. Stark Youth Correctional Facility (three site visits), N.A. Chaderjian Youth Correctional Facility (one site visit), and Preston Youth Correctional Facility (one site visit). The Safety & Welfare Expert submitted a narrative report dated September 7, 2007, after commencing these visits and reported on findings from meetings held at DJJ Headquarters. However, the Safety & Welfare Expert report did not provide specific compliance ratings to specific action items; therefore, DJJ could not quantify the information in an objective manner. However, since the commencement of the Round One audits, with the November 2007 audit of El Paso de Robles Youth Correctional Facility, the Safety & Welfare Expert's audit reports have aligned with the Safety & Welfare audit tool. To date, DJJ has received Round One audit reports for all of its facilities, except for Heman G. Stark Youth Correctional Facility and DJJ Headquarters.

After reviewing the Safety & Welfare audit reports received to date, DJJ requested clarification from the Safety & Welfare Expert on some of the audit items that did not receive Substantial Compliance ratings. Specific feedback from the Safety & Welfare Expert is required for DJJ to remedy any shortcomings and determine what actions are needed to obtain Substantial Compliance on these audit items. DJJ has developed a draft document which attempts to identify what documentation would be necessary to determine Substantial Compliance. DJJ scheduled a meeting with the Safety & Welfare Expert for mid-December 2008 to go over this document and make any necessary modifications based on the Expert's feedback.

The chart below provides a more detailed schedule of the audits conducted to date by the Safety & Welfare Expert. The Safety & Welfare Expert scheduled a visit to audit Heman G. Stark Youth Correctional Facility on April 15 and 16, 2008, but was called away from the site before the audit could be completed.

Facility	ROUND ONE	ROUND TWO		ROUND THREE	
	Date Audited	Date Audited	Time Since Last Audit	Date Audited	Time Since Last Audit
El Paso de Robles	Nov. 7-9, 2007	N/A	N/A	N/A	N/A
Ventura	Mar. 5-6, 2008	N/A	N/A	N/A	N/A
SYCRCC	Mar. 20-21, 2008	N/A	N/A	N/A	N/A
Heman G. Stark	April 15, 2008	N/A	N/A	N/A	N/A
N.A. Chaderjian	April 2-4, 2008	N/A	N/A	N/A	N/A
O.H. Close	Jan. 28-29, 2008	N/A	N/A	N/A	N/A
Preston	May 27-29, 2008	N/A	N/A	N/A	N/A

Future Audit Schedule

The Safety & Welfare Expert recently provided DJJ his schedule for future audits up through the end of this fiscal year.

- DJJ Headquarters — January 14-15, 2009
- O.H. Close Youth Correctional Facility — January 27-28, 2009
- N.A. Chaderjian Youth Correctional Facility — February 17-18, 2009
- Heman G. Stark Youth Correctional Facility — March 3-4 & March 10-11, 2009
- Ventura Youth Correctional Facility — March 31-April 1, 2009
- Southern Youth Correctional Reception Center and Clinic — April 14-15, 2009
- Preston Youth Correctional Facility — April 28-29, 2009

2.5.2 Most Recent Audit Findings

Audit Reports Received During Last Quarter

DJJ has not received an audit report from the Safety & Welfare Expert during the last quarter. However, DJJ did receive an audit report from the Office of the Special Master for N.A. Chaderjian Youth Correctional Facility that provided compliance ratings for both Safety & Welfare and Mental Health audit items.

The Office of the Special Master is responsible for monitoring certain audit items within the Safety & Welfare and Mental Health audit tools. In her report, the Special Master provided compliance ratings that were specific to N.A. Chaderjian Youth Correctional Facility, as identified in the Court-approved audit tool. However, the Special Master also provided compliance ratings for the facility that, according to the Court-approved audit tool, are supposed to be used to assess only at DJJ Headquarters.

While DJJ is very appreciative of the additional information that is provided on these Headquarters-specific audit items, DJJ believes that it would be less confusing and provide for a fairer assessment of Headquarters-specific audit items if the Office of the Special Master adhered to the Court-approved audit tool and provide compliance ratings in accordance with what the audit tool requires. DJJ respectfully requests that, for those Headquarters-specific audit items that the Special Master wishes to use to provide information at the facility level, the Office of the Special Master simply provide a N/A rating to the item along with her comments or merely leave the space blank in the compliance rating section.

The chart on the following page is a listing of the Safety & Welfare audit items where the Office of the Special Master provided facility-specific compliance ratings for N.A. Chaderjian Youth Correctional Facility as they are identified in the Court approved audit tool. Compliance ratings that were provided but were not facility-required were not included in this list. Also, the chart only identifies audit items that received a compliance rating of Substantial Compliance, Partial Compliance, or Non-compliance. The chart does not list the audit items that received a "N/A" ("Not Applicable"), "NR" ("Not Rated"), or "Defer to Expert" rating. It is important to note that these compliance ratings are still considered to be in draft as DJJ has not yet had the opportunity to respond to any item(s) that it may wish to challenge or note any item(s) that has a new future deadline and therefore is not yet appropriate to be assessed with a compliance rating.

OSM Compliance Ratings For Safety & Welfare Audit Items Specific To:					
N.A. Chaderjian Youth Correctional Facility					
Date Of Audit: October 17 & 22, 2008					
#	S&W Audit Item #	Audit Item Description	Substantial Compliance	Partial Compliance	Non-Compliance
1	8.5.1	Grievance forms available without assistance	X		
2	8.5.2	Lock boxes for grievances in all living units	X		
3	8.5.3	Grievance clerk duties	X		
4	8.5.4	Notice of receipt of grievance or allegation of misconduct	X		
5	8.5.5a	Facility grievance coordinator monthly reports		X	
6	2.2.3	Designate facility compliance monitors and schedule	X		
7	2.3.3c	Establish PbS site coordinators at each facility	X		
8	2.4.3	*Facility Vocational Specialist positions filled/assigned			X
9	3.4.c	Remaining direct care staff trained (crisis mgt.)		X	
10	4.1.b	Provide training in use of risk/needs tool		X	
11	8.1.1	*All needed program space added		X	
12	8.1.1	*All needed staff space added		X	
13	6.6	*Program Service Day schedule for BTPs.			X
14	8.4.2a	Disciplinary fact finding hearings held within 14 days			X
15	8.4.2b	Disciplinary disposition hearings held within 7 days			X
16	8.6.3b	Restored months rounded up		X	
17	8.6.4c	Full program credit if youth not responsible for non-participation		X	
18	8.7.5	Print libraries replaced with electronic or internet materials		X	
19	8.3.2b	On-going family phone contact facilitated		X	
20	8.3.3	Family visiting days occur at least four times a year at each facility		X	
TOTAL			6	10	4
COMPLIANCE %			30%	50%	20%

**Denotes items that are not clearly identified in the audit tool to be specific to N.A. Chaderjian Youth Correctional Facility*

Figure 46: OSM Safety & Welfare Audit Results – N.A. Chaderjian Youth Correctional Facility

As identified in the chart above, the Office of the Special Master provided ratings for twenty Safety & Welfare audit items that are specifically attributed to N.A. Chaderjian Youth Correctional Facility in the audit tool. Of the twenty items that the Special Master provided ratings for, 30% were assessed to be in Substantial Compliance, 50% were in Partial Compliance, and 20% were in Non-compliance. These ratings will be included with those provided by the Safety & Welfare Expert and Mental Health Experts for Safety & Welfare audit items for N.A. Chaderjian Youth Correctional Facility. This combined information will be reflected in graphs and charts depicting the cumulative compliance percentages for this facility in future Quarterly Reports.

2.5.3 Safety & Welfare Audit Results

Audit Results Introduction

The Safety & Welfare charts on the following pages document the most up-to-date compliance ratings for each site audited by the Office of the Special Master, the Mental Health Experts and the Safety & Welfare Expert. These charts also include the cumulative results of the most recent audits as well as a comparison of a facility's prior audit results from previous rounds. Since this is the first round of audits for the Safety & Welfare Remedial Plan, the bar graph will illustrate the same audit results as that of the pie chart. Attached to these charts are the statistical data for each audit performed for the identified facility.

The percentages identified in the charts on the following pages have been rounded off and therefore, may have a slight variance of no more than 1% of either less than or greater than 100%. For example, in adding up the different compliance percentages, the sum total for a given item could either be 99%, 100%, or 101% due to the rounding off process.

To help fully understand the charts on the following pages, the items below are more clearly defined:

- **SC** = Substantial Compliance
- **PC** = Partial Compliance
- **NC** = Non-compliance
- **N/A** = Not Applicable
- **Numbers in red font** = A negative number denoting a decrease in a compliance percentage.
- **Raw %** = The compliance percentages with the N/A items included in the calculations.
- **Adjusted %** = The compliance percentages with the N/A items excluded from the calculations.
- ***UPDATED THIS QUARTER:** = Identifies charts and graphs that have been updated since the last Quarterly Report.

CUMULATIVE RESULTS

The pie chart below identifies the cumulative averages for all of the compliance data received to date from the Safety & Welfare Expert's current round of audits plus any compliance ratings provided by the Office of the Special Master. This data represents an incomplete round of audits as the Safety & Welfare Expert has yet to audit Heman G. Stark Youth Correctional Facility and DJJ Headquarters. The bar graph on the right compares the cumulative percentages from the different rounds of audits. Because this is the first round of audits, the bar graph will illustrate the same compliance data as that of the pie chart. Below these graphs are the statistical data associated with this round of audits.

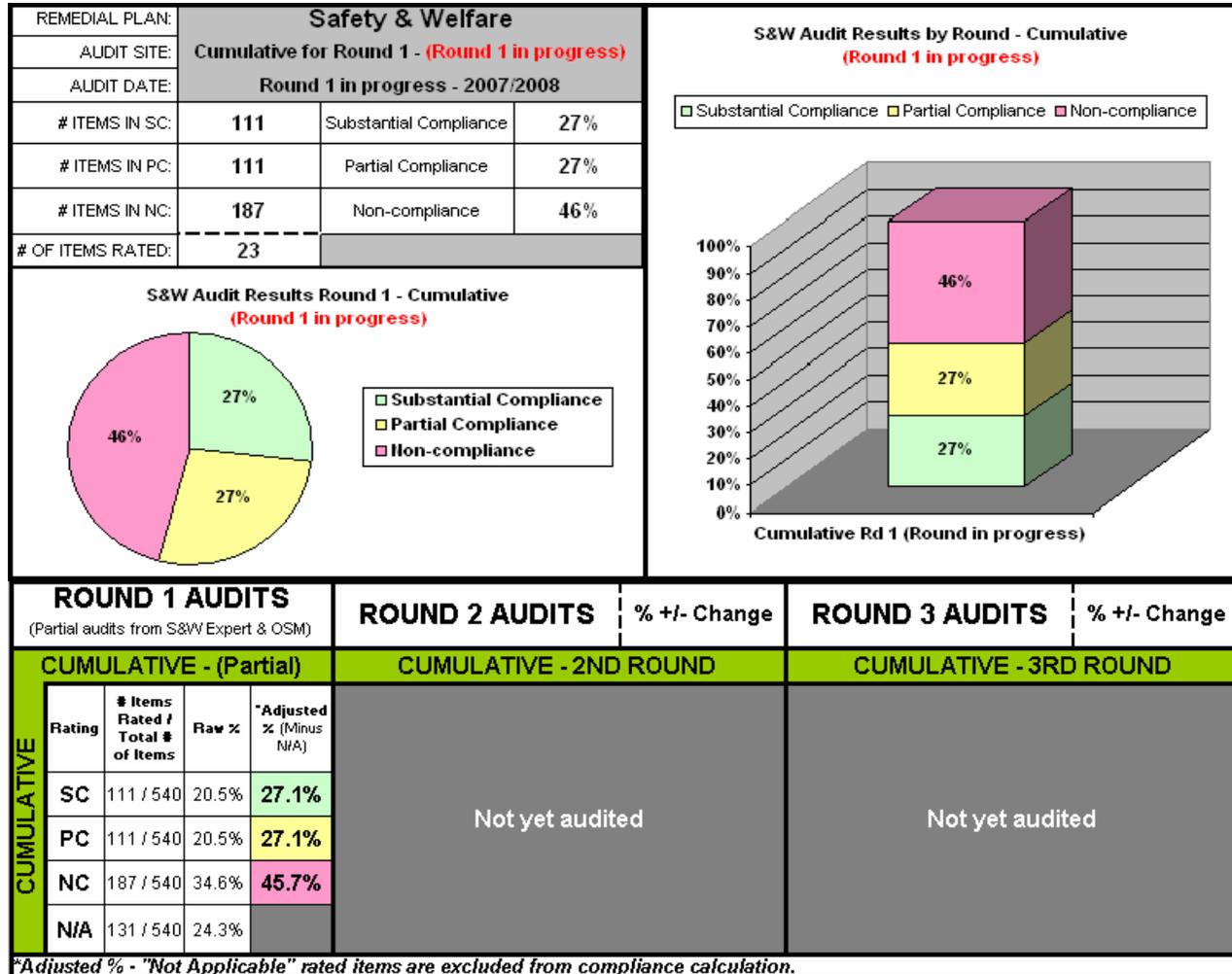


Figure 47: Safety & Welfare Audit Results – Cumulative

- The cumulative Substantial Compliance average to date is 27%.
- The cumulative Non-compliance average to date is 46%.
- The cumulative average when combining the Substantial Compliance percentage with the Partial Compliance percentage totals 54%.

N.A. CHADERJIAN YOUTH CORRECTIONAL FACILITY

The Safety & Welfare Expert last audited the N.A. Chaderjian Youth Correctional Facility on April 2-3, 2008. The pie chart below identifies the results from this audit plus any compliance ratings provided by the Office of the Special Master. The bar graph on the right provides a side-by-side comparison from the facility's previous audits. Because this is the first round of audits, the bar graph will illustrate the same compliance data as that of the pie chart. Below these graphs are the statistical data associated with this audit.

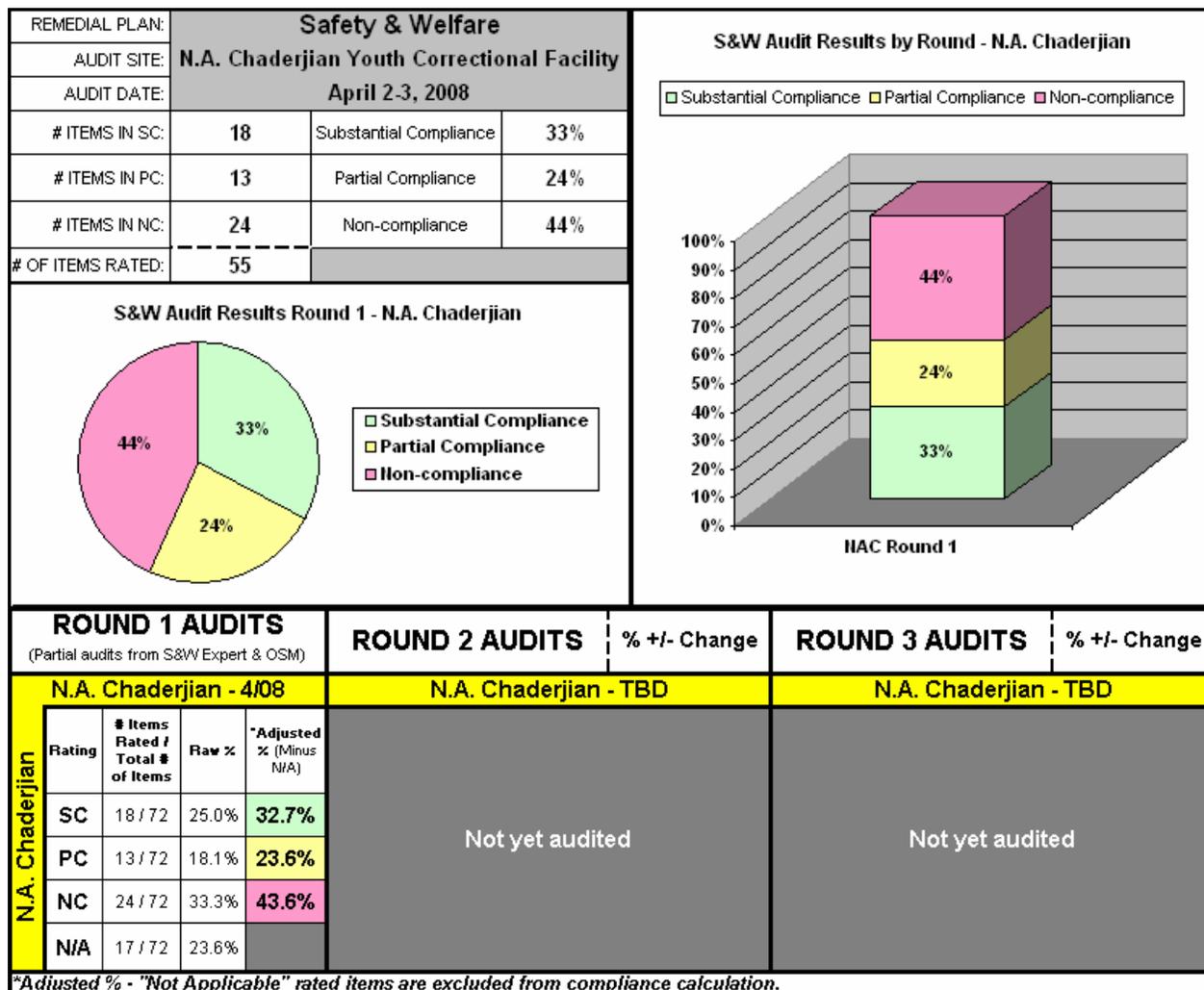


Figure 48: Safety & Welfare Audit Results – N.A. Chaderjian Youth Correctional Facility

- The facility's Substantial Compliance percentage is 33%.
- The facility's Non-compliance percentage is 44%.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 57%.

O.H. CLOSE YOUTH CORRECTIONAL FACILITY

The Safety & Welfare Expert last audited the O.H. Close Youth Correctional Facility on January 28-29, 2008. The pie chart below identifies the results from this audit plus any compliance ratings provided by the Office of the Special Master. The bar graph on the right provides a side-by-side comparison from the facility's previous audits. Because this is the first round of audits, the bar graph will illustrate the same compliance data as that of the pie chart. Below these graphs are the statistical data associated with this audit.

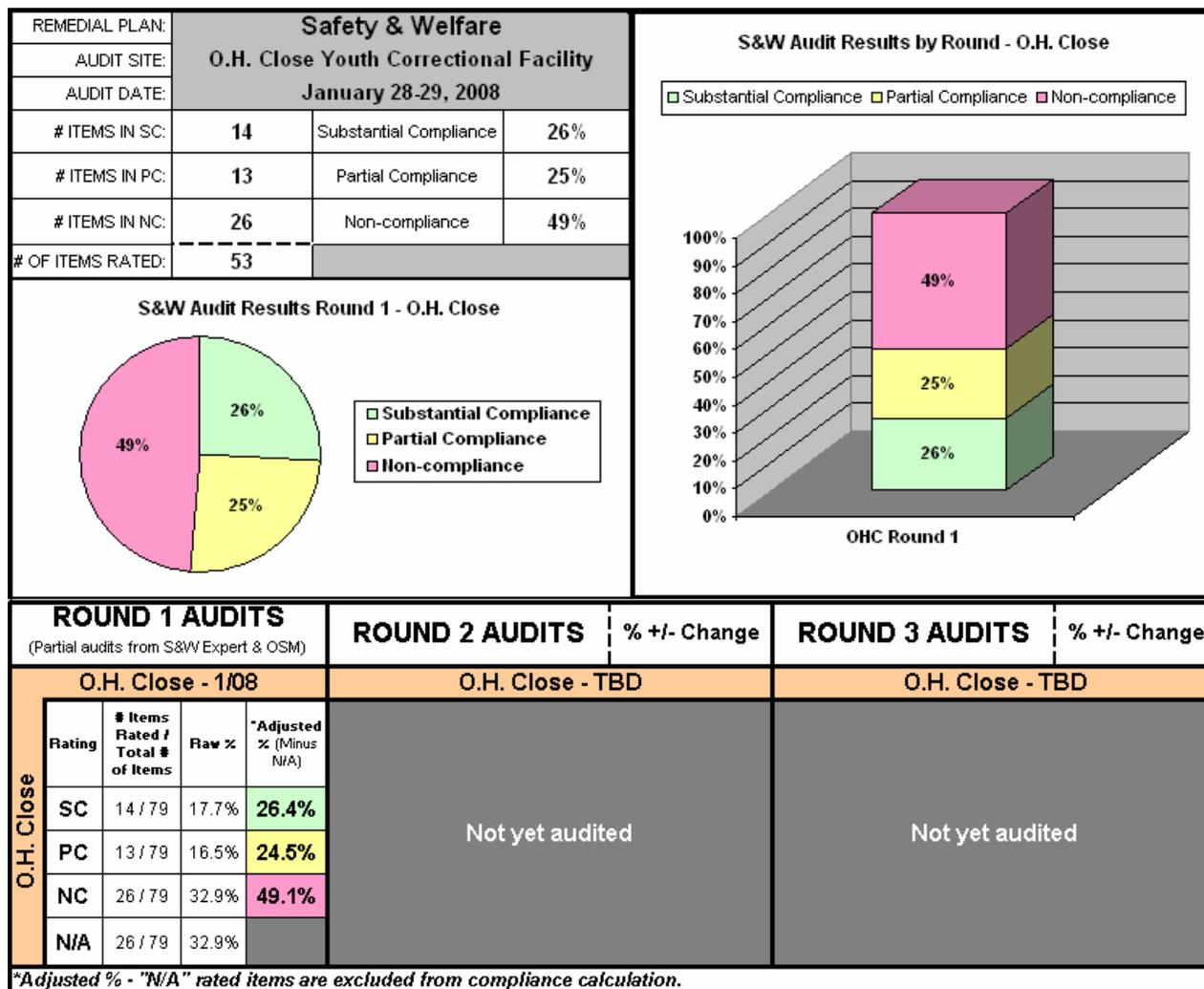


Figure 49: Safety & Welfare Audit Results – O.H. Close Youth Correctional Facility

- The facility's Substantial Compliance percentage is 26%.
- The facility's Non-compliance percentage is 49%.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 51%.

HEMAN G. STARK YOUTH CORRECTIONAL FACILITY

The Safety & Welfare Expert has not yet audited the Heman G. Stark Youth Correctional Facility. The compliance ratings below are those provided from the Office of the Special Master. The pie chart below identifies the results received to date, and the bar graph on the right provides a side-by-side comparison from the facility's previous audits. Because this is the first round of audits, the bar graph will illustrate the same compliance data as that of the pie chart. Below these graphs are the statistical data associated with the limited amount of compliance data received to date.

