



A QUARTERLY REPORT FOR:

***FARRELL VS. CATE***

AS REQUIRED BY THE  
CONSENT DECREE

FOR PERIOD:

**SECOND QUARTER  
OF 2008**

DATE SUBMITTED:

**JULY 31, 2008**

**California Department of  
Corrections and Rehabilitation**

**Division of  
Juvenile Justice**

## TABLE OF CONTENTS

EXECUTIVE INTRODUCTION TO THIS QUARTERLY REPORT .....	2
1 PROGRESS .....	6
1.1 Farrell Compliance Summary.....	6
2 PROGRESS .....	10
2.1 Education Services Remedial Plan Compliance Status .....	10
2.2 Sex Behavior Treatment Remedial Plan Compliance Status .....	23
2.3 Wards with Disabilities Program .....	31
2.4 Health Care Services Remedial Plan Compliance Status.....	50
2.6 Mental Health Remedial Plan Compliance Status.....	72
3 COMPLIANCE WITH DATES.....	76
4 ACTIONS TAKEN .....	81
4.1 Education Services Remedial Plan Accomplishments .....	81
4.2 Health Care Services Accomplishments .....	86
4.3 Mental Health Remedial Plan Accomplishments.....	89
4.4 Safety & Welfare Remedial Plan Accomplishments.....	96
4.5 Sex Behavior Treatment Program Remedial Plan Accomplishments .....	102
4.6 Wards with Disabilities Program Accomplishments .....	105
5 REPORT IMPROVEMENTS.....	109
5.1 Quarterly Report Improvements.....	109

## TABLE OF FIGURES

Figure 1: Remedial Plan Compliance Summaries.....	8
Figure 2: Farrell Roll-up Compliance Summaries.....	9
Figure 3: Education Services Audit Results: Round 3 - Complete .....	13
Figure 4: Education Audit Results - Round 3 .....	13
Figure 5: Education Overall Compliance Percentages by Round .....	16
Figure 6: Education Audit Results Round 3: Substantial Compliance by Facility & by Round .....	17
Figure 7: Education Audit Results Round 3: Substantial + Partial Compliance by Facility & by Round .....	18
Figure 8: SBTP Audit Results for O.H. Close Youth Correctional Facility by Round.....	25
Figure 9: SBTP Audit Results – Round 2 (May & July 2007) .....	27
Figure 10: SBTP Audit Results – Substantial Compliance + Partial Compliance by Facility by Round.....	28
Figure 11: Wards with Disabilities Program Audit Results: Round 3 - Complete .....	33
Figure 12: WDP “Draft” Audit Results – Round 3.....	34
Figure 13: WDP Overall Compliance Percentages by Round .....	37
Figure 14: WDP Draft Audit Results – Round 3: Substantial Compliance by Facility & by Round .....	38
Figure 15: WDP “Draft” Audit Results – Round 3: Substantial + Partial Compliance by Facility & by Round.....	39
Figure 16: Health Care Services Audit Results by Facility for Round 1 (in progress).....	52
The Health Care Experts have not provided DJJ with an audit report since the last Quarterly Report.....	53
Figure 17: Health Care Services Audit Results: Round 1 – In progress.....	53
Figure 18: Health Care Services Overall Audit Results by Category – Round 1 (in progress).....	54
Figure 19: Audits from S & W Expert Since Last Quarterly Report .....	59
Figure 20: Safety & Welfare Audit Results: Round 1 – In progress.....	63
Figure 21: Facility Audits from S & W Expert – Round 1 (in progress).....	64
Figure 22: Audits from S & W Expert – Round 1 (in progress): Substantial Compliance + Partial Compliance .....	65
Figure 23: Mental Health Audit Results: Round 1 – In progress.....	73

Figure 24: Project Management Structure ..... 78

Figure 25: Solution Diagram ..... 79

## EXECUTIVE INTRODUCTION TO THIS QUARTERLY REPORT

The California Department of Corrections, Division of Juvenile Justice (DJJ), is proud to submit this Quarterly Report in compliance with the Consent Decree associated with the *Farrell* court case. In response to various requests and notations found in many of the Expert audit reports and Special Master reports that have been filed thus far, this report has been revised to provide what we believe is better, more structured information that accurately reflects progress and compliance with the action items identified in the six Remedial Plans associated with the Consent Decree. DJJ wishes to ensure that this report provides accurate, traceable information in a repeatable manner so that all of our efforts in implementing the *Farrell* Remedial Plans remain transparent to all stakeholders.

The Quarterly Report has been newly 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 this section is to report progress made in completing the action items on a statistical basis. The statistical information is drawn from the audit reports that have been completed and submitted, each based on the audit tool that was submitted for each of the six respective Remedial Plans. Providing this kind of reporting allows DJJ to provide to all stakeholders objective data-based results of the information that was submitted by each of the Experts after the completion of each of their audits.