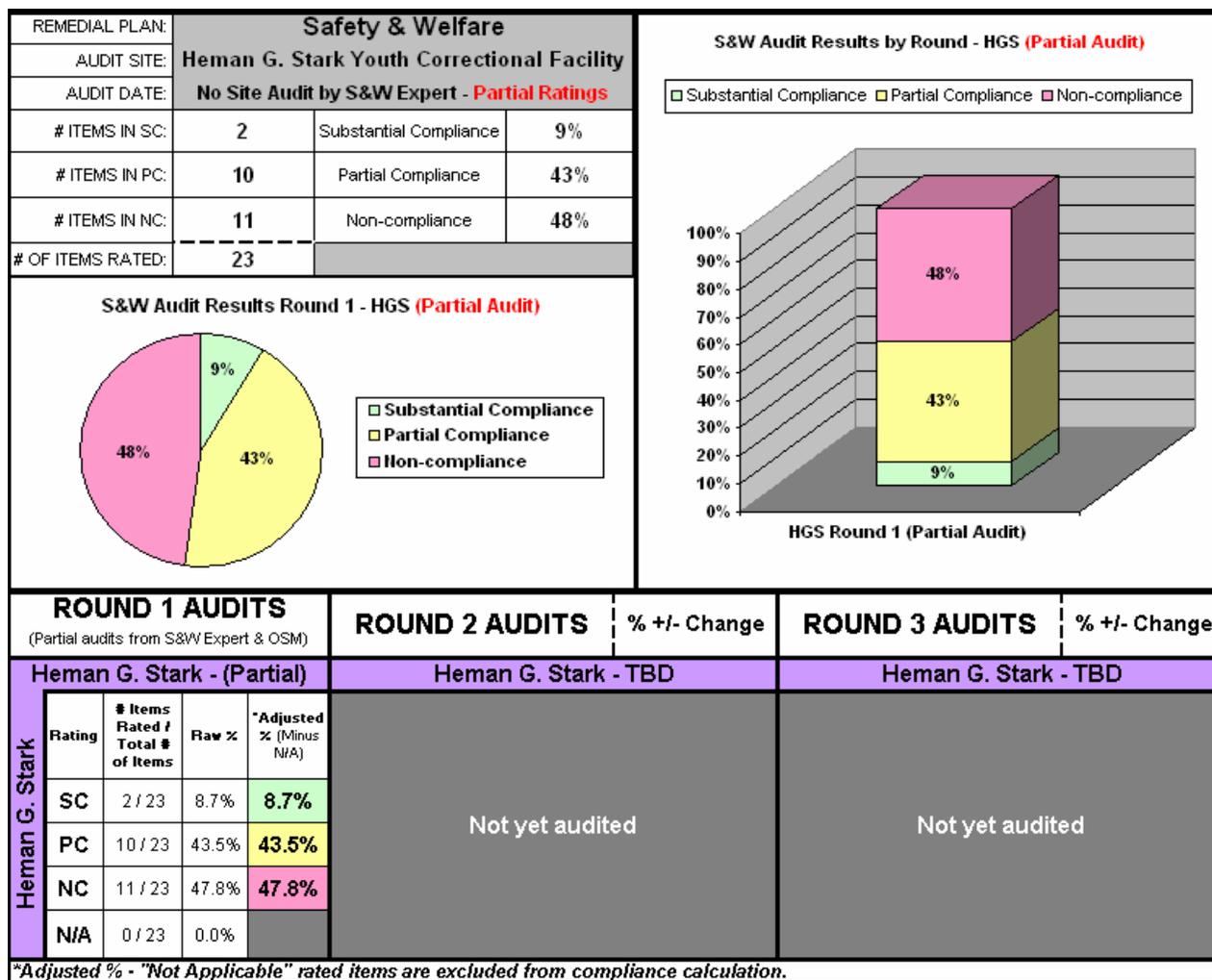


Figure 50: Safety & Welfare Audit Results – Heman G. Stark Youth Correctional Facility

- The facility's Substantial Compliance percentage is 9% in this very limited number of compliance ratings.
- The facility's Non-compliance percentage is 48% in this very limited number of compliance ratings.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 52% in this very limited number of compliance ratings.

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER-CLINIC

The Safety & Welfare Expert last audited the Southern Youth Correctional Reception Center-Clinic on March 20-21, 2008. The pie chart below identifies the results from this audit plus any compliance ratings provided by the Office of the Special Master. The bar graph on the right provides a side-by-side comparison from the facility's previous audits. Because this is the first round of audits, the bar graph will illustrate the same compliance data as that of the pie chart. Below these graphs are the statistical data associated with this audit.

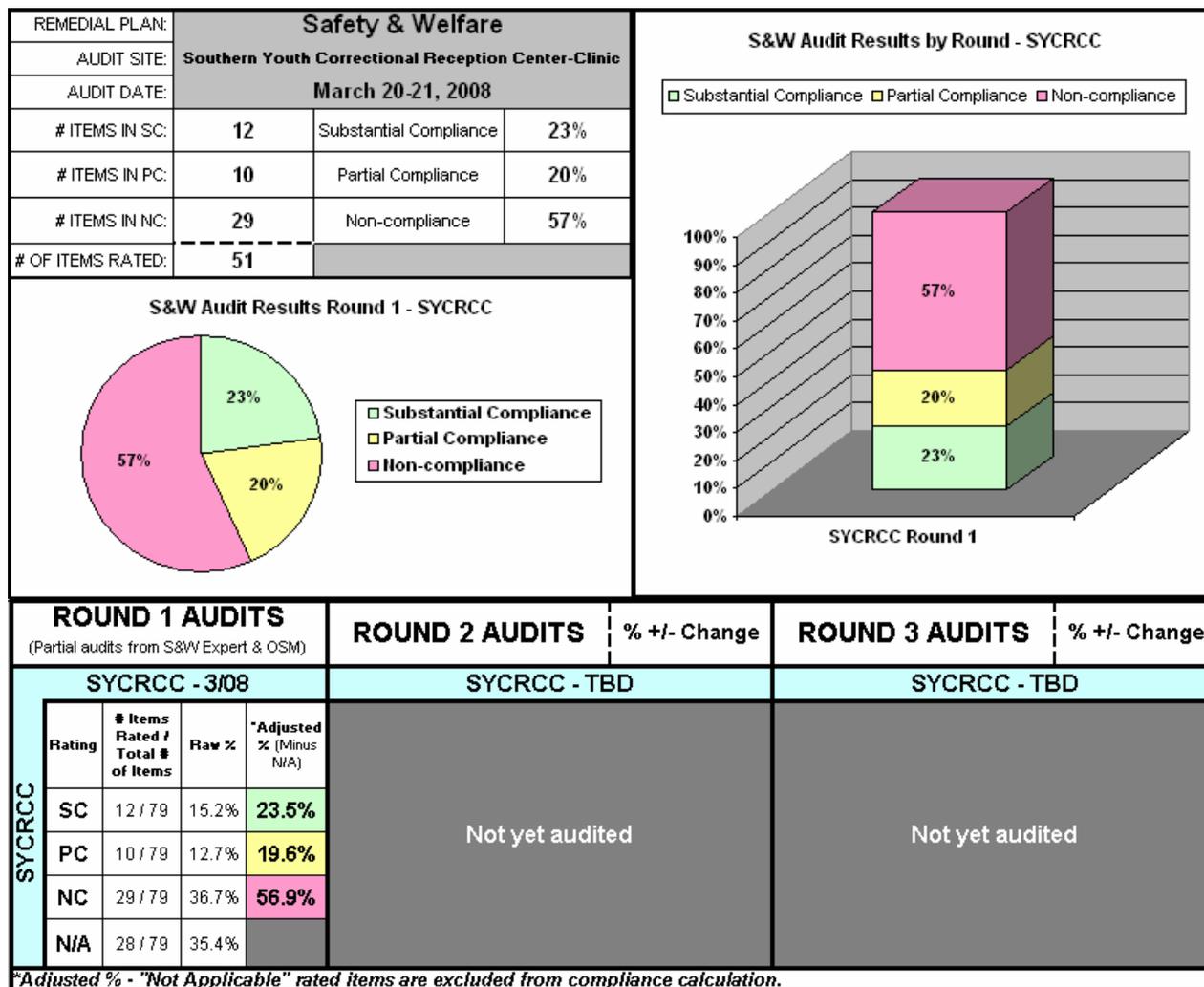


Figure 51: Safety & Welfare Audit Results – Southern Youth Correctional Reception Center-Clinic

- The facility's Substantial Compliance percentage is 23%.
- The facility's Non-compliance percentage is 20%.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 43%.

PRESTON YOUTH CORRECTIONAL FACILITY

The Safety & Welfare Expert last audited the Preston Youth Correctional Facility on May 27-29, 2008. The pie chart below identifies the results from this audit plus any compliance ratings provided by the Office of the Special Master. The bar graph on the right provides a side-by-side comparison from the facility's previous audits. Because this is the first round of audits, the bar graph will illustrate the same compliance data as that of the pie chart. Below these graphs are the statistical data associated with this audit.

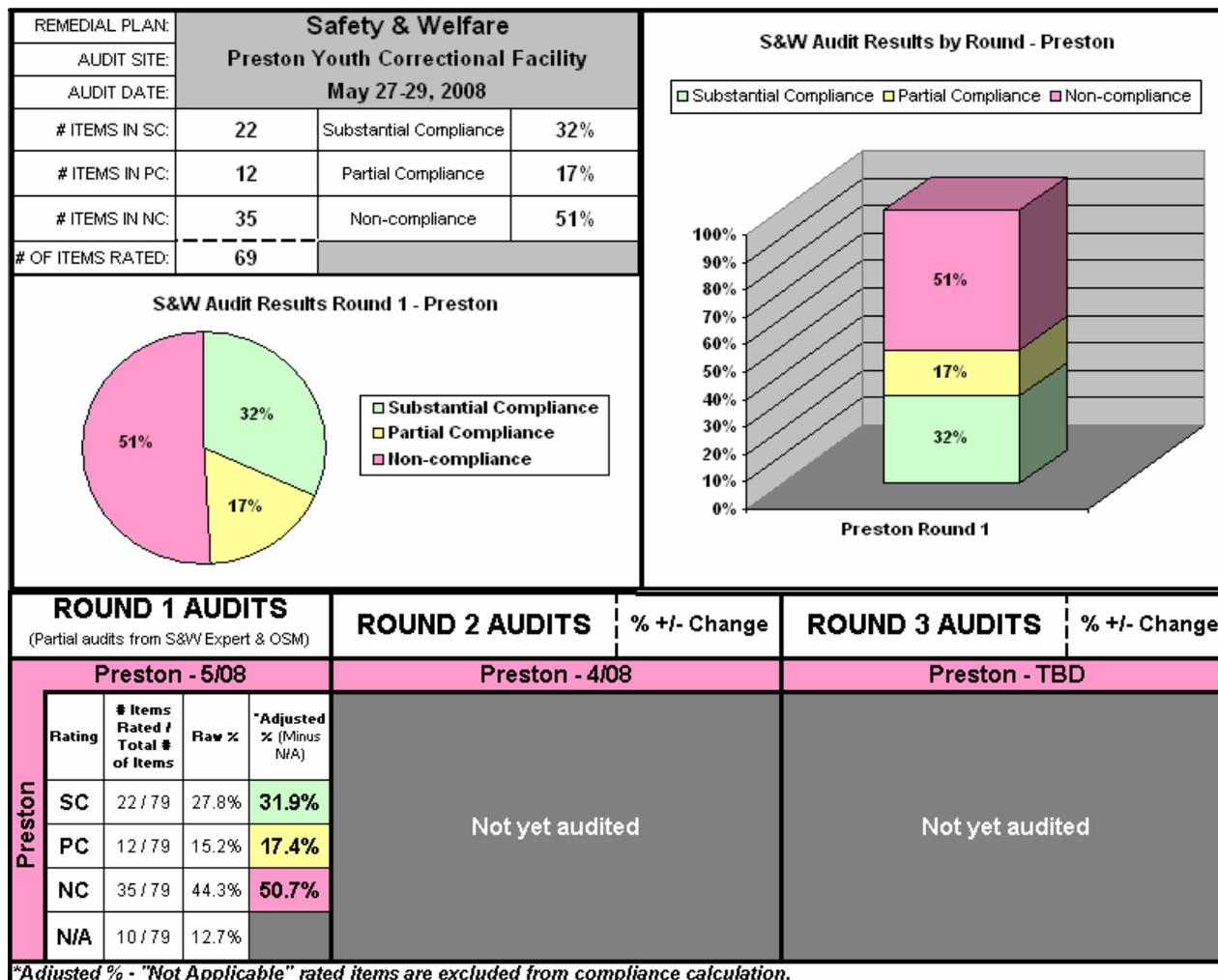


Figure 52: Safety & Welfare Audit Results – Preston Youth Correctional Facility

- The facility's Substantial Compliance percentage is 32%.
- The facility's Non-compliance percentage is 17%.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 49%.

VENTURA YOUTH CORRECTIONAL FACILITY

The Safety & Welfare Expert last audited the Ventura Youth Correctional Facility on March 5-6, 2008. The pie chart below identifies the results from this audit plus any compliance ratings provided by the Office of the Special Master. The bar graph on the right provides a side-by-side comparison from the facility's previous audits. Because this is the first round of audits, the bar graph will illustrate the same compliance data as that of the pie chart. Below these graphs are the statistical data associated with this audit.

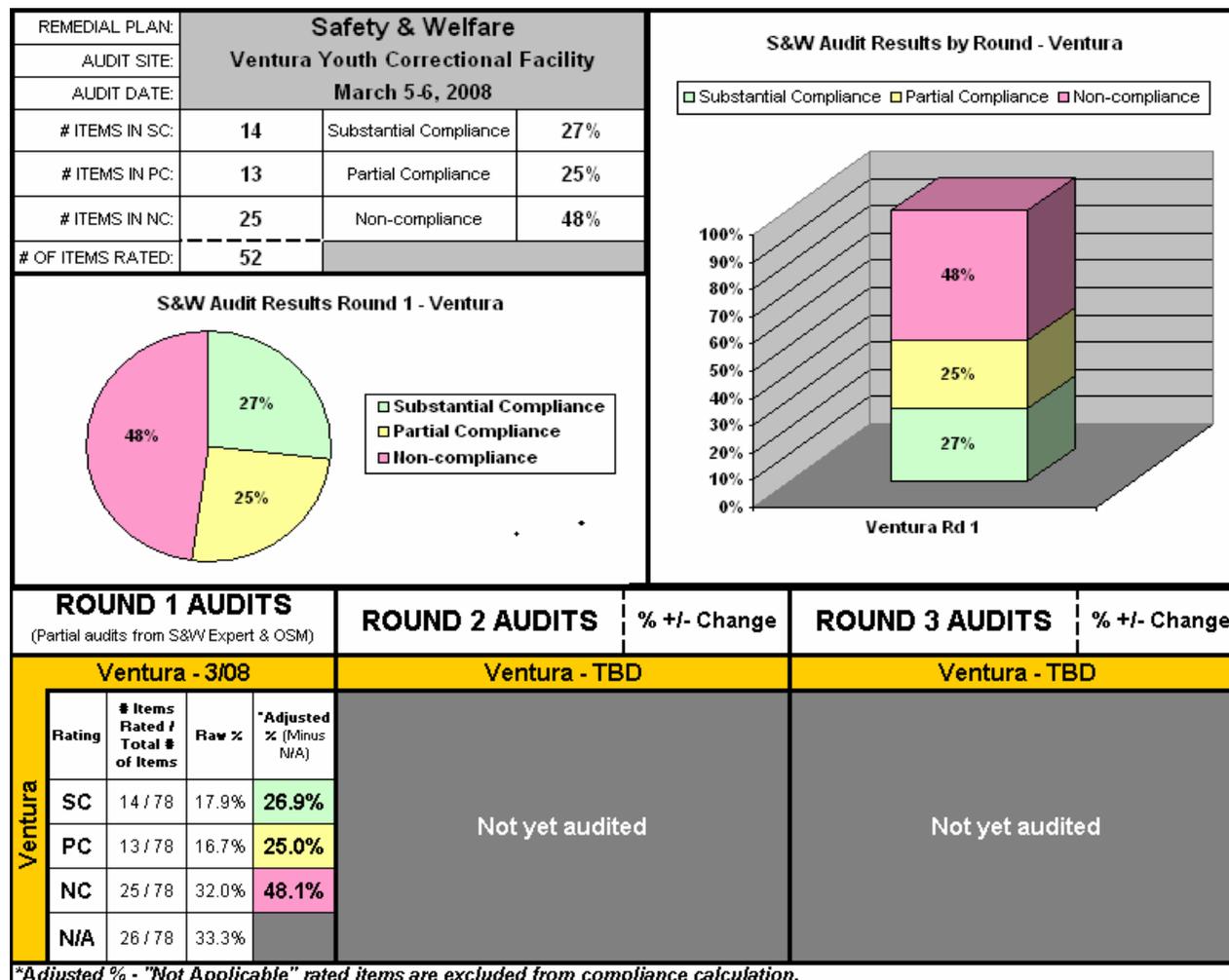


Figure 53: Safety & Welfare Audit Results – Ventura Youth Correctional Facility

- The facility's Substantial Compliance percentage is 27%.
- The facility's Non-compliance percentage is 25%.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 52%.

EL PASO DE ROBLES YOUTH CORRECTIONAL FACILITY

The Safety & Welfare Expert last audited the El Paso de Robles Youth Correctional Facility on November 7-9, 2007. The pie chart below identifies the results from this audit plus any compliance ratings provided by the Office of the Special Master. The bar graph on the right provides a side-by-side comparison from the facility's previous audits. Because this is the first round of audits, the bar graph will illustrate the same compliance data as that of the pie chart. Below these graphs are the statistical data associated with this audit. It is important to note that since this audit took place the facility has closed due to a decline in the population and therefore will not be audited in future rounds.

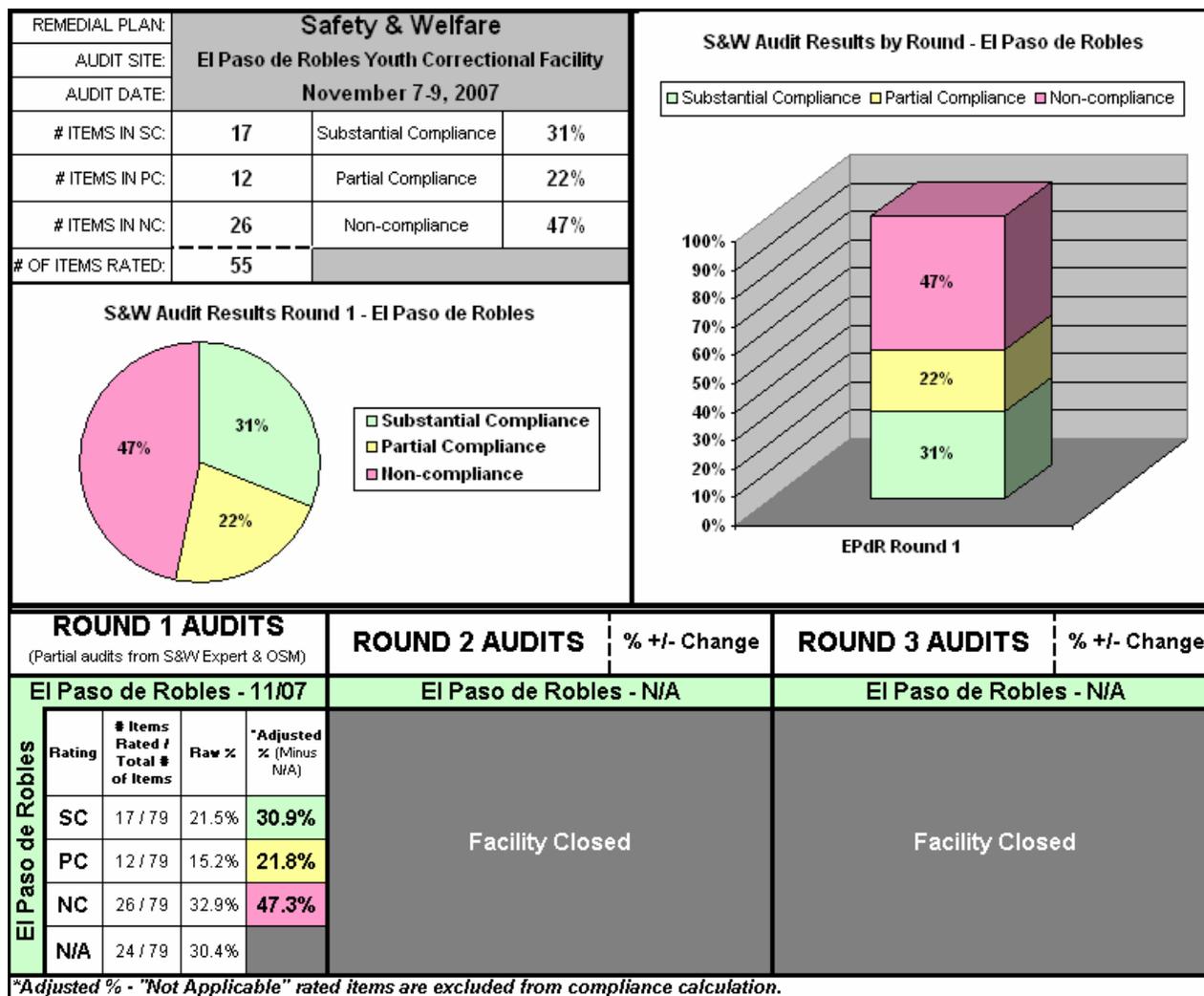


Figure 54: Safety & Welfare Audit Results – El Paso de Robles Youth Correctional Facility

- The facility's Substantial Compliance percentage is 31%.
- The facility's Non-compliance percentage is 22%.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 53%.
- This facility has been closed and will no longer be audited in future rounds.

DEWITT NELSON YOUTH CORRECTIONAL FACILITY

The Safety & Welfare Expert has not audited the DeWitt Nelson Youth Correctional Facility. The compliance ratings identified below are those that were provided by the Office of the Special Master. The pie chart below identifies the compliance results received from the Special Master and the bar graph on the right provides a side-by-side comparison from the facility's previous audits. However, this facility has since been closed due to a decline in the population and therefore will not be audited in future rounds.

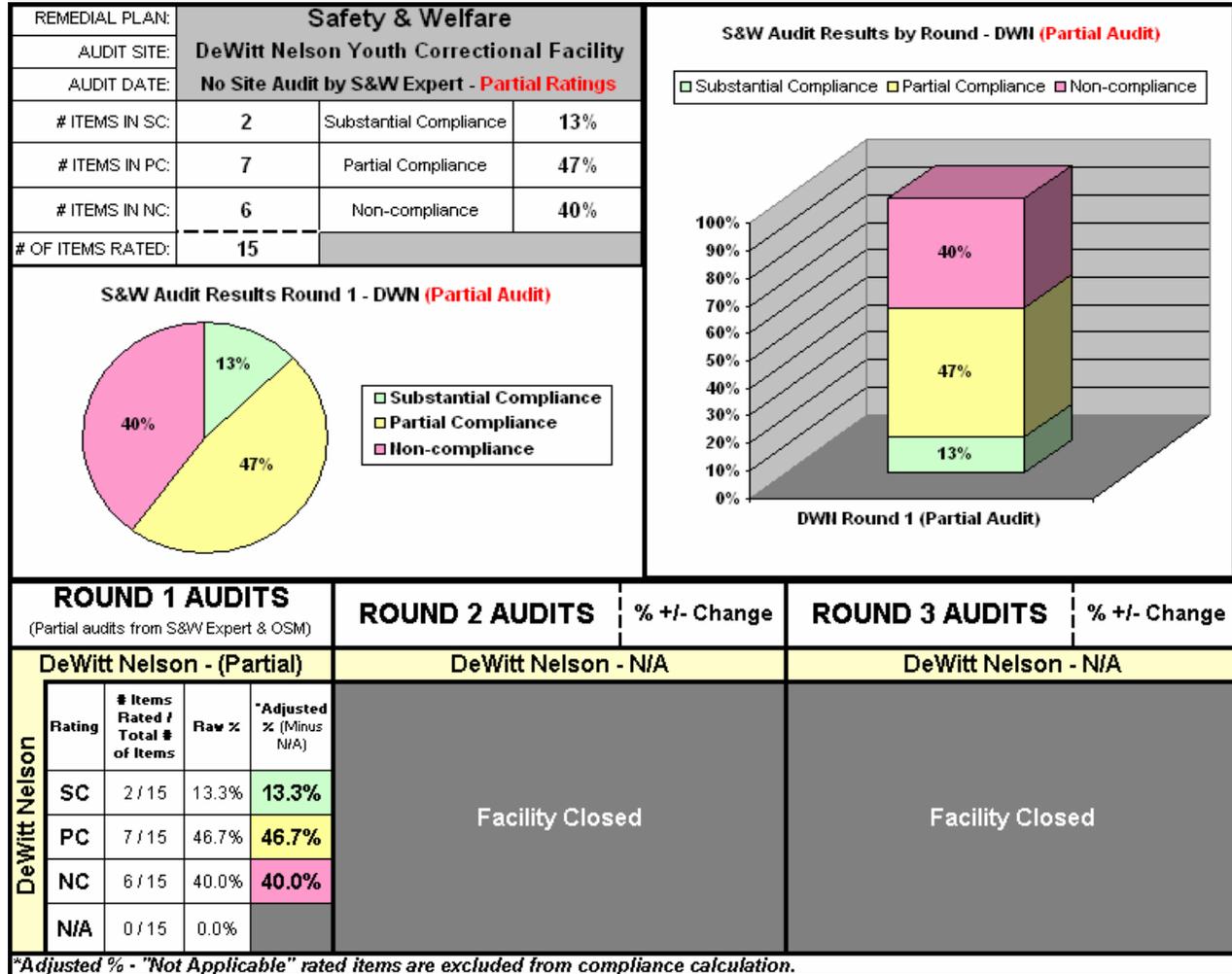


Figure 55: Safety & Welfare Audit Results – DeWitt Nelson Youth Correctional Facility

- The facility's Substantial Compliance percentage is 13% in this very limited number of compliance ratings.
- The facility's Non-compliance percentage is 40% in this very limited number of compliance ratings.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 60% in this very limited number of compliance ratings.
- This facility has been closed and will no longer be audited in future rounds.

DJJ HEADQUARTERS

The Safety & Welfare Expert has not yet audited DJJ Headquarters for this current round of audits. The compliance ratings identified below were provided by the Office of the Special Master. The pie chart below identifies the results received to date. The bar graph on the right provides a side-by-side comparison from the facility's previous audits. Because this is the first round of audits, the bar graph will illustrate the same compliance data as that of the pie chart. Below these graphs are the statistical data associated with the limited amount of compliance data received by DJJ to date.

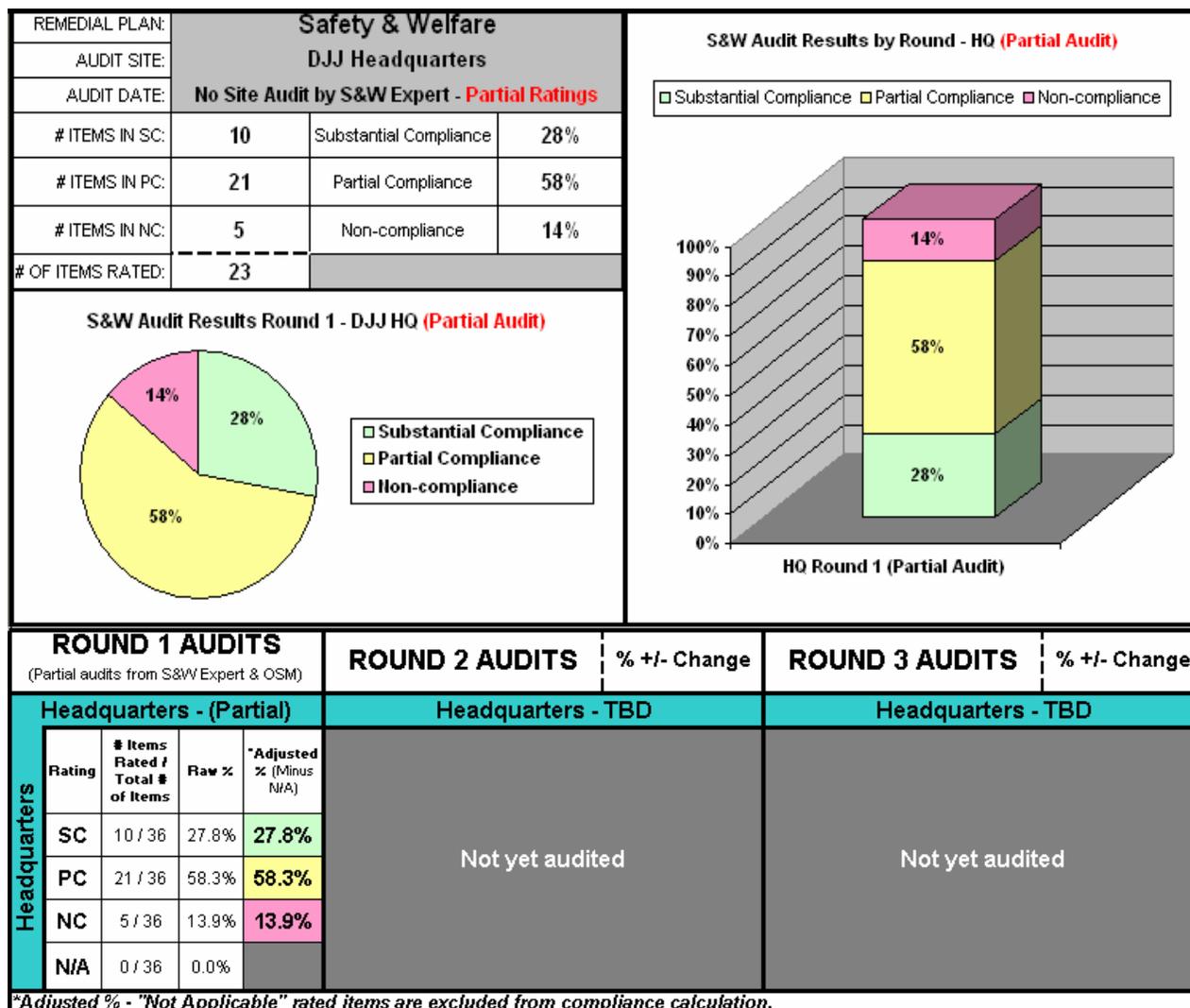


Figure 56: Safety & Welfare Audit Results – DJJ Headquarters

- DJJ Headquarters' Substantial Compliance percentage is 28% in this very limited number of compliance ratings.
- DJJ Headquarters' Non-compliance percentage is 14% in this very limited number of compliance ratings.
- DJJ Headquarters' combined Substantial Compliance and Partial Compliance percentages total 86% in this very limited number of compliance ratings.

SITE COMPARISON FOR ROUND ONE (in progress)

The graph below illustrates the compliance percentages for the six facilities audited by both the Safety & Welfare Expert and the Office of the Special Master during this round of audits as well as the cumulative compliance averages of those audits.

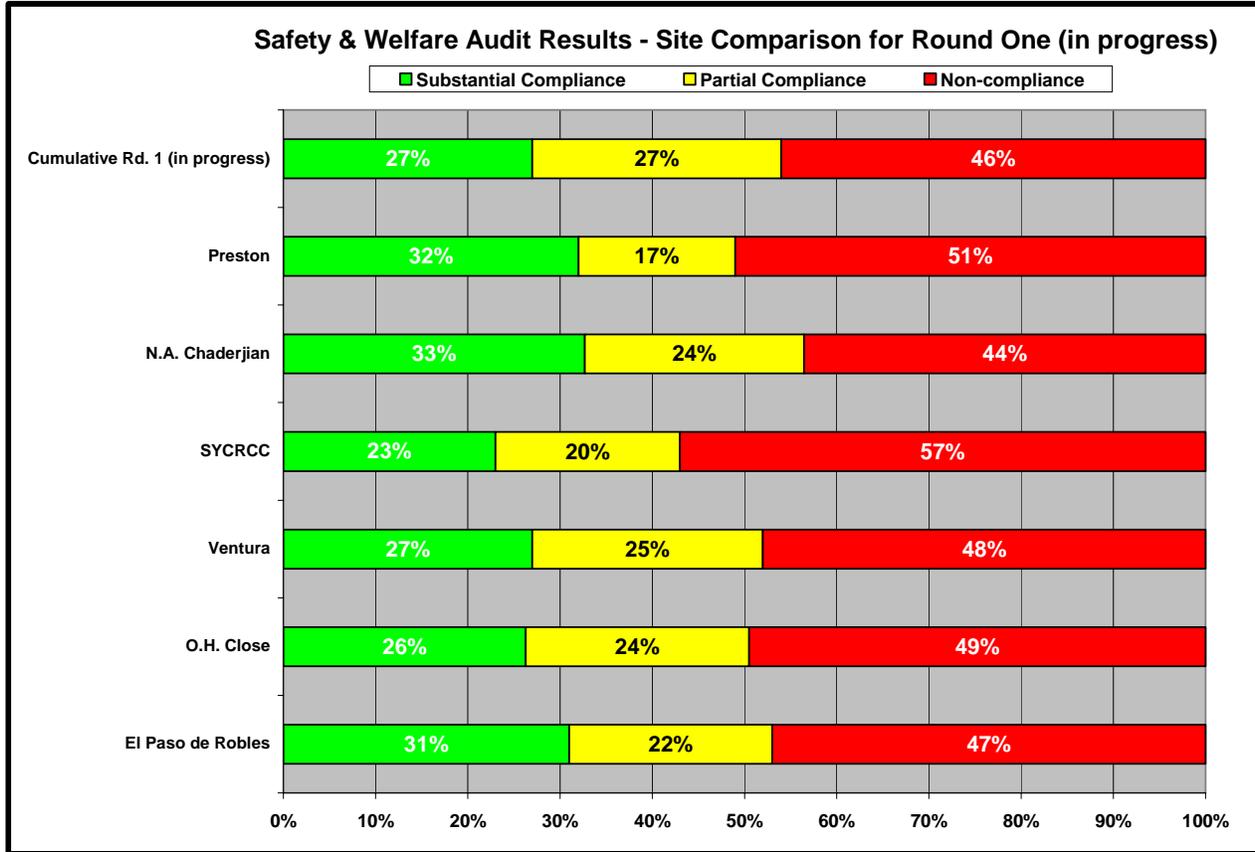


Figure 57: Safety & Welfare Audit Results – Site Comparison for Round One (in progress)

- Substantial Compliance percentage for the six facilities covers a range of 33% to 23%.
- Non-compliance percentage covers a range of 57% to 44%.
- Partial Compliance percentage covers a range of 25% to 17%.
- Three of the six facilities have a Substantial Compliance percentage of 31% or greater.
- Four of the six facilities have a Non-compliance percentage of 49% or less.
- The cumulative compliance averages for all six facilities are as follows:
 - 27% in Substantial Compliance
 - 27% in Partial Compliance
 - 46% in Non-compliance

SUBSTANTIAL PLUS PARTIAL COMPLIANCE COMPARISON FOR ROUND ONE

A Partial Compliance rating, while not at the same high level as Substantial Compliance, does demonstrate that progress and work effort have been achieved to move a given audit item towards Substantial Compliance. The graph below reflects ratings for each of the facilities that combines Substantial Compliance and Partial Compliance into a single score and is based on the compliance ratings provided to date by both the Safety & Welfare Expert and the Office of the Special Master. The cumulative average of these audits is also illustrated. This data is still in progress and may be subject to change, since the Safety & Welfare Expert has not yet completed this first round of audits.

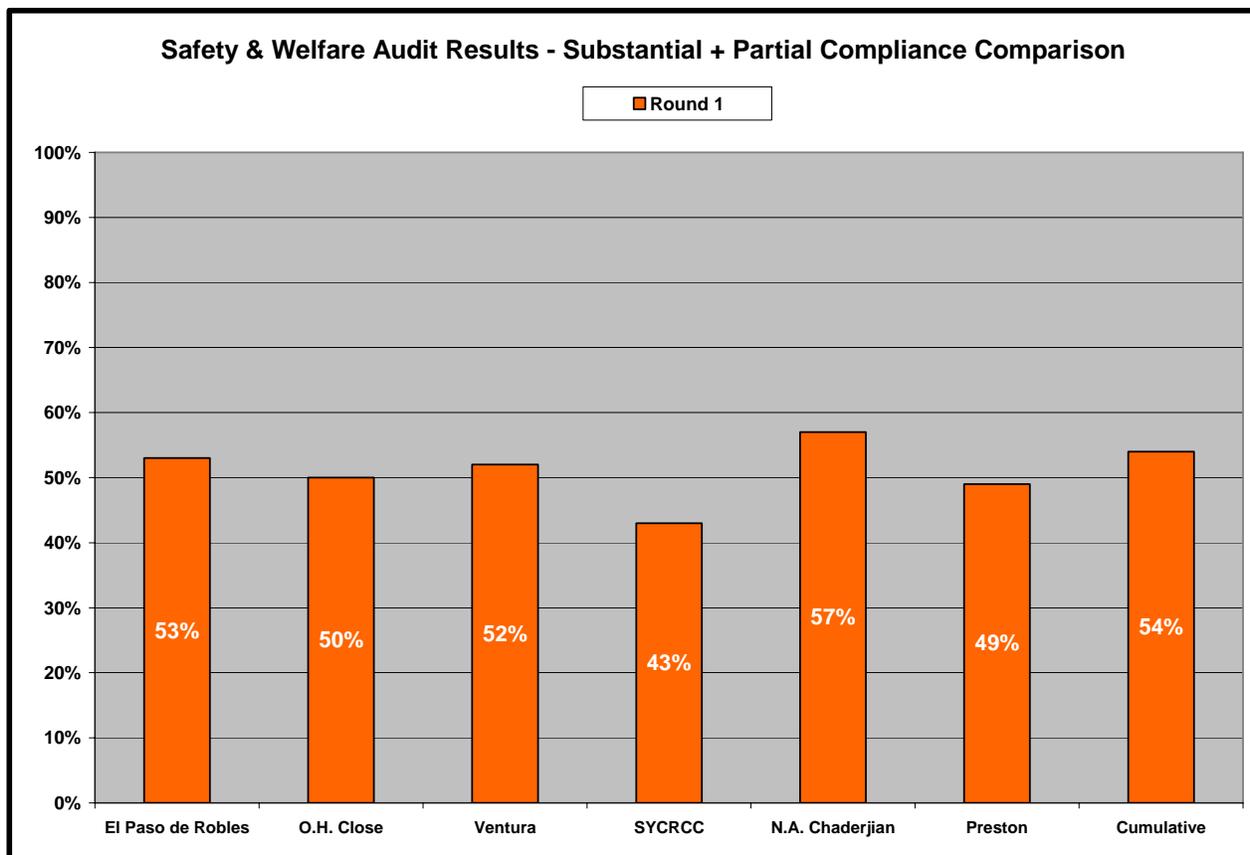


Figure 58: Safety & Welfare Audit Results – Substantial Plus Partial Compliance Comparison

- The combined Substantial Compliance and Partial Compliance percentages for each of the six facilities audited ranged from 57% to 43%.
- N.A. Chaderjian Youth Correctional Facility has the highest combined Substantial and Partial compliance percentages at 57% and the Southern Youth Correctional Reception Center-Clinic has the lowest at 43%.
- Four of the six facilities had a combined Substantial and Partial compliance percentage of 50% or greater.
- DJJ Headquarters and Heman G. Stark Youth Correctional Facility compliance data were not used in this graph due to the limited number of compliance ratings currently available for those two sites.

2.5.4 Expert Feedback

During the last quarter, DJJ received an audit report from the Office of the Special Master for N.A. Chaderjian Youth Correctional Facility. This report contained compliance information for both Safety & Welfare and Mental Health audit items that the Office of the Special Master is responsible to monitor. Below are a sampling of the comments made by the Office of the Special Master in regards to its audit of N.A. Chaderjian Youth Correctional Facility.

Office of the Special Master's Comments – N.A. Chaderjian Youth Correctional Facility

- *"We were impressed by the leadership at the facility. Top managers are experienced, very able, and committed to achieving the reform outlined in the Farrell remedial plans in a sensible and cost-effective way."*
- *"DJJ has transferred treatment programs from other facilities so that Chaderjian now is comprised mainly of residential treatment units. This is consistent with the transformation outlined in the safety and welfare plan. The cooperation among facility and treatment staff has improved since 2006 and 2007. Still, there is a divide between treatment and facility staff that needs to be bridged. Clinical and facility staff tend to divide issues between their spheres and then fight over whether a particular set of issues or decisions is in one sphere or the other. They need to collaborate more in order to deliver treatment services as they are supposed to be delivered and to create an environment that supports treatment and rehabilitation. Programs need to be structured to facilitate a greater level of interdisciplinary cooperation."*
- *"Violence among youth continues to be at a relatively low level compared to Chaderjian's history and compared to the levels at Preston and Stark. This is a significant step towards the transformation of Chaderjian to a treatment facility."*
- *"There is insufficient office space for clinical staff and treatment programs. Many staff also lack working telephone lines. DJJ has been ineffectual in the enterprise of completing the necessary renovation and construction. This is a serious impediment to Chaderjian's transformation to a treatment facility."*
- *"Chaderjian (like most facilities) needs to focus on increasing family involvement. It needs to focus on quickly increasing activity and positive incentives for relatively recently arrived treatment program youth. (We got the most information about the IBTP program which was characterized by little activity and few positive incentives compared to what was available for the youth at Preston.)"*
- *"Chaderjian (like most facilities) needs to increase and clarify and positive incentives in order to effectively motivate youth to eschew negative youth culture and to apply themselves to constructive and pro-social activities."*
- *"Chaderjian continues to house some youth in an SMP, although the safety and welfare remedial plan required these units to be eliminated by April 2007. Reportedly, youth housed on the SMP at Chaderjian are not allowed to spend time in the unit's day room except for a brief period every other evening. If, for example, a youth wishes to file a grievance, he must be shackled and led to and from his cell to the grievance lock box. These youth continue to be clothed in the orange jumpsuits used by CDCR."*

- “Chaderjian has done an exemplary job of implementing the new grievance policy. It does an exemplary job of collecting COMPSTAT and PbS data on violence and use of force, within the limits of the current manual systems. The law library materials are of little use because no one has the responsibility, authority and experience to arrange for them to be available to youth. The materials are also outdated.”

2.5.5 Status of Specific Action Items

Relieved Items

On page 11, paragraph 23, the Consent Decree states:

When a facility is found to be in substantial compliance on an issue for one full year, and is found to remain in substantial compliance after review by the relevant expert(s) one year later, expert tours regarding that issue at that facility shall end.

An audit item is “relieved” when DJJ has met or exceeded the two-year Substantial Compliance threshold for the item and the appropriate Expert has formally noted that the audit item is to be removed from that Expert’s future monitoring.

Currently, none of the Safety & Welfare audit items meet the time threshold to be deemed relieved by the Safety & Welfare Expert or any other monitor of the Safety & Welfare Remedial Plan.

Audit Items in Substantial Compliance Two Years or Longer

Since this is the Safety & Welfare Expert’s first round of audits, at this time, there are no audit items that have met this time threshold.

Items Removed from Relieved Status

Since this is the Safety & Welfare Expert’s first round of audits, at this time, there are no audit items that have met the time threshold, as identified in the Consent Decree, to be eligible to be relieved from future monitoring at this time.

Statewide Compliance Items

The Safety & Welfare Expert has not completed his first round of audits. Therefore, DJJ is not able to identify the audit items that would qualify as being in Statewide Compliance.

Action Items with Majority Rating of Non-compliance

The Safety & Welfare Expert has not completed his first round of audits therefore DJJ is not able to identify the audit items that would qualify as receiving the majority of its ratings for Non-compliance.

2.5.6 Proof of Practice

The following chart identifies the Safety & Welfare-related Proof of Practice documents that have been sent to the Safety & Welfare Expert and the Special Master during the last quarter. The Proof of Practice documents provide evidence of DJJ's efforts to come into compliance with the action items, as noted below, of the Safety & Welfare Remedial Plan.

Safety & Welfare Proof of Practice Documents Submitted During the Last Quarter				
#	Section	Audit Item Description	Documents Submitted	Date
279	8.7-1a	<i>"Education Services operates law libraries"</i>	1 – Memorandum, dated October 8, 2008, from Jim Cripe, Principal, Library Services, to all Principals, regarding the policy and process for providing youths with access to law libraries (1 page). The memorandum was accompanied with four attachments as follows:	11/12/08
	8.7-4	<i>"Automated tracking system re: law library access/help"</i>	2 – Law Library Request form (DJJ Form 8.514) to be completed by the youth to schedule a law library appointment or to obtain legal information, materials, or forms (3 pages);	
	8.7-6a	<i>"Written policy & procedures for access to courts and library"</i>	3 – WIN 2000 Call List instructional guide that provides directions to DJJ staff who have access to the Ward Information Network (WIN) system on how to schedule ward appointments and how to track the status of an appointment after it is established (24 pages); 4 – Excerpt from the California Code of Regulation, Title 15, for § 4701 regarding the use of law libraries (2 pages); and 5 – DJJ's Education Services Branch Manual, §§ 4560, 4565, and 4570 regarding library services (3 pages). Pursuant to State law and also as required by the Safety & Welfare Remedial Plan, this memorandum serves to put all Principals on notice of DJJ's policy and procedures for providing youths with access to law libraries at all facilities.	
280	9.1-3	<i>"Consolidated report on SMP use prepared by HQ and sent to S & W expert, Plaintiff's Counsel, and Special Master"</i>	Monthly SMP Reports for the following months: 1 – July 2008, for N.A. Chaderjian YCF (1 page); Preston YCF (2 pages); and Heman G. Stark YCF (3 pages); 2 – August 2008, for N.A. Chaderjian YCF (1 page); Preston YCF (2 pages); and Heman G. Stark YCF (2 pages); and 3 – September 2008, for N.A. Chaderjian YCF (1 page); Preston YCF (1 page); and Heman G. Stark YCF (2 pages). As required by the Safety & Welfare Standards and Criteria, these documents are being sent to the Safety & Welfare Expert; the Plaintiff's Counsel; and the Special Master.	11/12/08

Safety & Welfare Proof of Practice Documents Submitted During the Last Quarter				
#	Section	Audit Item Description	Documents Submitted	Date
285	N/A	N/A	<p>This document is being submitted to the Safety & Welfare Expert to allow them the opportunity to review it and ensure that the document correctly identifies the items that were submitted.</p> <p>This constitutes DJJ's second submission of the reporting tool to the Safety & Welfare Expert. This submission also contains additional information that DJJ relied upon in drafting the reporting tool, including information provided by and/or derived from consultations with the Expert.</p>	11/20/08
295	8.7-1a	<i>"Education Services operates law libraries"</i>	<p>1 – Memorandum, dated November 13, 2008, from Jim Cripe, Principal, to Doug Ugarkovich, regarding the current status of providing law library access to youths (1 page);</p> <p>2 – List summarizing Safety & Welfare action items applicable to the law library as well as supporting documents attached to the list that demonstrate DJJ's progress in implementing law library access (1 page);</p> <p>3 – Formal Request, dated October 23, 2008, from Donna Brorby, Special Master, requesting information regarding the establishment of a deadline for providing access to legal materials (1 page);</p> <p>4 – Document entitled "Solution Status," which provides an update as of November 2008 regarding the status of obtaining and providing access to law library materials (6 pages);</p> <p>5 – Memorandum, dated October 8, 2008, from Jim Cripe, Principal, to all CDCR Principals, subject: "Law Library Access," which instructs Principals how to ensure that youths are provided with access to legal materials, attached with various law library request forms; these documents have previous been issued to the Experts as Proof of Practice # 279 (33 pages);</p> <p>6 – Two sets of e-mails pertaining to DJJ's development of a law library access process and forms (6 pages).</p> <p>These documents are being provided to the Education Services Experts as well as the Safety & Welfare Expert to demonstrate the chronology of DJJ's activities, since July 2007 to the present, in regards to developing and implementing a process for youths to access legal materials at the facilities.</p>	12/01/08
	8.7-1c	<i>"Education Services controls budgets and manages purchases"</i>		
	8.7-3	<i>"Needed law library materials purchased annually"</i>		
	8.7-4	<i>"Automated tracking system re: law library access/help"</i>		
	8.7-5	<i>"Print libraries replaced with electronic or internet materials"</i>		
	8.7-6a	<i>"Written policy & procedures for access to courts and library"</i>		
298	8.1-4	<i>"Designate project coordinator for master plans"</i>	<p>1 – Memorandum, dated November 17, 2008, from Sandra K. Youngen, Director, Division of Juvenile Facilities to Bernard Warner, Chief Deputy Secretary, subject: "Master Plan Assignments" (1 page).</p> <p>This memorandum is being submitted to the Safety & Welfare Expert to inform him of the fact that DJJ has formally designated two staff, Mark Blaser, Program Administrator, and Eleanor Silva, Case Services Supervisor (A), as Project Coordinator for DJJ's Facility Master Plan and Project Coordinator for DJJ's Operational Master Plan, respectively.</p>	11/25/08

Safety & Welfare Proof of Practice Documents Submitted During the Last Quarter				
#	Section	Audit Item Description	Documents Submitted	Date
299	8.3		1 – An electronic message from Rachel Veerman to CDCR staff that expresses thanks to CDCR on behalf of families at Ventura Youth Correctional Facility for new kitchen and camera equipment, vending machines, and games for kids (1 page).	12/11/08
	(and WDP)		This document is being provided to the Safety & Welfare and the Wards with Disabilities Program (WDP) Experts to demonstrate the improvements DJJ has made in ensuring that quality equipment and apparatuses are in place for families that visit youths in the facilities. Although there is no specific audit item in either the WDP or Safety & Welfare Standards and Criteria to which this document directly applies, it is DJJ's belief that it nonetheless does demonstrate that improvements have been made to help foster a more positive environment as families visit youths at the facilities.	
302	3-4b	<i>"Crisis management training for direct care staff at two facilities"</i>	1 –Reform Training Schedule for November 2008 (4 pages).	12/11/08
	3-4c	<i>"Crisis management training for remaining direct care staff"</i>	This Reform Training Schedule is being submitted to the Safety & Welfare Expert to provide him with a list of training courses that were provided to staff during the month of November 2008. The courses offered encompassed topics that include Safe Crisis Management, Effective Casework, and Motivational Interviewing, among others, and took place at various locations at the facilities. These training classes comport with the requirements of the Safety & Welfare Standards and Criteria action items as are noted above.	
	6-7c	<i>"Complete Training: Treatment plan development"</i>		
	6-7d	<i>"Complete Training: Motivational Interviewing"</i>		
303	8.6-4d	<i>"System developed to report net time added & restored"</i>		1 – Document entitled "Time Add Tracking System" which describes DJJs development of a system for reporting net time added and restored, analyzing the reasons for the time adds, and developing a plan to reduce the frequency and duration of such time adds.
	8.6-4e	<i>"Time adds and reasons analyzed"</i>	This document comes with two attachments, Attachment A and Attachment B (5 pages). These documents are being submitted to the Safety & Welfare Expert as part of the requirements of the Safety & Welfare Remedial Plan, which calls for DJJ to develop a time add tracking system.	
	8.6-4f	<i>"Plan developed to reduce the frequency and duration of time adds based on inadequate access to programs"</i>	As stated on page 1 of the documents provided here, Attachment A contains time add data collected for the months of July 2008 through September 2008, and Attachment B provides a break-down of the specific reasons for the time adds mentioned in Attachment A.	
305	8.4-2a	<i>"Disciplinary fact finding hearings held within 14 days"</i>	1 – Memorandum dated November 25, 2008, from Sandra K. Youngen, Director, Division of Juvenile Facilities, to all Superintendents, subject: "Changes to DDMS," with DJJ Form 8.509, "Level 1 DDMS Appeal," as an attachment (2 pages).	12/11/08
	8.4-2b	<i>"Disciplinary disposition hearings held within 7 days"</i>	These documents are being provided to the Safety & Welfare Expert to demonstrate that DJJ is in the final stages of completing the DDMS policy and that training of the policy will soon begin in March 2009. The changes to the DDMS policy incorporate the requirements of the Safety & Welfare Standards and Criteria as are noted above.	
	8.4-4	<i>"Level 1 infraction appeals process implemented"</i>		

Safety & Welfare Proof of Practice Documents Submitted During the Last Quarter				
#	Section	Audit Item Description	Documents Submitted	Date
308	N/A	N/A	<p>1 – Department of the Youth Authority, Institutions and Camps Manual, Arming Policy, Sections 2900 through 2910 (24 pages).</p> <p>During a telephone conference on October 20, 2008, between DJJ and the Safety & Welfare Expert to discuss the feedback that the Safety & Welfare Expert had just provided on the Use of Force policy draft, the Safety & Welfare Expert indicated that he wished to review DJJ's Arming Policy.</p> <p>As a result, the Arming Policy is being submitted with this Proof of Practice to the Safety & Welfare Expert for his review. This policy has been in effect since February 16, 2000.</p>	12/15/08
309	3-5	<i>"Develop and use databases to track violence and use of force"</i>	<p>This Proof of Practice consists of PbS data, current as of November 23, 2008, that are being submitted for each of the following facilities:</p> <p>1 – Heman G. Stark Youth Correctional Facility (114 pages);</p> <p>2 – N.A. Chaderjian Youth Correctional Facility (112 pages);</p> <p>3 – O.H. Close Youth Correctional Facility (112 pages);</p> <p>4 – Preston Youth Correctional Facility (112 pages);</p> <p>5 – Southern Youth Correctional Reception Center and Clinic (114 pages); and</p> <p>6 – Ventura Youth Correctional Facility (112 pages).</p> <p>These documents are being submitted to the Safety & Welfare Expert in conformity with the requirements of the Safety & Welfare Standards and Criteria as specified above.</p>	12/11/08
	3-6a	<i>"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"</i>		
	3-6b	<i>"Quarterly reports on selected PbS data elements"</i>		
313	3-9a	<i>"Open sufficient BTPs for projected 2008-'09 demand"</i>	<p>1 – Memorandum, dated December 10, 2008, from Tami McKee-Sani, Program Administrator, Design and Development Unit, to selected participants of the BTP Project Team, subject: "Behavior Treatment Program Project Charter" (1 page).</p> <p>This memorandum is being provided to the Safety & Welfare Expert to demonstrate that the Behavior Treatment Program charter has been approved and that participants for the BTP project team have been selected. The orientation meeting for these participants, as identified in the memorandum, will take place on Thursday, December 18, 2008.</p>	12/22/08
	3-9b	<i>"Produce annual estimates of need for BTP units"</i>		
	6-5	<i>"Phase in Behavior Treatment Programs . . . Full Implementation"</i>		
	6-6	<i>"Program Service Day schedule for BTPs"</i>		
	(and other MH sections)	See Proof of Practice # 313 in the Mental Health section of this report.		

Safety & Welfare Proof of Practice Documents Submitted During the Last Quarter				
#	Section	Audit Item Description	Documents Submitted	Date
315	3-5	<i>"Develop and use databases to track violence and use of force"</i>	<p>1 – Quarterly Statistical Report (COMPSTAT data) for 2nd Quarter, 2008, containing roll-up data (32 pages); and</p> <p>2 – Quarterly Statistical Report (COMPSTAT data) for 3rd Quarter, 2008, including roll-up data and data broken down by facility (121 pages).</p> <p>These Quarterly Statistical Reports, also referred to as COMPSTAT data, are being submitted for both the 2nd and 3rd quarters of 2008 pursuant to the requirements of the Safety & Welfare Standards and Criteria as noted above.</p> <p>The 2nd quarter report provided here contains a roll-up of all data while the 3rd quarter reports contain both a roll-up of data as well as data broken down for each of the six youth correctional facilities and the two youth camps.</p>	12/17/08
317	9.1-3	<i>"Consolidated report on SMP use prepared by HQ and sent to S & W expert, Plaintiff's Counsel, and Special Master"</i>	<p>Monthly Special Management Programs (S.M.P.) Reports for the following months:</p> <p>1 – October 2008, for Heman G. Stark Y.C.F. (2 pages); N.A. Chaderjian Youth Correctional Facility (Y.C.F.) (1 page); and Preston Y.C.F. (2 pages); and</p> <p>2 – November 2008, for N.A. Chaderjian Y.C.F. (2 page); Preston Y.C.F. (1 page); and Heman G. Stark Y.C.F. (1 page).</p> <p>As required by the Safety & Welfare Standards and Criteria, these documents are being sent to the Safety & Welfare Expert; the Plaintiff's Counsel; and the Special Master.</p>	12/29/08
318	3-4b	<i>"Crisis management training for direct care staff at two facilities"</i>	<p>Training Attendance Reports for DJJ staff through November 2008 for the following courses:</p> <p>1 – Aggression Replacement Training (12 pages);</p> <p>2 – Safe Crisis Management (23 pages);</p> <p>3 – ORBIS Partners (10 pages);</p> <p>4 – Motivational Interviewing (25 pages);</p> <p>5 – Crisis Intervention and Conflict Resolution (12 pages); and</p> <p>6 – Understanding and Preventing Suicide (22 pages).</p> <p>This Reform Training Schedule is being submitted to the Safety & Welfare Expert to provide him with a list of training courses that were provided to staff during the month of November 2008. The courses offered encompassed topics that include Safe Crisis Management, Effective Casework, and Motivational Interviewing, among others, and took place at various locations at the facilities. These training classes comport with the requirements of the Safety & Welfare Standards and Criteria action items as are noted above.</p>	12/29/08
	3-4c	<i>"Crisis management training for remaining direct care staff"</i>		
	6-7c	<i>"Complete Training: Treatment plan development"</i>		
	6-7d	<i>"Complete Training: Motivational Interviewing"</i>		

Safety & Welfare Proof of Practice Documents Submitted During the Last Quarter				
#	Section	Audit Item Description	Documents Submitted	Date
320	3-4b	<i>"Crisis management training for direct care staff at two facilities"</i>	1 –Reform Monthly Training Schedule for December 2008 (1 page); and 2 – Reform Training course descriptions (10 pages).	12/29/08
	3-4c	<i>"Crisis management training for remaining direct care staff"</i>	This Reform Training Schedule is being submitted to the Safety & Welfare Expert to provide a list of training courses that were provided to staff during the month of December 2008.	
	6-7c	<i>"Complete Training: Treatment plan development"</i>	The courses offered encompassed topics that include Safe Crisis Management, Effective Casework, and Motivational Interviewing, among others, and took place at various locations at the facilities. These training classes comport with the requirements of the Safety & Welfare Standards and Criteria action items as are noted above.	
	6-7d	<i>"Complete Training: Motivational Interviewing"</i>		

2.5.7 Summary and Application of Audit Findings

DJJ is looking forward to the Safety & Welfare Expert’s completion of his Round One audits and the beginning of the Round Two audits. While DJJ has made great strides in implementing the requirements of the Safety & Welfare Remedial Plan, it also recognizes the significant number of items that the Safety & Welfare Expert has rated as Non-Compliant and expects that some of the departmental changes of considerable scope that are filed under this Remedial Plan, such as Normative Culture, Integrated Behavior Treatment Model, Classification, and other programs and policies, will continue to proceed in their development. Upon completion of these projects, DJJ expects to find a significant, positive impact being made on the youths it serves.

In the meantime, DJJ has met with the Safety & Welfare Expert to identify and reach consensus on the documentation that would be needed to help identify whether an audit item is in Substantial Compliance, the highest level of all the compliance ratings. DJJ will continue to communicate with and seek guidance from the Safety & Welfare Expert as it continues to implement the reforms identified in the Safety & Welfare Remedial Plan.

2.6 Mental Health Remedial Plan Compliance Status

2.6.1 Historical Audit Perspective

Court Filings

The Mental Health Remedial Plan filed with the Court on August 25, 2006, was the last *Farrell* Remedial Plan to be filed. The audit tool (Standards & Criteria) was filed with the Court on December 14, 2006.

Audit Tool

The Mental Health audit tool contains 118 action items, all of which have a deadline. There are approximately 182 audit items associated with the 118 action items. The 182 audit items are the number of compliance ratings DJJ will receive in a typical round of Mental Health audits. The Mental Health audit tool is weighted heavily toward Headquarters action items, which explains the relatively low number of audit items (182) in relation to the number of action items (118).

Audit Tool Breakdown

Audit Item Numbers Based on Six Facilities	Filing Dates		Action Items			Audit Items		
	Remedial Plan	Audit Tool	# of Action Items with a Deadline	# of Action Items without a Deadline	Total # of Action Items	# of Audit Items with a Deadline	# of Audit Items without a Deadline	Total # of Audit Items
Mental Health	8/25/06	12/14/06	118	0	118	182	0	182

Audit History

The Mental Health Experts completed their first facility audit, using the Court-filed audit tool at Preston Youth Correctional Facility on July 17-18, 2008. DJJ has not yet received the Experts' audit report for this visit; therefore, any compliance data in this section is the same as reported in previous Quarterly Reports. The compliance data was collected during visits to Headquarters by the Mental Health Experts and the Special Master.

During these Headquarters visits, the Mental Health Experts and the Special Master were able to assign compliance ratings to certain facility audit items based on the information and documentation provided to them during their Headquarters visits.

The chart on the following page lists the Mental Health Experts' facility audit schedule for their current round of audits.

Mental Health	ROUND ONE	ROUND TWO		ROUND THREE	
Facility	Date Audited	Date Audited	Time Since Last Audit	Date Audited	Time Since Last Audit
Ventura	NA	NA	NA	NA	NA
SYCRCC	NA	NA	NA	NA	NA
Heman G. Stark	October 2-3, 2008	NA	NA	NA	NA
N.A. Chaderjian	October 17, 2008	NA	NA	NA	NA
O.H. Close	October 16, 2008	NA	NA	NA	NA
Preston	July 17-18, 2008	NA	NA	NA	NA

Future Audit Schedule

The Mental Health Experts recently provided DJJ with an audit schedule that goes up to the end of this fiscal year. The N.A. Chaderjian Youth Correctional Facility and the Southern Youth Correctional Reception Center-Clinic originally had proposed dates, but upon DJJ's request, those dates are being rescheduled because they fell on State-mandated furlough days.

- Ventura Youth Correctional Facility — April 15-16, 2009
- Heman G. Stark Youth Correctional Facility — May 6-7, 2009
- Preston Youth Correctional Facility — June 17-18, 2009
- Southern Youth Correctional Reception Center-Clinic — To be determined
- N.A. Chaderjian Youth Correctional Facility — To be determined

2.6.2 Most Recent Audit Findings

Audit Reports Received During the Last Quarter

The Mental Health Experts did not provide DJJ with an audit report during the last reporting period. However, shortly after the expiration of the reporting period, the Mental Health Experts did provide DJJ with five facility audit reports; these audit reports will be discussed in more detail in the next Quarterly Report.

The Office of the Special Master did provide an audit report during this last reporting period for N.A. Chaderjian Youth Correctional Facility that contains an assessment of both Mental Health and Safety and Welfare audit items that the Office of the Special Master is responsible for monitoring. After the reporting period passed, the Office of the Special Master provided another audit report, this one for O.H. Close Youth Correctional Facility. Details of that report will also be addressed in the next Quarterly Report.

The Office of the Special Master is responsible for monitoring certain audit items within the Safety & Welfare and Mental Health audit tools. In her report, the Special Master provided compliance ratings that were specific to N.A. Chaderjian Youth Correctional Facility, as identified in the Court- approved audit tool, as well as additional compliance ratings that were provided for the facility but are actually supposed to be Headquarters-specific only, as per the Court-approved audit tool.

While DJJ is very appreciative of the additional information that is provided on these Headquarters-specific audit items, DJJ believes that it would be less confusing and provide for a fairer assessment of Headquarters-specific audit items if the Office of the Special Master adhered to the Court-approved audit tool and provide compliance ratings in accordance with what the audit tool requires. As a result, DJJ respectfully requests that, for those Headquarters-specific audit items that the Special Master wishes to use to provide information at the facility level, the Special Master office simply provide a N/A rating to the item along with her comments or merely leave the space blank in the compliance rating section.

The chart below is a listing of the seven Mental Health audit items for N.A. Chaderjian Youth Correctional Facility for which the Office of the Special Master provided facility-specific compliance ratings, as required by the Court-approved audit tool. The chart does not include compliance ratings that were provided but were not facility-required. Also, the chart only identifies audit items that received a rating of Substantial Compliance, Partial Compliance, or Non-compliance. The chart does not list the audit items that received "N/A" ("Not Applicable"), "NR" ("Not Rated"), or "Defer to Expert" ratings. It is important to note that these compliance ratings are still considered to be in draft as DJJ has not yet had the opportunity to respond to any item(s) that it may wish to challenge or note any item(s) that has a new future deadline and therefore is not yet appropriate to be assessed with a compliance rating.

OSM Compliance Ratings For Mental Health Audit Items Specific To:					
N.A. Chaderjian Youth Correctional Facility					
Date Of Audit: October 17 & 22, 2008					
#	S&W Audit Item #	Audit Item Description	Substantial Compliance	Partial Compliance	Non-Compliance
1	5.14a	Reduce ITPs and SCPs to no more than 30	X		
2	5.14b	Reduce IBTPs to no more than 20	X		
3	5.14c	Reduce ITPs and SCPs to no more than 24	X		
4	5.14d	Reduce IBTPs to no more than 16	X		
5	5.11	Outpatient MH staffing consistent with MH Remedial Plan		X	
6	11.1	Implement plan for offices and MH treatment rooms		X	
7	5.5	Appoint MH administrator at each facility w/residential MH program	X		
TOTAL			5	2	0
COMPLIANCE %			71%	29%	0%

As identified in the chart above, the Office of the Special Master rated seven Mental Health audit items that were specific to N.A. Chaderjian Youth Correctional Facility. Of those seven items rated, 71% were assessed to be in Substantial Compliance, 29% were assessed to be in Partial Compliance and 0% was assessed to be in Non-compliance. These ratings will be included with that of the Mental Health Experts' for the Mental Health audit items specific to N.A. Chaderjian Youth Correctional Facility and will be reflected in graphs and charts depicting the cumulative compliance percentages for this facility in future Quarterly Reports.

2.6.3 Mental Health Audit Results

Audit Results Introduction

The Mental Health charts on the following pages are the most up-to-date compliance ratings provided by the Mental Health Experts and the Office of the Special Master. DJJ has yet to receive a complete facility audit report from the Mental Health Experts; as a result, the compliance

data identified in the following pages represent a very limited snapshot of the progress made thus far in the implementation of the Mental Health Remedial Plan.

In fact, the data is so limited that DJJ warns against drawing any conclusions about the progress in this plan from the data received to date. For example, some of the charts identify as few as two audit items that have been assessed and received compliance ratings. DJJ does not believe this set of data is large enough to provide a clear understanding of the progress that has been and is continuing to be made up to this point. However, in an effort for full disclosure, the compliance ratings that DJJ has received are being shared in this section. It is anticipated that once the Mental Health Experts begin to provide DJJ with facility audit reports, then DJJ will be in a better position to demonstrate a more reliable level of progress in the implementation of the Mental Health Remedial Plan.

The Mental Health charts also include the cumulative results of the limited audit data received thus far as well as a comparison of a facility's prior audit results in previous rounds. Because this is the first round of the Mental Health audits, there will not be a comparison of a site's prior audits but rather just a different visual representation of the same compliance results. Attached to these charts is the statistical data for each item audited to date at each site.

The percentages identified have been rounded off and therefore, may have a slight variance of no more than 1% of either less than or greater than 100%. For example, in adding up the different compliance percentages, the sum total for a given item could either be 99%, 100%, or 101% due to rounding.

To help fully understand the charts on the following pages, the items below are more clearly defined:

- **SC** = Substantial Compliance
- **PC** = Partial Compliance
- **NC** = Non-compliance
- **N/A** = Not Applicable
- **Numbers in red font** = A negative number denoting a decrease in a compliance percentage.
- **Raw %** = The compliance percentages with the N/A items included in the calculations.
- **Adjusted %** = The compliance percentages with the N/A items excluded from the calculations.
- ***UPDATED THIS QUARTER:** = Identifies charts and graphs that have been updated since the last Quarterly Report.

CUMULATIVE RESULTS

The pie chart below identifies the cumulative averages for all of the compliance data received to date from the various monitors of the Mental Health Remedial Plan. It is important to note that all of the compliance data for the Mental Health Remedial Plan to date is from a very limited number of compliance ratings. Because this is the first round of audits, the bar graph on the right illustrates the same results as that of the pie chart. Below these graphs are the statistical data associated with these audit results.

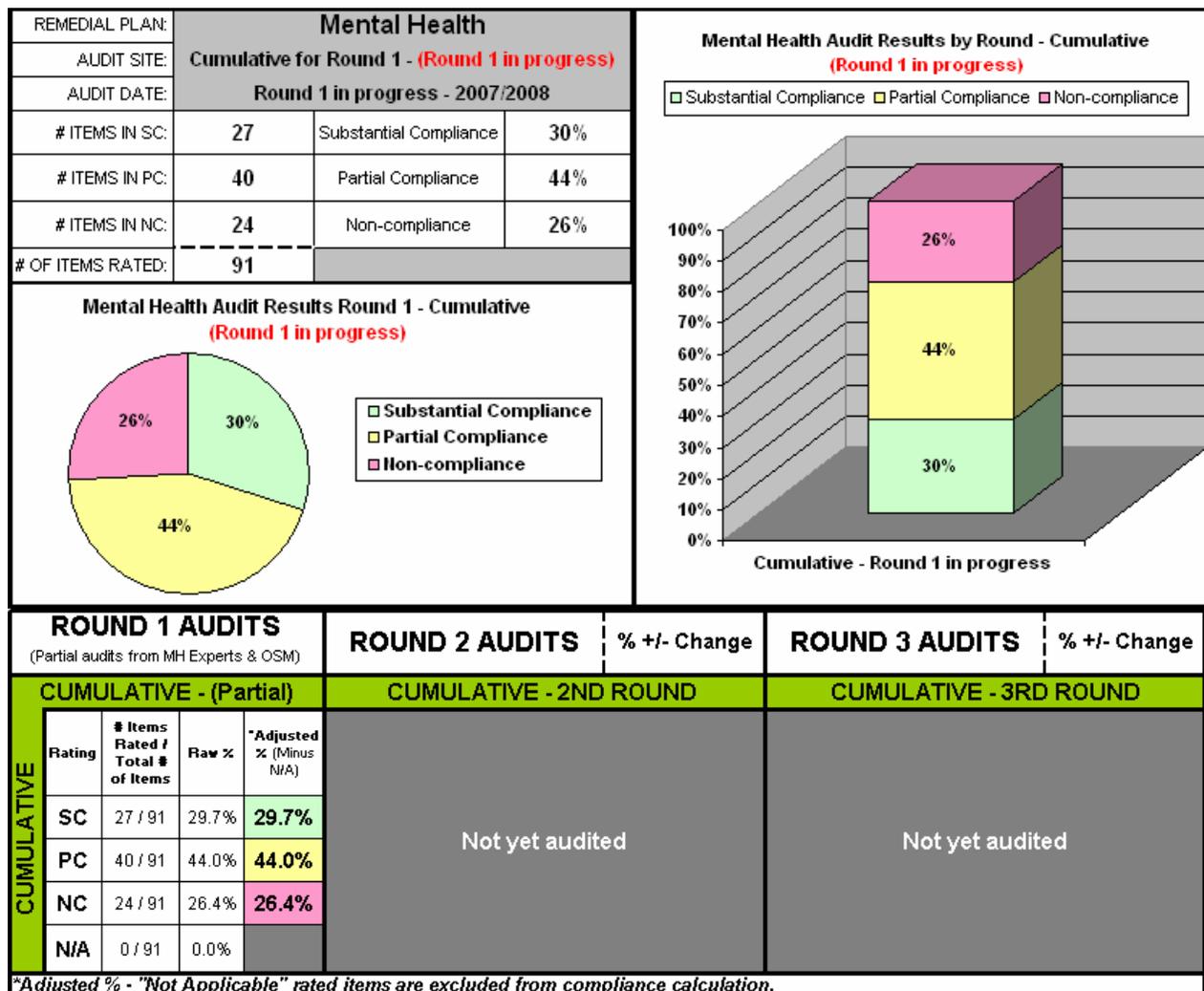


Figure 59: Mental Health Audit Results – Cumulative

- The cumulative Substantial Compliance percentage is 30%.
- The cumulative Non-compliance percentage is 26%.
- The cumulative combined Substantial Compliance and Partial Compliance percentages total 74%.
- These results are from just 91 total audit items which represents a very limited number and may not be a reliable indicator of progress.

N.A. CHADERJIAN YOUTH CORRECTIONAL FACILITY

The Mental Health Experts last audited the N.A. Chaderjian Youth Correctional Facility on October 17, 2008, but have not yet provided DJJ with the compliance data from this audit. The chart below identifies the compliance data received to date from the Mental Health Experts and the Special Master via their Headquarters visits. Because this is the first round of audits, the bar graph on the right illustrates the same results as that of the pie chart. Below these graphs are the statistical data associated with these audit results.

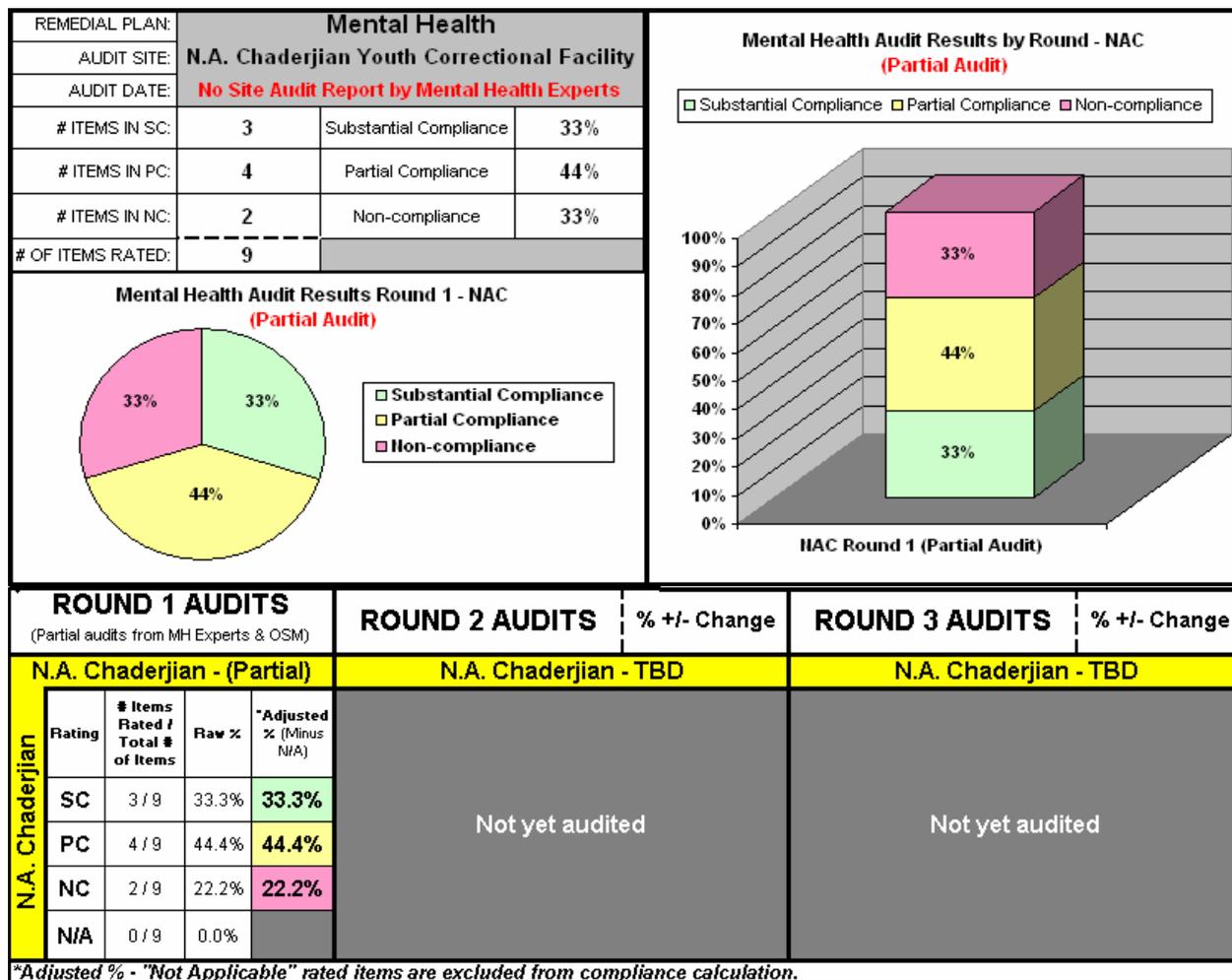


Figure 60: Mental Health Audit Results – N.A. Chaderjian Youth Correctional Facility

- The facility’s Substantial Compliance percentage is 33%.
- The facility’s Non-compliance percentage is 33%.
- The facility’s combined Substantial Compliance and Partial Compliance percentages total 77%.
- These results are from just nine (9) audit items which represents a very limited number and may not be a reliable indicator of progress.

O.H. CLOSE YOUTH CORRECTIONAL FACILITY

The Mental Health Experts last audited the O.H. Close Youth Correctional Facility on October 16, 2008, but have not yet provided DJJ with the compliance data from this audit. The pie chart below identifies the compliance data received to date from the Mental Health Experts and the Special Master via their Headquarters visits. Because this is the first round of audits, the bar graph on the right illustrates the same results as that of the pie chart. Below these graphs are the statistical data associated with these audit results.

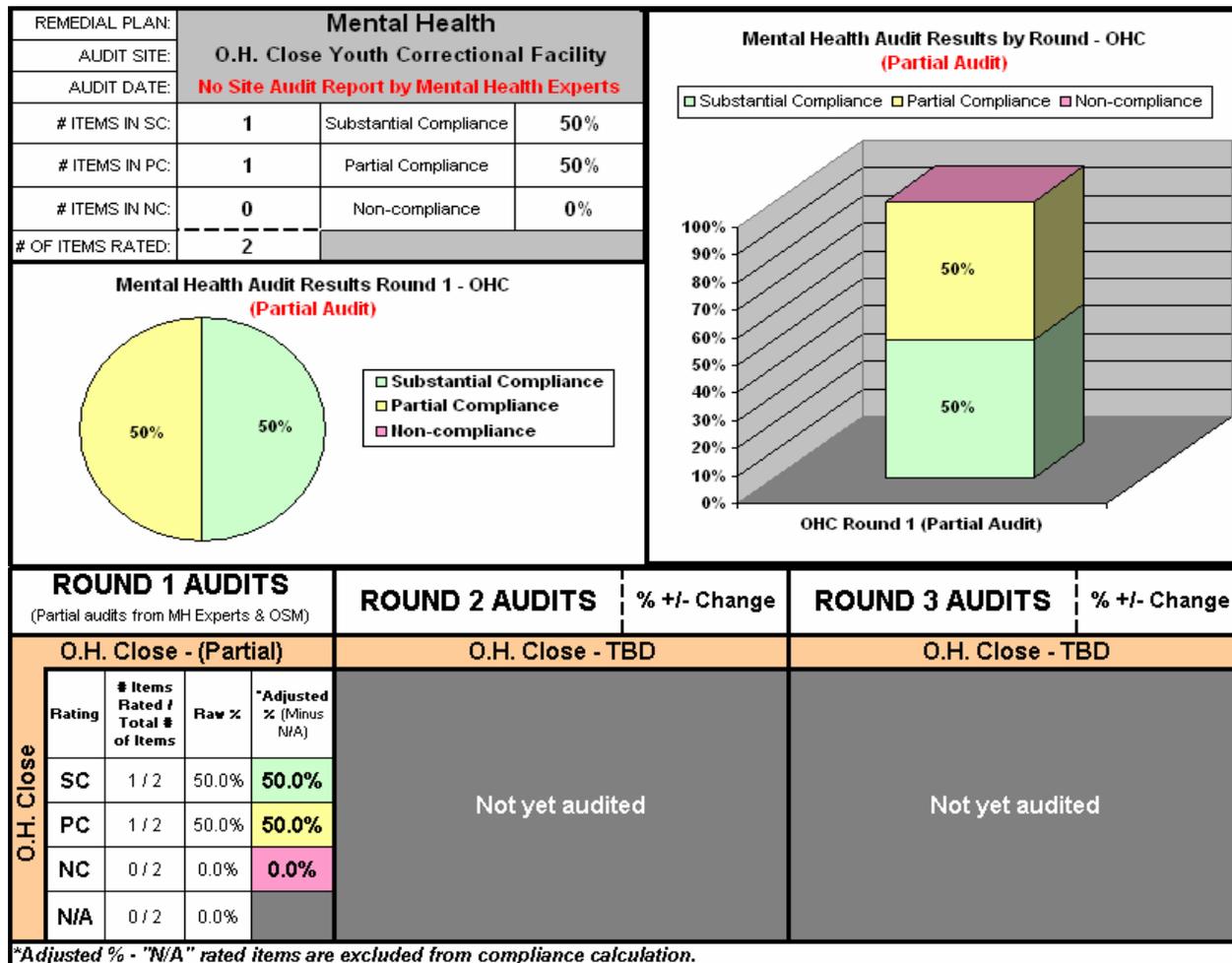


Figure 61: Mental Health Audit Results – O.H. Close Youth Correctional Facility

- The facility’s Substantial Compliance percentage is 50%.
- The facility’s Non-compliance percentage is 0%.
- The facility’s combined Substantial Compliance and Partial Compliance percentages total 100%.
- These results are from just two (2) audit items which represents a very limited number and may not be a reliable indicator of progress.

HEMAN G. STARK YOUTH CORRECTIONAL FACILITY

The Mental Health Experts last audited the Heman G. Stark Youth Correctional Facility on October 2-3, 2008, but have not yet provided DJJ with the compliance data from this audit. The pie chart below identifies the compliance data received to date from the Mental Health Experts and the Special Master during their Headquarters visits. Because this is the first round of audits, the bar graph on the right illustrates the same results as that of the pie chart. Below these graphs are the statistical data associated with these audit results.

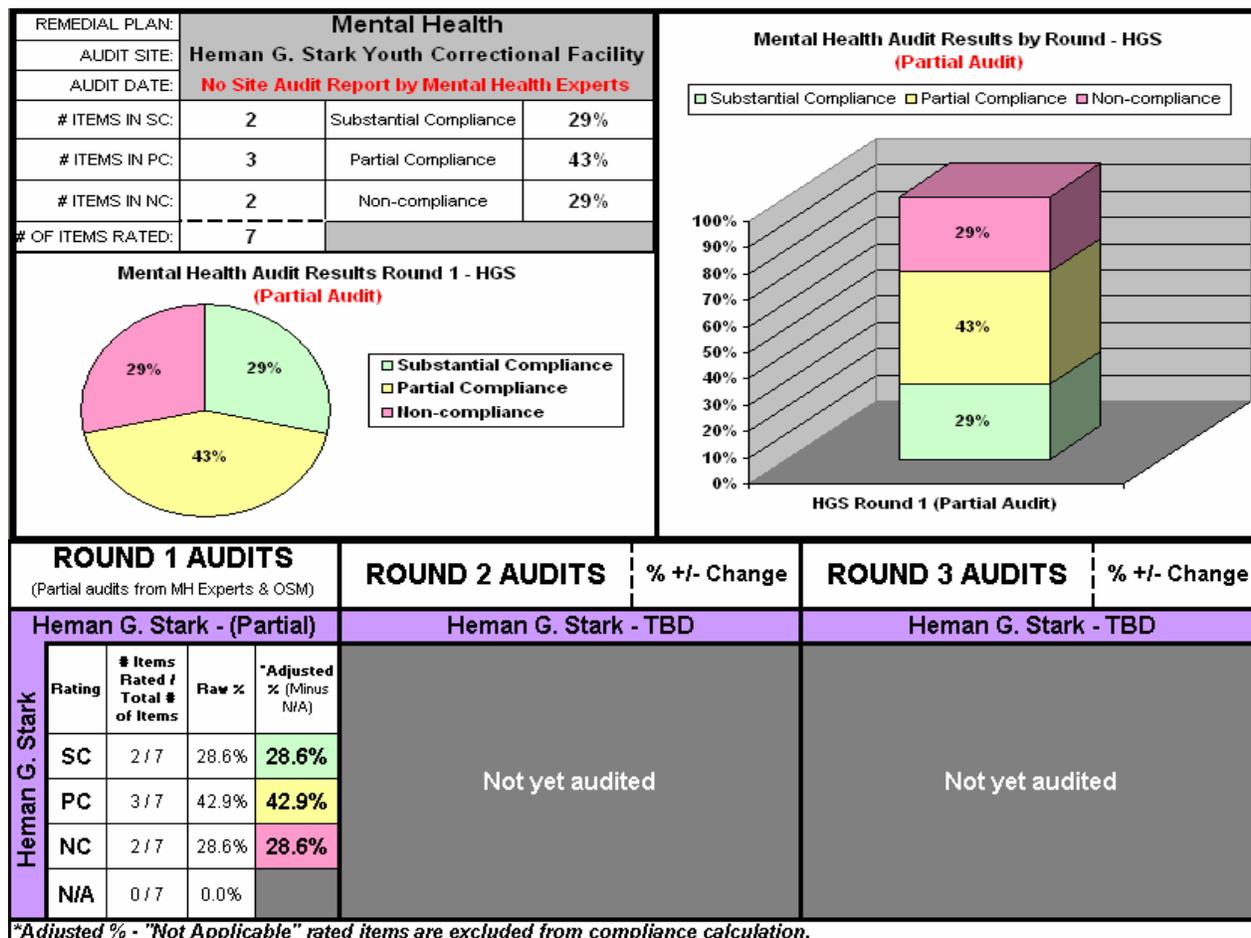


Figure 62: Mental Health Audit Results – Heman G. Stark Youth Correctional Facility

- The facility's Substantial Compliance percentage is 29%.
- The facility's Non-compliance percentage is 29%.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 72%.
- These results are from just seven (7) audit items which represents a very limited number and may not be a reliable indicator of progress.

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER-CLINIC

The Mental Health Experts have not yet audited the Southern Youth Correctional Reception Center-Clinic. The pie chart below identifies the compliance data received to date from the Mental Health Experts and the Special Master via their Headquarters visits. Because this is the first round of audits, the bar graph on the right illustrates the same results as that of the pie chart. Below these graphs are the statistical data associated with these audit results.

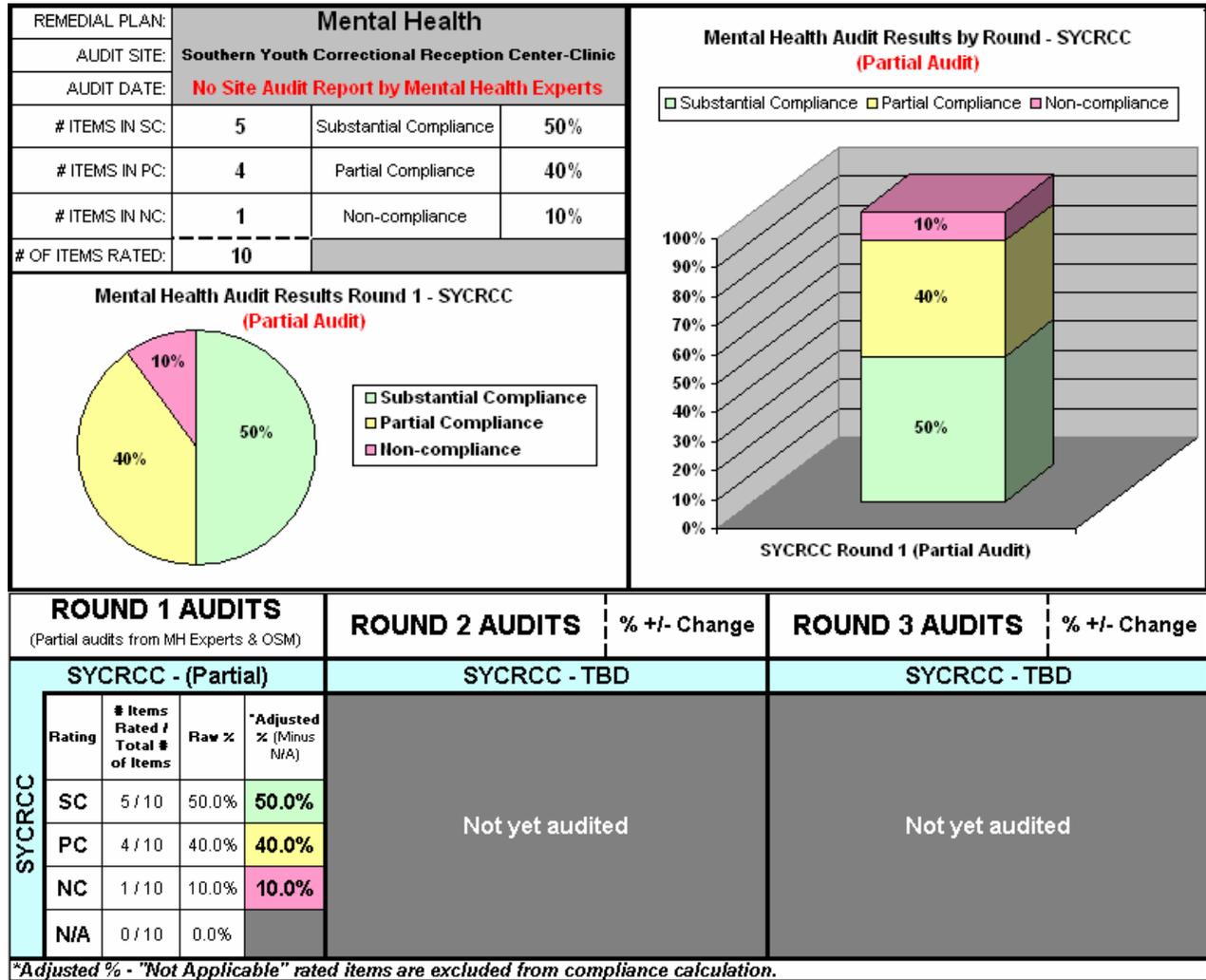


Figure 63: Mental Health Audit Results – Southern Youth Correctional Reception Center-Clinic

- The facility’s Substantial Compliance percentage is 50%.
- The facility’s Non-compliance percentage is 10%.
- The facility’s combined Substantial Compliance and Partial Compliance percentages total 90%.
- These results are from just ten audit items which represents a very limited number and may not be a reliable indicator of progress.

PRESTON YOUTH CORRECTIONAL FACILITY

The Mental Health Experts last audited the Preston Youth Correctional Facility on July 17-18, 2008, but have not yet provided DJJ with the compliance data from this audit. The pie chart below identifies the compliance data received to date from the Mental Health Experts and the Special Master via their Headquarters visits. Because this is the first round of audits, the bar graph on the right illustrates the same results as that of the pie chart. Below these graphs are the statistical data associated with these audit results.

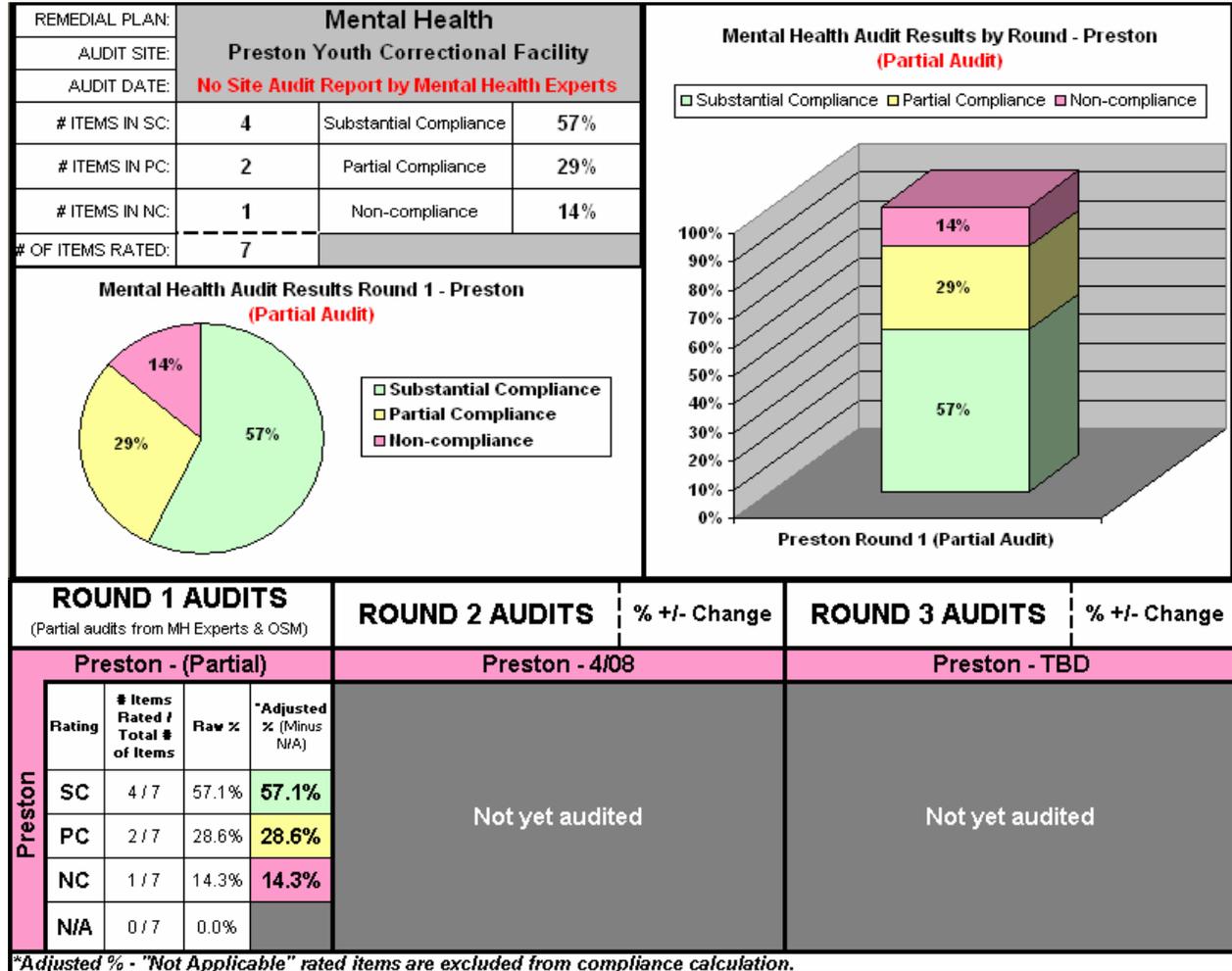


Figure 64: Mental Health Audit Results – Preston Youth Correctional Facility

- The facility’s Substantial Compliance percentage is 57%.
- The facility’s Non-compliance percentage is 14%.
- The facility’s combined Substantial Compliance and Partial Compliance percentages total 86%.
- These results are from just seven audit items which represents a very limited number and may not be a reliable indicator of progress.

VENTURA YOUTH CORRECTIONAL FACILITY

The Mental Health Experts audited the Ventura Youth Correctional Facility on December 4, 2009 but have not yet provided DJJ with the compliance data from this audit. The pie chart below identifies the compliance data received to date from the Mental Health Experts and the Special Master during their Headquarters visits. Because this is the first round of audits, the bar graph on the right illustrates the same results as that of the pie chart. Below these graphs are the statistical data associated with these audit results.

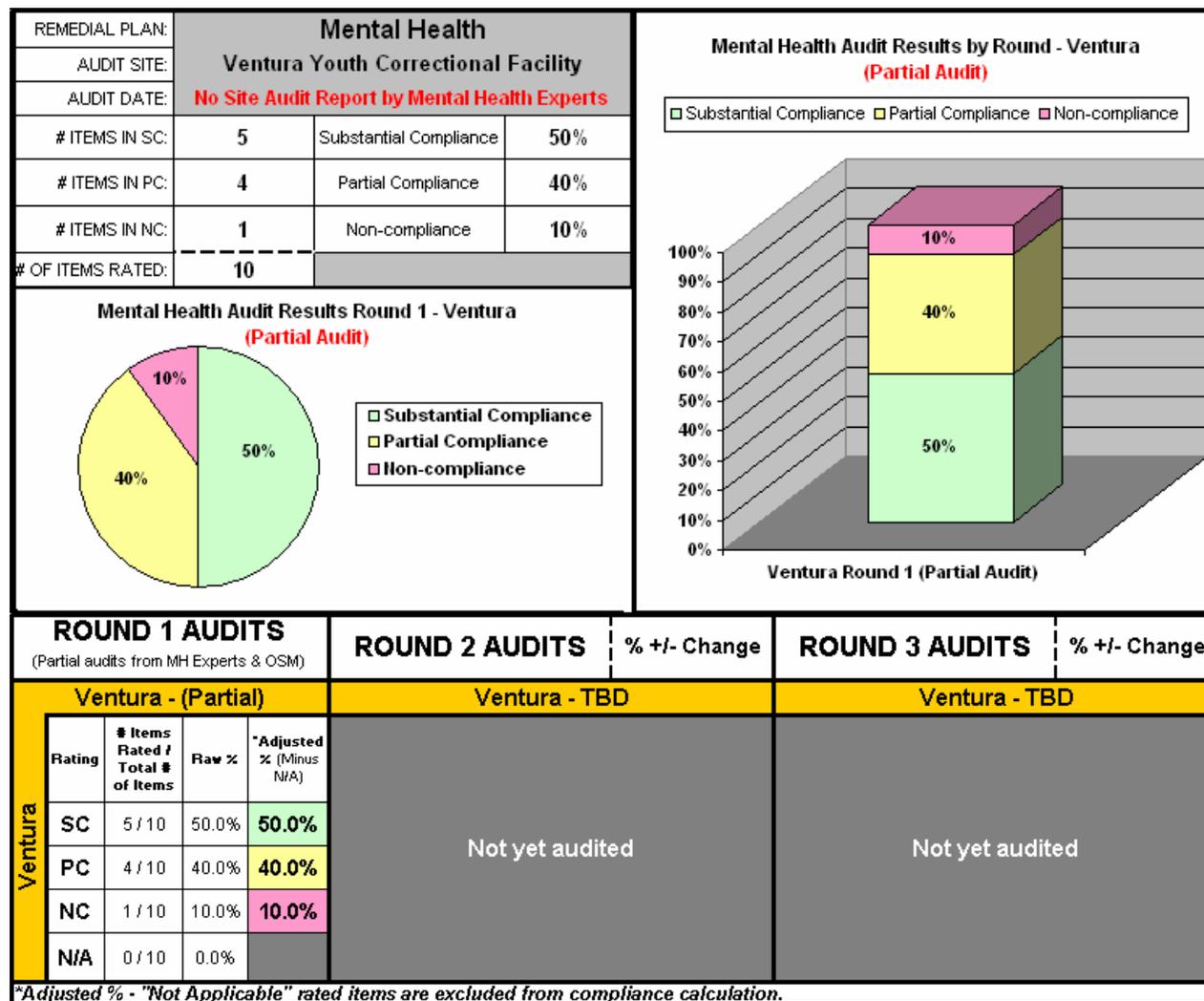


Figure 65: Mental Health Audit Results – Ventura Youth Correctional Facility

- The facility’s Substantial Compliance percentage is 50%.
- The facility’s Non-compliance percentage is 10%.
- The facility’s combined Substantial Compliance and Partial Compliance percentages total 90%.
- These results are from just ten audit items which represents a very limited number and may not be a reliable indicator of progress.

EL PASO DE ROBLES YOUTH CORRECTIONAL FACILITY

The Mental Health Experts have not audited the El Paso de Robles Youth Correctional Facility and will not do so in the future due to the facility's closure. The pie chart below identifies the compliance data received from the Mental Health Experts and the Special Master during their Headquarters visits. Because this was the first round of audits, the bar graph on the right illustrates the same results as that of the pie chart. Below these graphs are the statistical data associated with these audit results.

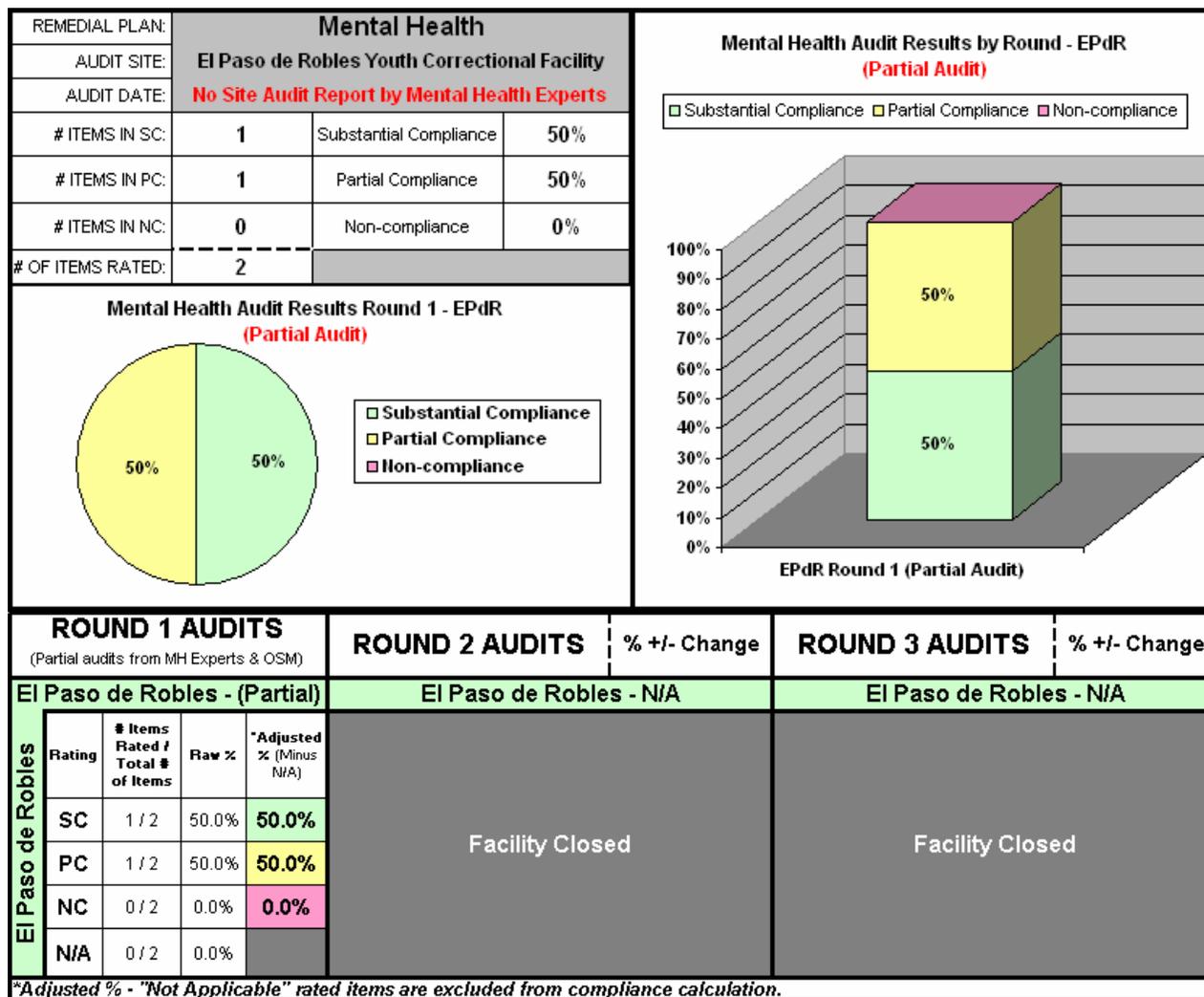


Figure 66: Mental Health Audit Results – El Paso de Robles Youth Correctional Facility

- The facility's Substantial Compliance percentage is 50%.
- The facility's Non-compliance percentage is 0%.
- The facility's combined Substantial Compliance and Partial Compliance percentages total 100%.
- These results are from just two audit items which represents a very limited number and may not be a reliable indicator of progress. This facility has since been closed and will not be audited in future rounds.

DJJ HEADQUARTERS

The Mental Health Experts and the Office of the Special Master have made several visits to DJJ Headquarters over the last 18 months and have been able to assess the compliance level of some Headquarters-specific audit items as well as that of some facility audit items. The pie chart below identifies the compliance data received from the Mental Health Experts and the Special Master during these visits. Because this is the first round of audits, the bar graph on the right illustrates the same results as that of the pie chart. Below these graphs are the statistical data associated with these audit results.

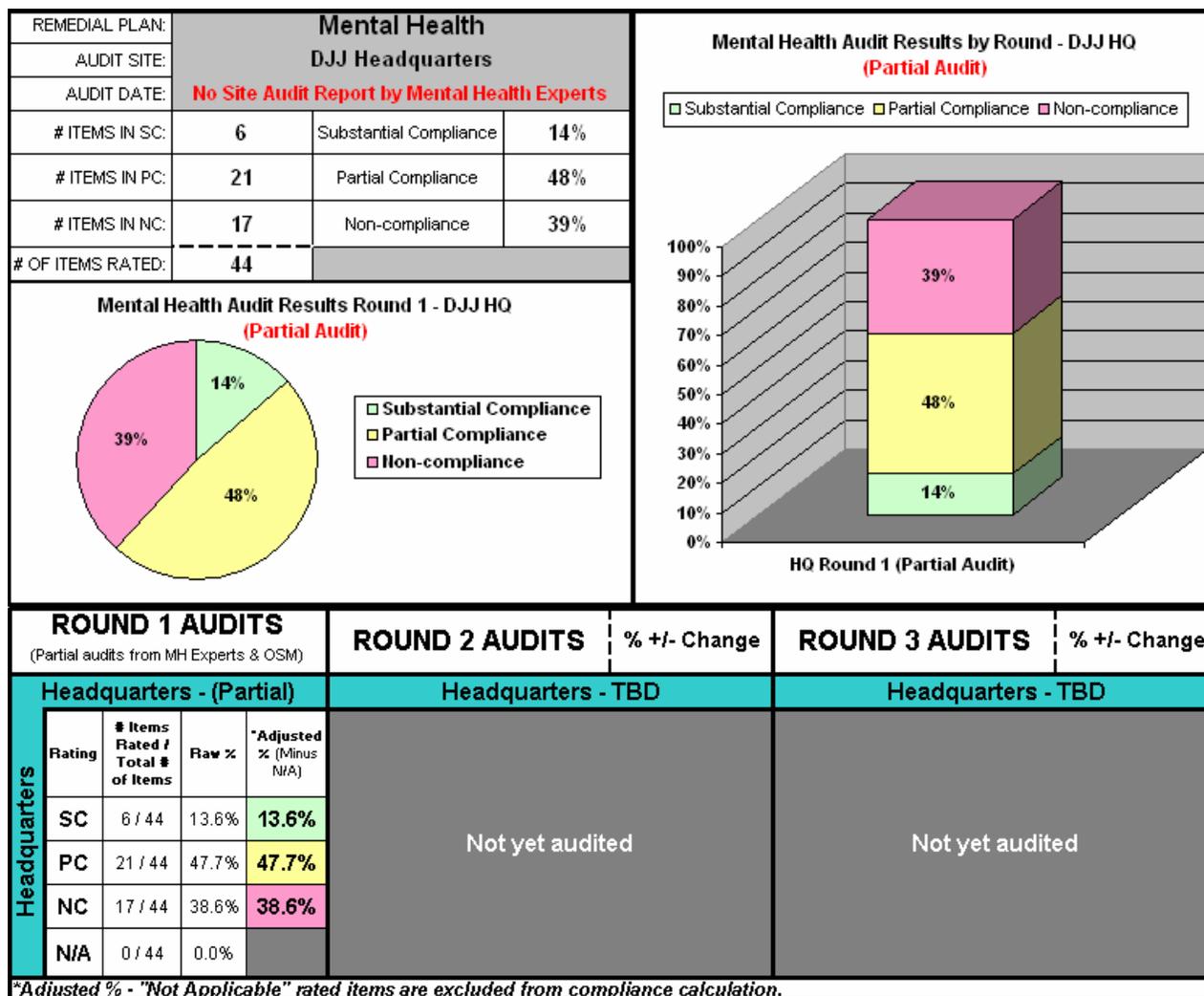


Figure 67: Mental Health Audit Results – DJJ Headquarters

- Headquarters' Substantial Compliance percentage is 14%.
- Headquarters' Non-compliance percentage is 39%.
- Headquarters' combined Substantial Compliance and Partial Compliance percentages total 62%.
- These results are based on only 44 audit items, which is a very limited number and may not be a reliable indicator of progress.

2.6.4 Expert Feedback

During the last quarter, DJJ received an audit report from the Office of the Special Master for the N.A. Chaderjian Youth Correctional Facility. This report contained compliance information for both Safety & Welfare and Mental Health audit items that the Office of the Special Master is responsible for monitoring. For a sampling of the comments made by the Special Master, please refer to the previous section in Safety & Welfare.

2.6.5 Status of Specific Action Items

Relieved Items

Page 11, paragraph 23, of the Consent Decree states:

When a facility is found to be in substantial compliance on an issue for one full year, and is found to remain in substantial compliance after review by the relevant expert(s) one year later, expert tours regarding that issue at that facility shall end.

A “relieved” audit item is one that has met or exceeded the two-year Substantial Compliance threshold and for which the appropriate Expert has formally noted that the audit item is to be removed from that Expert’s future monitoring.

Currently, none of the Mental Health audit items meet the time threshold to be deemed relieved by the Mental Health Experts or any other monitor of the Mental Health Remedial Plan.

Audit Items in Substantial Compliance Two Years or Longer

Since this is the Mental Health Experts’ first round of audits, there are no audit items that have met this time threshold.

Items Removed from Relieved Status

Since this is the Mental Health Experts’ first round of audits, there are no audit items that have met the time threshold, as identified in the Consent Decree, to be eligible to be relieved from future monitoring at this time.

Statewide Compliance Items

The Mental Health Experts have not completed their first round of audits. Therefore, DJJ is not able to identify audit items that would qualify as being in Statewide Compliance.

Action Items with Majority Rating of Non-compliance

The Mental Health Experts have not completed their first round of audits. Therefore, DJJ is not able to identify audit items that would qualify as receiving a majority rating of Non-compliance.

2.6.6 Proof of Practice

The following chart identifies the Mental Health-related Proof of Practice documents that have been sent to the Mental Health Experts and the Special Master during the last quarter. The Proof of Practice documents provide evidence of DJJ's efforts to come into compliance with the specific audit items in the Mental Health audit tool.

Mental Health Proof of Practice Documents Submitted During the Last Quarter				
#	Section	Audit Item Description	Documents Submitted	Date
275	5-21a	<i>"DJJ manually tracks select MH data, including wait lists, in Excel"</i>	<p>1 – Compact disc that contains Mental Health data for July 2008 through September 2008; and</p> <p>2 – E-mail from Paul Woodward, Program Administrator, Mental Health, providing a description of the data contained on the compact disc (8 pages).</p> <p>DJJ is providing this Mental Health data to the Mental Health Experts on a quarterly basis as required under the Consent Decree. The data contained on the enclosed compact disc contains information pertaining to the quarter spanning July 2008 through September 2008.</p> <p>The e-mail also attached here contains important information as to the types of data that is being provided to the Mental Health Experts and, in short, can be read as a Table of Contents. The last page of the e-mail, page 8, also contains important information as to how the collected data that DJJ now offers to the Mental Health Experts differ from past submissions.</p>	11/06/08
	5-21b	<i>"In consultation with the Consent Decree MH experts, DJJ identifies additional data elements to track"</i>		
	5-21d	<i>"Modify manual tracking system to include data elements in 5.21b. Produce consolidated and archivable reports"</i>		
289	N/A	N/A	<p>1 – Document entitled "Key Audit Items for Expert's Verification" (31 pages).</p> <p>This document is being submitted to the Mental Health Experts to allow them the opportunity to review it and ensure that the document correctly identifies the items that were submitted.</p> <p>This constitutes DJJ's second submission of the reporting tool to the Mental Health Experts. This submission also contains additional information that DJJ relied upon in drafting the reporting tool, including information provided by and/or derived from consultations with the Experts.</p>	11/20/08

Mental Health Proof of Practice Documents Submitted During the Last Quarter				
#	Section	Audit Item Description	Documents Submitted	Date
293	8-1b	<i>"Health Care policies & procedures on pharmacy & medication administration guided by principles outlined in Section 8 of the MH Remedial Plan with regard to psychotropic medications"</i>	<p><u>Documents for Staff Training</u></p> <p>1 – Document entitled, "Appendix A: JV-220 Court Application for Psychotropic Medication – Juvenile" for Staff (30 pages); and</p> <p>2 – Powerpoint presentation entitled, "Psychopharmacology Treatment Guidelines for Staff," produced by the DJJ Mental Health Training Team (82 pages).</p> <p><u>Documents for Psychiatrist Training</u></p> <p>3 – Powerpoint presentation entitled, "Psychopharmacology Treatment Guidelines for Psychiatrists," produced by the DJJ Mental Health Training Team (88 pages);</p> <p>4 – Draft of DJJ's Psychopharmacological Treatment Guidelines manual (41 pages); and</p> <p>5 – Document entitled, "Appendix A: JV-220 Court Application for Psychotropic Medication – Juvenile" for Psychiatrists (35 pages).</p> <p>These documents are being provided to the Mental Health Experts for their review and feedback. They consist of training materials that will be provided separately to DJJ staff and to DJJ's psychiatrists regarding the use of psychotropic medication.</p> <p>DJJ respectfully requests the return of feedback from the Experts by the close of business of Friday, December 5, 2008.</p>	11/20/08
296	8-1a	<i>"Develop comprehensive set of essential MH policies and procedures in consultation with Consent Decree MH experts"</i>	<p>1 – Policy draft for Mental Health Referrals (10 pages); and</p> <p>2 – DJJ Form 8.039, "Mental Health Referral" (1 page).</p> <p>This policy draft of the Mental Health Referral as well as the Mental Health Referral draft form are being submitted to the Mental Health Experts for their review in accordance with action item 8-1a of the Mental Health Standards and Criteria, which require DJJ to work with the Mental Health Experts in developing policies and procedures essential to Mental Health.</p> <p>DJJ respectfully requests the Experts' feedback, after their review, by the close of business of Monday, December 8, 2008.</p>	11/24/08
297	N/A	N/A	<p>1 – Memorandum, dated November 17, 2008, from Ed Morales, M.D., Chief Psychiatrist, to Doug McKeever, Director, Division of Juvenile Programs, subject: "Treatment Teams" (1 page).</p> <p>This memorandum is being submitted to the Mental Health Experts to demonstrate that all member of the treatment teams, consisting of member from both facility and clinical staff, will have access to youths' mental health records. The memorandum also disseminates important guidelines regarding confidentiality that all staff who access the records should adhere to.</p>	11/26/08

Mental Health Proof of Practice Documents Submitted During the Last Quarter				
#	Section	Audit Item Description	Documents Submitted	Date
304	8-1a	<i>"Develop comprehensive set of essential MH policies and procedures in consultation with Consent Decree MH experts"</i>	Informed consent forms for 30 different psychotropic medications. These documents are drafts of informed consent forms (ICFs) to be used by psychiatrists prior to the administration of psychotropic medications. There are a total of 30 individual ICFs.	12/11/08
	8-1b	<i>"Coordinate psychopharmacological policy with HC Services Plan"</i>	DJJ respectfully requests review of these ICFs by the Mental Health Experts, with feedback to be provided back to DJJ by the close of business of Friday, December 26, 2008.	
306	Consent Decree	<i>"By November 1, 2004, Defendant shall develop policies and procedures to immediately provide for the treatment and management of wards on suicide watch and those with acute psychiatric needs" (p. 4).</i>	<p>This Proof of Practice consists of documents pertaining to DJJ's Suicide Prevention, Assessment, and Response (SPAR) policy and training. These documents consist of DJJ's draft policy on Suicide Prevention, Assessment, and Response as well as training materials that will be provided to Health Care and facility staff; volunteers and direct-care staff; and Mental Health staff. These documents are being submitted pursuant to the terms of the Farrell Consent Decree.</p> <p>DJJ respectfully requests the review and feedback from the Mental Health Experts and the Safety & Welfare Expert regarding the training materials, documents 2 through 11, by the close of business of Monday, December 29, 2008. However, document 1, the draft policy, does not require feedback; the Experts have already reviewed and provided feedback on this version.</p>	12/12/08
313	5-12c	<i>"Open residential mental health treatment units . . . 1 Intensive Behavior Treatment Program"</i>	<p>1 – Memorandum, dated December 10, 2008, from Tami McKee-Sani, Program Administrator, Design and Development Unit, to selected participants of the BTP Project Team, subject: "Behavior Treatment Program Project Charter" (1 page).</p> <p>This memorandum is being provided to the Safety & Welfare Expert to demonstrate that the Behavior Treatment Program charter has been approved and that participants for the BTP project team have been selected. The orientation meeting for these participants, as identified in the memorandum, will take place on Thursday, December 18, 2008.</p>	12/22/08
	5-13b	<i>"Open residential mental health treatment units . . . 1 Intensive Behavior Treatment Program"</i>		
	(and other S & W items)	See Proof of Practice # 313 in the Safety & Welfare section of this report.		

2.6.7 Summary and Application of Audit Findings

DJJ is currently reviewing the Mental Health Experts' audit reports that were provided after the lapse of this past reporting period. DJJ expects to discuss in detail the findings in these reports. DJJ is appreciative of the Experts' time and guidance in assisting the department in its efforts to fully implement all the reforms identified in the Mental Health Remedial Plan.

2.7 Reform Management

2.7.1 Section Purpose

This section documents the performance of the DJJ Reform Management Structure in facilitating the remediation of the action items within the six Farrell Remedial Plans.

During the Fourth Quarter of 2008, a document entitled “Proposed Revision Dates for Specific Standards & Criteria and Remedial Plan Items,” dated November 21, 2008, was filed with the Court, and it identified revised due dates for 18 projects. The document was split, for reference, into appendices J through AA in DJJ’s Response to the Court Order dated October 27, 2008, which was filed with the Court on December 12, 2008.

Each of the projects was documented as fulfilling one or more of the Standards and Criteria items or one or more referenced items in the Remedial Plans. The count of those with revised or added dates is reflected in the following table:

Remedial Plan	Number of Action Items ¹	Number of Action Items with Due Dates Last Quarter	Number of Action Items with Due Dates This Quarter
Education Services	115	12	16
Sex Behavior Treatment Program	53	0	0
Wards with Disabilities Program	122	25	27
Health Care Services	205	0	0
Safety & Welfare	227	225	225
Mental Health	118	118	118
Totals	840	380	386

2.7.2 The DJJ Reform Management Structure

During the Fourth Quarter of 2008, the next step towards full implementation of the structure was taken. An internal organization structure, known as the Court Compliance team, was introduced for the purposes of managing and completing the work effort represented in the *Farrell* remedial plans. This organizational staffing structure provides a focus toward achieving results in offering improved services, and it also complements and supports the DJJ Reform Management Structure that was introduced in the third quarter of 2008.

¹ The table includes in the “Number of Action Items” count the removal of 2 items from Health Care and the addition of 1 item to Sex Behavior Treatment.

3 ACTIONS TAKEN

3.1 Education Services Remedial Plan Accomplishments

1. Education Services Remedial Plan Significant Accomplishments

The Education Services Remedial Plan was filed with the Court on March 1, 2005. Significant accomplishments in the implementation of the Education Services Remedial Plan include:

- **Behavior Management System in All Classrooms** (*Education Services Standards and Criteria, Section III, Item 3.33; and Safety & Welfare Standards and Criteria, Section 8.4b*)

The Education Services Remedial Plan requires a written policy, procedure, and practice to provide a structured, positive behavior-management system in each classroom throughout the state.

In addition, both the Education Services Remedial Plan and the Safety & Welfare Remedial Plan mandate the establishment of a Youth Incentive Program. The Youth Incentive Program was implemented in July 2005. The goal of the Youth Incentive Program is to encourage youths to engage in socially acceptable behavior and participate in DJJ's education and rehabilitation programs.

In November 2008, all DJJ schools within the California Education Authority received the electronic version of the Positive Behavior Classroom Guide adopted and presented to Principals and Education Services Managers by the Acting Superintendent of Education.

The Positive Behavior Classroom Guide, initially implemented at Southern Youth Correctional Reception Center-Clinic's Jack B. Clarke High School, is designed to promote youth's positive behavior classroom management and is based on building developmental assets of each student. The Positive Behavior Classroom Guide was adopted for implementation at all DJJ schools to meet compliance standards, as required by Item 3.35 of the Education Services Remedial Plan.

A Training Lesson Plan was developed for both the Youth Incentive Program and the Positive Behavior Classroom Guide. Training for educational staff on these topics is scheduled January 5 or January 6, 2009, during the Staff Development Days. The training was listed in the California Education Authority Academic Calendar for 2008-'09.

- **Alternative Behavior Learning Environment** (*Education Services Standards and Criteria, Section III, Item 3.34*)

The Alternative Behavior Learning Environment (ABLE) program, which provides opportunities for students to continue their learning when they are in need of an alternative education location due to regular classroom behavioral issues, is operational at all youth correctional school sites as of the start of the 2008-'09 school-year.

ABLE's primary focus is to encourage the student to remain in the classroom setting and to reinforce and encourage compliant, cooperative behaviors. ABLE provides DJJ staff with the opportunity to intervene when youths engage in disruptive behavior and encourage them to engage in positive behavior instead, all while maintaining the integrity of the classroom setting.

To ensure the successful implementation of ABLE, Education Services' Mentor Teachers provide on-going guidance to ABLE teachers at all the facilities. The Mentor Teachers worked closely with Education Services and were instrumental in helping to develop the ABLE program.

The Mentor Teachers met on November 12 and 13, 2008, to evaluate ABLE data and, as a result of this evaluation and the resulting operation discussion, began to revise the program. The Mentor Teachers also initiated an ABLE policy development process, which will subsequently require any technical assistance or training to be provided at each school by the school's Mentor Teacher; this will ensure that ABLE continues to evolve and improve. The target date for completion of the ABLE policy is set for April 2009.

The Mentor Teachers will meet on January 28 and 29, 2009, to complete the revision of the ABLE policy, develop a training schedule based on these revisions, and complete the ABLE policy draft.

- **Teacher Monitoring Standards & Criteria Item(s)** (*Education Services Standards and Criteria, Section IV, Item 4.2*)

The Education Services Remedial Plan requires quarterly classroom observations to ensure that teachers are responsive to the cultural, linguistic, and socio-economic backgrounds of all students and to create an inclusive environment in classrooms that encourage students of diverse backgrounds and varying abilities to be engaged and challenged as learners.

In conducting classroom observations, DJJ utilizes a rubric that was generated from the *California Standards for the Teacher Profession*, a report produced by the California Department of Education that puts forth standards for teaching that is based on current pedagogical research and expert advice pertaining to best teaching practices.

All quarterly teacher observations for the first quarter of the 2008-'09 school year were completed by the October 27, 2008, due date. On October 30, 2008, Education Services e-mailed all school principals to provide them with notice that the next quarter's teacher observations were due no later than January 27, 2009. E-mailed reminders were sent out to the principals on December 1, 2008, and again on December 23, 2008. To ensure consistency, Education Services management will continue to monitor compliance with this directive and provide a report of its status.

2. Items in Progress

- **Superintendent of Education** (*Education Services Remedial Plan, page 6 and page 23*)

To ensure that leadership is in place until the position can be filled on a permanent basis, DJJ has appointed Leda Medearis as Acting Superintendent of Education.

- **Program Service Day** (*Education Services Standards and Criteria, Section III, Item 3.34; Safety & Welfare Standards and Criteria, Sections 6, Items 2a, 2b, 2c, and 6; Mental Health Standards and Criteria, Section 5, Item 18*)

On November 5, 2008, the Program Service Day Charter was approved by DJJ's Architect Project Review Board (APRB) as well as by all DJJ Directors, and a Project Leader was identified. On November 13, 2008, an orientation meeting was held with the identified DJJ Headquarters Program Service Day project team members. The team has been working on finalizing the task schedule and identifying any barriers to implementation to ensure the successful execution of Program Service Day.

Team members then met with Superintendents, Chief Medical Officers, Principals, and other staff from each facility to discuss the Program Service Day. A copy of the finalized task schedule was sent to each facility's Program Service Day site leader to guide them through the implementation process. Facilities have been working on finalizing education and living unit Program Service Day schedules. Implementation of Program Service Day is scheduled for March 2009.

- **Access to Courts and Law Library** (*Safety & Welfare Standards and Criteria, Section VIII, Items 8.7.1a; 8.7.1b; 8.7.1c; 8.7.2; 8.7.5; 8.7.6a; and 8.7.7*)

On December 19, 2008, the annual law library training course for on-site library staff was scheduled for March 4, 2009, and will be provided by the Sacramento County Law Library.

On December 22, 2008, Education Services then received recommendations from the Office of Legal Affairs as to the types of legal materials that DJJ's libraries ought to have available in both hardcopy and electronic form. These recommendations were then forwarded to the Chief of Court Compliance for purchase authorization.

- **Access to Electronic Law Library** (*Safety & Welfare Standards and Criteria, Section VIII, Item 8.7.5*)

On November 6, 2008, Education Services requested information from the Architectural Design and Development Unit as to whether it has a feasibility study report pertaining to the purchase of technology-related materials; neither Education Services nor the Division of Juvenile Facilities currently possess a feasibility study report for such purchases.

The Enterprise Information Systems (EIS) responded on November 7, 2008, and informed Education Services that they need a feasibility study report to be completed in order to make technology-related purchases.

On December 22, 2008, Education Services received guidance from the Office of Legal Affairs in determining the types of legal materials that DJJ's law libraries should include in their collections. These recommendations from the Office of Legal Affairs were then forwarded to the Chief of DJJ's Court Compliance Unit for his review. When the Chief of the Court Compliance Unit provides his authorization, the appropriate materials may then be purchased to fill the law libraries at each of the facilities.

Once all elements of the electronic law library solution have received authorization from the Chief of the Court Compliance Unit, a recommendation to purchase the materials will then be submitted to the Executive Management Team for final review and approval.

3.2 Health Care Services Remedial Plan Accomplishments

1. Health Care Services Remedial Plan Significant Accomplishments

The Health Care Services Remedial Plan was filed with the Court on June 7, 2006. Significant accomplishments in the implementation of the Health Care Services Remedial Plan include:

- **Medical Care** (*Health Care Services Standards and Criteria, Section 7, page 16*)

The Health Care Services Experts' final report for the second audit conducted at Preston Youth Correctional Facility received a passing score of 85%. A second audit of Ventura Youth Correctional Facility was conducted from December 4 through 6, 2008.

- **Farrell Dental Expert** (*Health Care Services Standards and Criteria, Section 1, page 6*)

The review at Preston Youth Correctional Facility by the Dental Expert resulted in a 90% compliance rating, with most of the items found to be in substantial compliance. The dental audit tool was modified by the Dental Expert to meet the changes requested by Health Care Services with one area still outstanding: the definition of the term, "missed appointments" and the scoring of this item. Discussions between the Office of Legal Affairs and the Dental Expert are continuing on this particular subject.

2. Items in Progress

In addition to the above accomplishments that have been achieved, there are a number of other items that are still in progress and that DJJ anticipates fully implementing soon in accordance with the Health Care Services Remedial Plan. The items still in progress include the following:

- **The Physical Assessment, Nursing Process, and Documentation Course** (*Health Care Services Standards and Criteria, Section 6, page 14*)

The Physical Assessment, Nursing Process, and Documentation courses that had originally been scheduled for July, August, and September 2008 were cancelled last year due to the lack of a State budget. However, the Physical Assessment courses have since resumed, and all remaining sessions to train all nurses have now been scheduled to take place through March 2009.

- **Vision Testing and Eyeglass Procurement Policy** (*Health Care Services Standards and Criteria, Section 4, page 10*)

The Health Care Services Experts have provided their written approval of this policy, and it is now currently awaiting approval from the Office of Legal Affairs.

- **Disaster Management Policy** (*Health Care Services Standards and Criteria, Section 1, page 6*)

This policy has been vetted by the Policy, Procedures, Programs & Regulations Unit and by all DJJ Directors. The Office of Legal Affairs is in the process of reviewing this policy.

- **Out Patient Housing Unit Policy** (*Health Care Services Standards and Criteria, Section 1, page 6; and Section 13, page 28*)

The updated, revised policy has been reviewed by Policy, Procedures, Programs & Regulations Unit, DJJ Directors, and the Office of Legal Affairs. It is now currently being prepared for the Chief Deputy Secretary's review and signature.

3.3 Mental Health Remedial Plan Accomplishments

1. Mental Health Remedial Plan Significant Accomplishments

The Mental Health Remedial Plan was filed with the Court on August 25, 2006. Significant accomplishments in the implementation of the *Farrell* Mental Health Remedial Plan include:

- **Suicide Prevention, Assessment, and Response (SPAR)** (*Farrell vs. Cate Consent Decree, Section II, Interim Measures, Item 7c*)

The final draft of the Suicide Prevention Assessment and Response (SPAR) Policy was submitted to the Chief Deputy Secretary on December 23, 2008, for his approval.

Phase IV of the SPAR Policy pilot, which consists of the development and implementation of Information Technology support for the SPAR Policy, began on August 5, 2008, and was concluded in December 2008.

The SPAR Training-for-Trainers pilot was conducted at DJJ headquarters on November 18, 2008, and resulted in the finalized Training-for-Trainer training, which began on December 29, 2008.

The SPAR Policy is scheduled for statewide implementation in March 2009.

- **Forensic Services: WIC 1800 Policy** (*Mental Health Standards and Criteria, Item 5.3*)

The Forensic Services: WIC 1800 Policy has been submitted to the Office of Labor Relations and has been sent to the Office of Legal Affairs for review. After feedback from the Office of Legal Affairs is received, the policy will be submitted for signature from the Chief Deputy Secretary and will also undergo labor negotiation. Implementation will take place at the conclusion of these negotiations.

Training was completed in December 2008. The Forensic Services policy is on track for statewide implementation by March 2009.

- **Develop Comprehensive Set of Essential Mental Health Policies and Procedures** (*Mental Health Standards and Criteria, Item 8.1a*)

Priority I policies submitted to the Policy, Procedures, Programs & Regulations Unit include SPAR, WIC 1800, Psychopharmacologic and Mental Health Referrals. Priority I policies presently under development are Mental Health, Evaluations and Integrated Screening and Assessments.

The table below lays out the priority policy order:

Priority	Policy Title
1	Suicide Prevention, Assessment, and Response (SPAR) Policy
1	Psychopharmacologic Treatment Guidelines
1	Forensic Services – WIC 1800/1800.5 Evaluation
1	Mental Health Referral Process
1	Mental Health Evaluations
1	Integrated Assessments
2	Integrated and Evidence-Based Treatment Services
2	Principles of Mental Health Treatment
2	Individualized Treatment Planning
2	Treatment Requirements in Licensed and Unlicensed Facilities
2	Involuntary Mental Health Treatment
3	Discharge, After care and Discharge Planning
3	Mental Health and Safety Liaison
3	Level of Care System
3	Standards for Protecting and Granting Access to Confidential Information
3	Guidelines for Documentation
3	Communication with Countries

The due date for the completion of Priority 1 policies is June 2009.

Priority 2 policies are currently scheduled for completion by April 2010.

Priority 3 policies are currently scheduled for completion by December 2010.

- **Further Reduce Size of Mental Health Treatment Units** (*Mental Health Standards and Criteria, Items 5.14; 5.1a; 5.16; and 5.1b*)

All Intensive Treatment Program, Special Counseling Program, and Intensive Behavior Treatment Program Units were restricted to populations of 24, 24, and 16 youths, respectively, as is required by the *Farrell* Mental Health Remedial Plan. As of December 31, 2008, the actual census of these programs reflects these numbers.

- **Evaluation/Recommendations Regarding Current Array of Mental Health Services; Evaluate Practices, Make Recommendations Regarding Contract Services and Assess Inpatient Resources for Females and Northern California Males** (*Mental Health Standards and Criteria, Items 5.22; 5.23; and 5.24*)

Northern California males continue to be transferred to Sierra Vista Hospital when a higher level of residential care is required. If a youth is denied admission to Sierra Vista Hospital for security reasons, the youth will be admitted to the Correctional Treatment Center at Heman G. Stark Youth Correctional Facility. All southern California males and females continue to be provided acute in-patient care at the Correctional Treatment center located at Heman G. Stark Youth Correctional Facility.

Intermediate care for males located in both northern and southern California is provided through a contract with the California Department of Mental Health in the Intermediate Care Facility in the Southern Youth Correctional Receiving Center and Clinic.

2. Items in Progress

Items in progress toward full implementation of the Mental Health Remedial Plan include:

- **Mental Health Referral Policy** (*Mental Health Standards and Criteria, Item 8.1a*)

The Mental Health Referral Policy was sent to the Policy, Procedures, Programs & Regulations Unit in December 2008. The reformatted policy will be submitted to the Office of Legal Affairs for review and to the Office of Labor Relations for discussion with the Bargaining Units. Statewide training for multidisciplinary staff will be developed and implemented.

The Mental Health Referral policy is on track for statewide implementation by April 2009.

- **Integrated Screening and Assessments** (*Mental Health Standards and Criteria, Item 8.1a*)

The Screening and Assessment tools that will be included in the Integrated Screening and Assessments policy were reviewed and approved by the Mental Health Experts in November 2008. This policy will be part of the Classification Charter that is expected to be started first quarter 2009.

- **Collaborate with the Department of Mental Health (DMH) to Expedite Transfers and Facilitate Transitions** (*Mental Health Standards and Criteria, Item 5.20*)

Communications continue to occur on a routine and as-needed basis to resolve barriers and improve mental health services to DJJ youths. A quarterly meeting between representatives from the DJJ and the California Department of Mental Health occurred on October 2, 2008, and is scheduled for January 8, 2009. A number of e-mail communications between DJJ and the California Department of Mental Health to deal with issues related to in-patient care of DJJ youths were also exchanged on October 1, 2, 6, and 7, 2008; November 20, 2008; and December 23 and 24, 2008.

- **Develop Program Services Day Schedule for Mental Health Living Units** (*Mental Health Standards and Criteria, Item 5.18*)

Mental Health is actively participating in the Program Service Day Charter. The Mental Health representative for this group is Dr. Eric Kunkel. Each facility has a local Mental Health representative for this Charter.

3.4 Safety & Welfare Remedial Plan Accomplishments

1. Safety & Welfare Remedial Plan Significant Accomplishments

The Safety & Welfare Remedial Plan was filed with the Court on July 10, 2006. The goals of the Safety & Welfare Remedial Plan are to take steps to reduce violence and fear at every facility and to create the capacity for change.

Of the six remedial plans filed with the Court, the Safety & Welfare Remedial Plan is the most over-arching and far-reaching of them all. The following is a listing of the significant accomplishments achieved during the last quarter:

- **Compliance Team** (*Safety & Welfare Standards and Criteria, Section 2.1, Item 3c*)

During the last reporting period, from October 1, 2008, through December 31, 2008, the *Farrell* Compliance Unit conducted compliance assessments at O.H. Close and N.A. Chaderjian Youth Correctional Facilities. With the implementation of two Temporary Departmental Orders facilitating the completion of the Youth Grievance and Staff Misconduct Complaint policies, the *Farrell* Compliance Unit prepared an assessment tool designed to measure facility compliance.

The *Farrell* Compliance Unit continues to facilitate the preparation and submission of Corrective Action Plans for DJJ. During the last quarter, Corrective Action Plans were reviewed and submitted to requesting agencies for Heman G. Stark Youth Correctional Facility; Southern Youth Correctional Reception Center-Clinic; O.H. Close Youth Correctional Facility; Central Valley Parole; and the Correctional Training Center.

- **Master Table of Contents for Policies** (*Safety & Welfare Standards and Criteria, Section 2.1, Item 4a*)

The Final Master Table of Contents for Policies was completed on October 31, 2008.

- **Use of Force Policy** (*Safety & Welfare Standards and Criteria, Section 3.2*)

The Crisis Preventive Management/Use of Force Workgroup reconvened in October 2008 to review and incorporate, as necessary, feedback received from the Office of Legal Affairs. It is anticipated that the policy will be completed by February 2009.

- **Program Service Day** (*Safety & Welfare Standards and Criteria, Sections 6, Items 2a, 2b, 2c & 6; Education Services Audit Tool, Item 3.34; Mental Health Standards and Criteria, Section 5, Item 18*)

The DJJ Directors approved the Program Service Day Charter on November 5, 2008. The Charter identifies team members for the design, development, deployment, and implementation of Program Service Day.

The Program Service Day team developed State-wide standards regarding Program Service Day schedules. These standards were presented to all facilities for their development of Program Service Day implementation schedules.

Training for trainers for the Program Service Day policy was scheduled for completion at all facilities in January 2009. Facility staff will be trained on Program Service Day in February 2009.

The Preston Youth Correctional Facility has completed the pilot implementation of Program Service Day. Lessons learned from the pilot are being incorporated prior to full implementation. Following the completion of training for facility staff, Program Service Day will be launched at all remaining facilities.

- **Staff Training to Develop Knowledge and Skills to Implement Best Practices** (*Safety & Welfare Standards and Criteria, Section 6, Item 7*)

Staff training completed this quarter include the following:

- State-wide training on Classification; Youth Sexual Misconduct; Wards with Disabilities; Suicide Prevention, Assessment, and Response; Alternate Programs; Emergency Announcement Protocol; Youth with Disabilities; Confidential Youth Visits and Calls; Youth Grievance and Staff Misconduct Complaint; and Revocation Extension Hearings. After these trainings took place, exit interviews were conducted, and the resulting information that was collected will be used to assess and improve policy training efforts as indicated.

- Effective Case Work I (Risk Needs Assessment) Training

A total of 173 staff are trained to date; 26 staff were trained this quarter.

- Effective Case Work 2 (Case Planning)

A total of 60 staff were trained since the training was implemented on September 3, 2008.

- Safe Crisis Management

A total of 388 staff have completed this three-day training, 79 staff during this quarter.

- Aggression Replacement Training (Youth Intervention)

A total of 139 staff are trained; 18 staff were trained in Group Facilitation this quarter.

- Youth with Mental Disorders/Understanding and Prevention of Suicide

A total of 511 staff were trained; 55 staff during this quarter.

- Motivational Interviewing

750 total staff were trained; 26 staff were trained this quarter in the three-day class; 41 staff was trained in the two-day class; and 160 staff received a management overview.

A total of 282 staff have completed all 5 days of training, 74 staff during this quarter.

- Crisis Intervention/Conflict Resolution

321 staff were trained, with 41 staff completing the 40-hour course.

- Cognitive Behavior Primer

A total of 63 staff are trained along with an initial group of 14 staff trained as trainers since the implementation of the training on November 17, 2008.

- Group Facilitation Skills

26 staff trainers received this training on December 17 and 18, 2008.

In addition, DJJ has implemented a Division-wide process for scheduling Remedial Plan training.

- **Orientation** (*Safety & Welfare Standards and Criteria, Section 8.2., Item 5b*)

Updating, then disseminating the Youth Rights Handbook will be among the first steps in improving and standardizing orientation for youths.

In December 2008, focus groups were held with youths, and the feedback they provided was reviewed. It is anticipated that the Youth Rights Handbook will be released by February 2009.

- **Grievances** (*Safety & Welfare Standards and Criteria, Section 8.5 [all items, except for 5c, 10, and 12]*)

Automation of the reporting process was completed in November 2008. Audits have been performed by the *Farrell* Compliance Unit at O.H. Close Youth Correctional Facility and N.A. Chaderjian Youth Correctional Facility.

- **Time Adds – Time Add Tracking** (*Safety & Welfare Standards and Criteria, Section 8.4, Item 8b; and Section 8.6, Item.4d, Item 4e, and 4f*)

Time add data was received, analyzed, and submitted to the Court in December 2008. A conference call with facilities to discuss trends and tools to reduce time adds was conducted in December 2008.

2. Items in Progress

Items in progress toward full implementation of the Safety & Welfare Remedial Plan include:

- **Compliance Team** (*Safety and Welfare Standards and Criteria, Section 2.1, Item 3c*)

The *Farrell* Compliance Unit traveled to Heman G. Stark Youth Correctional Facility to assist in the preparation for the Office of Inspector General's report. This was completed on October 9, 2008. The purpose of this visit was to assist the facility in completing the Office of Inspector General's self-assessment prior to the Office of Inspector General's upcoming audit.

The *Farrell* Compliance Unit is in the process of writing Facility Compliance Monitor self-assessments. These were expected to be completed by December 2008. The assessments will then be completed by the Facility Monitor at each site on a continual basis every quarter thereafter. The purpose of these assessments is to gauge facility compliance of previously audited items.

Recommendations regarding CLETS, the internet-based enhancement of the California Law Enforcement Tracking System (CLETS), were completed on September 24, 2008. The purpose for obtaining these recommendations was to offer the facilities a solution for processing CLETS checks of potential visitors to youth in a more timely and efficient manner. Information was presented to the DJJ's Directors by both the Division of Juvenile Facilities and the Division of Juvenile Parole. It was ultimately decided that the Division of Juvenile Facilities would move forward with management of this project.

In December 2008, the *Farrell* Compliance Unit compiled a list for each facility of the Remedial Plan audit items that have been rated either partially compliant or non-compliant by the Experts for each respective Remedial Plan. This list will be used to help facilities prepare for future Expert audits.

- **Behavior Treatment Programs** (*Safety & Welfare Standards and Criteria, Section 6, Item 5*)

DJJ Directors approved the Behavior Treatment Program Charter on December 10, 2008. The Charter identifies team members for the design, development, deployment, and implementation of the Behavior Treatment Program.

The first meeting of the Behavior Treatment Program Team occurred in December 2008. The Behavior Treatment Program team is currently reviewing the Behavior Treatment Program recommendations along with implementation information from the Program Service Day team. The design process involves subject matter experts and various disciplines from DJJ that will work together to develop a deployment plan for the implementation of Behavior Treatment Program.

- **Disciplinary Decision Making System** (*Safety & Welfare Standards and Criteria, Section 8.4*)

While DJJ awaited feedback from the Experts and the Special Master regarding the Disciplinary Decision Making System (DDMS) policy, on September 9, 2008, the Policy, Procedures, Programs & Regulations Unit met with the Facilities Program Support Office. Feedback from the Executive Management Team was reviewed and incorporated into the policy as necessary.

Upon finalization of the policy, the Office of Labor Relations will contact the Bargaining Units to provide them with notice of the policy. DJJ will also develop training and ensure that the policy is implemented. The date of implementation has been set for March 2009.

- **Time Adds – Disciplinary Decision Making System (DDMS) Program Credit Contract** (*Safety & Welfare Standards and Criteria, Section 8.6, Items 2a, 2b, 2c, and 4b*)

The Disciplinary Decision Making System Program Credit policy is in the final stages of review. Once the Policy, Procedures, Programs & Regulations Unit finalizes this draft, it will be submitted to the Office of Labor Relations, and steps will be taken to implement the policy across all facilities.

- **Staff Training to Develop Knowledge and Skills to Implement Best Practices** (*Safety & Welfare Standards and Criteria, Section 6, Item 7*)

Staff training scheduled for the next quarter include the following:

- Girls Moving On (Intervention)

This training course is scheduled to be taught on February 2, 2009, through February 5, 2009, at Ventura Youth Correctional Facility.

- Counterpoint (Intervention)

This training is scheduled to be taught starting on March 23, 2009, through March 27, 2009.

3.5 Sexual Behavior Treatment Program Remedial Plan Accomplishments

1. Sexual Behavior Treatment Program Remedial Plan Significant Accomplishments

The Sexual Behavior Treatment Program Remedial Plan was filed with the Court on May 16, 2005. DJJ has made a number of significant accomplishments during the course of implementing the Sexual Behavior Treatment Program Remedial Plan. Accomplishments for this quarter include:

- **Sexual Behavior Treatment Program Remedial Plan Screening and Assessment Tools** (*Sexual Behavior Treatment Program Standards and Criteria, Standard 3*)

DJJ utilizes two risk-assessment tools in treating sex-offending youths: the Juvenile Sex Offender Recidivism Risk Assessment Tool-II (JSORRAT-II) and the Static-99. DJJ has identified a third assessment tool, the Juvenile Sex Offender Assessment Protocol II (J-SOAP-II), for future implementation to assess dynamic factors in treatment.

California Senate Bill 1128, passed in 2006, established a State committee called the State Authorized Risk Assessment Tool for Sex Offenders Review Committee, also known as the SARATSO Committee. This committee is tasked with making recommendations in the selection of sex-offender risk-assessment tools for California.

Based upon the SARATSO Committee's recommendations, State law mandates the use of the JSORRAT-II as the risk assessment tool used for males under the age of 18 years and the STATIC-99 for males 18 and older. DJJ uses both of these tools, the STATIC-99 and JSORRAT-II, during intake and again four months prior to a youth's release.

The initial intake assessments assist treatment staff in developing sex behavior treatment plans for each sex-offending youth. The sexual behavior treatment plan may include, among other things, a determination to place a youth in a residential Sexual Behavior Treatment Program, an out-patient Sexual Behavior Treatment Program, or the Healthy Living Program.

The second assessment utilizing the JSORRAT-II and STATIC-99 takes place four months prior to a youth's release assists treatment staff in determining the risk of recidivism in the youth upon release back into the community and forms a basis for assessing a youth's re-entry into the community as well as parole planning, supervision, and other related services.

On September 22, 2008, the Sexual Behavior Treatment Program Coordinator issued a directive to all certified trainers that instructed them to commence the training staff in the use of the assessment tools at each youth correctional facility. In the last quarter, 41 facility staff have been trained in the J-SORRAT-II, 60 facility staff have been trained in the Static 99, and 25 facility staff have been trained in the J-SOAP-II. Five field parole staff were trained in use of the STATIC-99. Full implementation of the JSORRAT-II and the Static 99 as well as the discontinuation of the Sex Offender Referral Document (SORD) is scheduled for January 2009.

- **Completion of the Transition from Four to Eight Residential Sexual Behavior Treatment Programs in the DJJ** (*Sexual Behavior Treatment Program Standards and Criteria, Standard 2 and Standard 23*)

As of November 2008, the DJJ has developed a total of eight residential Sexual Behavior Treatment Programs. There are four residential programs in the Northern Region: one located at O.H. Close Youth Correctional Facility and three located at N.A. Chaderjian Youth Correctional Facility. In addition, four other residential Sexual Behavior Treatment Programs serve youth in the Southern Region: one located at Southern Youth Correctional Facility and three at Heman G. Stark Youth Correctional Facility.

This increase in the number of residential Sexual Behavior Treatment Programs has resulted in a correlative decrease on the waiting list for entry into these programs. Currently, there are no youth waiting for placement into residential Sexual Behavior Treatment Programs merely because of a lack of bed space in these programs. Those who are currently on the waiting list are having their other treatment priority needs met before they are placed in Sexual Behavior Treatment Program.

2. Items in Progress

Items in progress toward full implementation of the Sexual Behavior Treatment Program Remedial Plan include:

- **Sexual Behavior Treatment Program Curricula** (*Sexual Behavior Treatment Program Standards and Criteria, Standards 4, 5, 6, and 26*)

Originally, three separate Sexual Behavior Treatment Program curricula were being developed to meet the requirements of the Sexual Behavior Treatment Program Remedial Plan: the Healthy Living Curriculum; the Residential Sexual Behavior Treatment Curriculum; and the Out-patient Sexual Behavior Treatment Curriculum.

The consultant who was initially retained by DJJ to develop the curricula provided DJJ with only a draft version of the Healthy Living curriculum. DJJ is in the process of developing an implementation plan to finalize and implement Healthy Living at all DJJ facilities.

The Sexual Behavior Treatment Program Coordinator conducted a search on both a national and international level for proven curricula and treatment programs for the purpose of studying and possibly utilizing them in developing both DJJ's residential and out-patient Sexual Behavior Treatment Program curricula. Nationally, the Coordinator's efforts included soliciting materials from every state, and the international search for curricula materials has encompassed nations such as Canada, New Zealand, the United Kingdom, and Australia.

The Sexual Behavior Treatment Program Coordinator completed his research in October 2008, and in November and December 2008, the material was assessed and sorted to determine what is currently considered best practices for DJJ's sex-offending population. This review was completed with assistance from the court-appointed Sexual Behavior Treatment Program Expert. A draft outline of the residential curriculum was developed in December 2008, and DJJ is ready to begin the process of developing the full curriculum.

- **Sexual Behavior Treatment Program Training** (*Sexual Behavior Treatment Program Standards and Criteria, Standard 11*)

In March 2009, DJJ will certify trainers and ensure that they receive the mandated refresher course in the use of JSORRAT-II.

- **Sexual Behavior Tracking System** (*Sexual Behavior Treatment Program Standards and Criteria, Standards 3, 13, and 19*)

Several new screens, or pages, on the Ward Information Network (WIN) are being developed by CDCR's Enterprise Information System staff to track progress in the Sexual Behavior Treatment Program curriculum and to create and archive sex-offender risk-assessment screening tools.

The new Sexual Behavior Treatment Program tracking system will be piloted at the O.H. Close Youth Correctional Facility in March 2009 for approximately two weeks. Complete roll-out of this tracking system to all DJJ facilities should occur within a couple of months after this brief pilot concludes.

- **Sexual Behavior Treatment Program Policies and Procedures** (*Sexual Behavior Treatment Program Standards and Criteria, Standard 1, page 1*)

Based on the recommendation of the court-appointed Sexual Behavior Treatment Program Expert, DJJ divided its Sexual Behavior Treatment Program policies into three separate categories:

- Policy I: Principles
- Policy II: Programs
- Policy III: Staffing and Training

Outlines were completed for each of these three sets of Sexual Behavior Treatment Program policies. The Sexual Behavior Treatment Program Coordinator is currently in the midst of finalizing the first set of policies for the first category, Policy I: Principles.

A draft policy for the first category was submitted to the Sexual Behavior Treatment Program Expert for her review. Now that the Sexual Behavior Treatment Program Expert has provided feedback and made recommendations, DJJ will begin to incorporate her suggestions into a new draft of the policy during the next quarterly reporting period. Given that the policies must support the Sexual Behavior Treatment Program curricula, the drafting and finalization of all three sets of policies will ultimately depend on the final development of the program's curricula.

3.6 Wards with Disabilities Program Remedial Plan Accomplishments

1. Wards with Disabilities Program Remedial Plan Significant Accomplishments

The Wards with Disabilities Program Remedial Plan was filed with the Court on May 31, 2005. DJJ's Wards with Disabilities Program has not seen any significant accomplishments since those reported in the last quarterly report. However, a number of items remain in progress, and DJJ remains proud of and confident about the progress that it continues to make in achieving the goals of the Wards with Disabilities Program Remedial Plan.

2. Items in Progress

Items in process toward full implementation of the Wards with Disabilities Program Remedial Plan include:

- **Assessment for Developmental Disabilities** (*Wards with Disabilities Program Standards and Criteria, Headquarters Policies, Section C, page 7*)

DJJ is in the process of developing a Data Use Agreement between DJJ and the California Department of Developmental Services. Entering into a Data Use Agreement would enable DJJ to obtain access to confidential data maintained by the Department of Developmental Services with the purpose of identifying youth who have been determined to be eligible to receive services through the Department of Developmental Services' service-delivery system. Obtaining access to this type of data will assist DJJ in assessing the effectiveness of its own efforts in identifying individuals who may qualify for the Wards with Disabilities Program.

After the Office of Legal Affairs completed its review and approved the terms of the Data Use Agreement, the revised draft was provided to the Department of Developmental Services. Finalization of this agreement is pending response from the Department of Developmental Services.

The Inter-Departmental Agreement, when finalized, will be in accordance with the standards set forth in the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts 160 and 164, and with the requirements for informational integrity and security as set forth in Section 4841.2 of the State Administrative Manual.

- **DJJ Headquarters Disability Sensitivity Training** (*Wards with Disabilities Program Standards and Criteria, Headquarters Policies, Section C, page 7*)

The Wards with Disabilities Program Remedial Plan requires DJJ to provide disability awareness training to staff that has been prepared with the assistance of an outside disability advocacy organization or consultant and also in consultation with the Wards with Disabilities Program Expert.

In accordance with this requirement, DJJ is seeking to contract with an outside consultant to revise its disability-sensitivity training curriculum. In furtherance of this end, DJJ has recently finished drafting the scope of work for a Service & Expense contract, with the assistance of and review from the Wards with Disabilities Program Expert. The scope of work for the contract has recently been approved, and the request-for-bid package was sent out to vendors on January 6, 2009. The application period closed on January 23, 2009, and DJJ is now in the process of reviewing the submitted bids for ultimate selection.

- **Residential Disabilities Program Study** (*Wards with Disabilities Standards and Criteria, Headquarters Policies, Section C, page 6*)

DJJ met with the Wards with Disabilities Program Expert during the last quarter, on November 21, 2008, to discuss the Residential Disabilities Program Study. The purpose of the study will be to assess the need for a residential program for youth with certain developmental disabilities. The discussion with the Expert focused on, among other things, desirable outcomes that would further the overall goals of the Wards with Disabilities Remedial Plan.

DJJ then began to conduct a series of internal meetings, starting on December 22, 2008, to further discuss the subject. It intends to meet with the Wards with Disabilities Program Expert again to resume the conversation about the Residential Disabilities Program Study. DJJ keenly anticipates continuing to glean insight from the Expert when the discussion about this study recommences.

4 REPORT IMPROVEMENTS

4.1 Quarterly Report Improvements

This section of the Quarterly Report discusses DJJ's intent to continually improve upon the content, structure, and format of this report. DJJ's goal is to provide information of greater value to all interested parties, including DJJ Management, staff, the Court, the Court Experts, the Special Master, Plaintiff's Counsel, and other stakeholders.

Kaizen is a Japanese term for "change for the better" or "improvement"; the common English usage is "continual improvement." *Kaizen* refers to a *quality* strategy and is often associated with the methods of W. Edwards Deming. The technique aims to eliminate waste, which is defined by Joshua Isaac Walters as "activities that add cost but do not add value." It is often the case that this process involves taking something apart and putting it back together in a better way.

This report is the third incarnation of DJJ's effort to take things apart and put them back together in an even better way. This version adds value and modifies what was previously marginal in contribution. Each quarter, stakeholders will review the Quarterly Report and will be encouraged to offer suggestions for future improvements. All well-intended thoughts and ideas will be considered for incorporation into subsequent reports as proper. Appropriate stakeholders will be encouraged to provide feedback on an on-going basis to facilitate continuous quality improvement of the Quarterly Report.

As DJJ shares both its progress and its challenges with all stakeholders, other interested parties, and the public, there will always be an opportunity for any party to bring a fresh point of view to various aspects of the effort. The greater the transparency of DJJ's progress, the more effective and rapid will be its ability to nimbly adjust its efforts and improve its results.

The first section of this Quarterly Report is designed to reveal the progress made in satisfying the remediation requirements. DJJ has established a database for all action items and audit items contained in the Standards and Criteria documents. Progress and challenges as observed by the Court's Experts and the Special Master are tracked, and these tracking mechanisms provide data that can be presented in graphs for easy reference. As a result, this first section is organized around these graphs and provides a visual story of DJJ's progress and the challenges it encounters during the course of its reformation.

The second section of the Quarterly Report is similar to the first section in that it is intended to reflect progress being made as compared to the deadline dates established for the action items throughout each of the six Remedial Plans. This section is based on a project management approach and is intended to share with the stakeholders the project management systems that are being developed in order to better assist DJJ in managing its efforts at reform.

The third section of the Quarterly Report is a report of significant accomplishments made towards completing action items which have occurred during the reporting quarter. It is very similar in intent and purpose to the incarnation of this section in previous Quarterly Reports.

And finally, **the fourth section** of the Quarterly Report addresses current and possible future improvements. For this Quarterly Report, improvements include:

- The addition of the Office of the Special Master audit information in regards to the Mental Health and the Safety & Welfare Remedial Plans; and
- The addition of Dental Services audit information in the Health Care Services section.