### **Section 2: Compliance with Dates**

The purpose of this section is to report on DJJ's commitments to complete action items by specific dates. This information is also based entirely on the data extracted from the audit tools created from the six Remedial Plans. It should be noted that there is quite a mixture of items, both with and without dates, identified within the audit tools. Therefore, this section can and will only report on those items for which dates have been identified. In the future, dates may be set with the court in relation to action items which currently have no due date set or existing dates may be adjusted; in such cases, this reporting will include those items as well.

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

### **Section III: Actions Taken This Quarter**

The purpose of this section is to report on significant accomplishments completed during the quarter and to add descriptions of significant effort being made on 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 this restructured 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 IV: Report Improvements**

The purpose of this section is to describe the revisions that were made to the Quarterly Report; the reasoning and explanation of why the changes were made; and 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 remedial plans. The chart also identifies the current number of items rated as being either in Substantial Compliance, Partial Compliance or Non-compliance. At the bottom of the chart, the compliance data from all six plans has been combined to provide an overall “*Farrell* Roll-up” compliance percentage. Because the number of items rated for the Health Care Services Remedial Plan is so large in comparison to the other remedial plans, the last section of the chart identifies the “*Farrell* Roll-up: Minus Health Care.” This was done to see how the overall compliance percentage would be affected without being skewed by the large number of Health Care Services audit items.

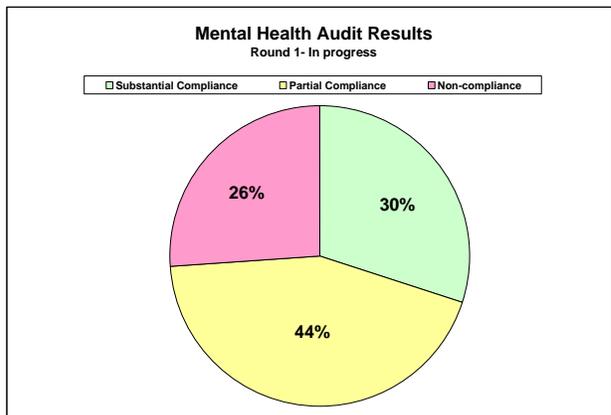
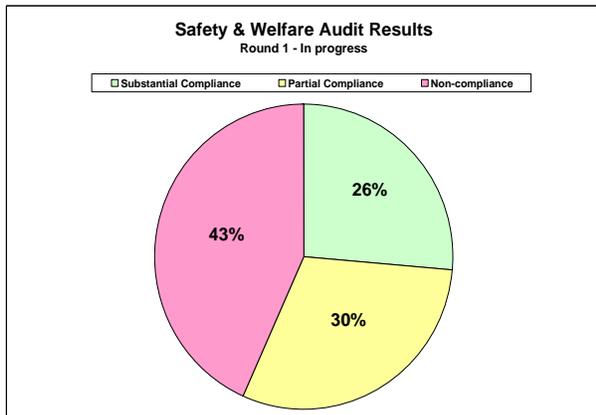
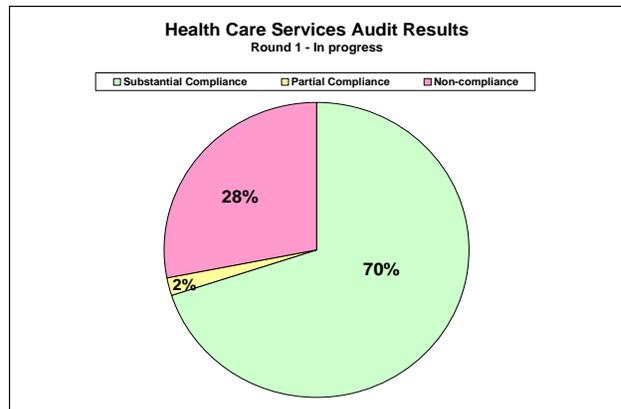
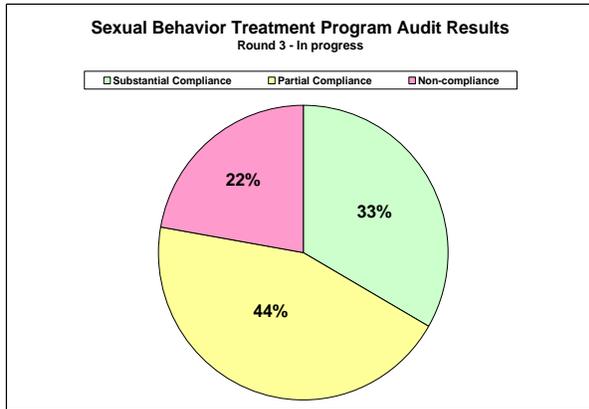
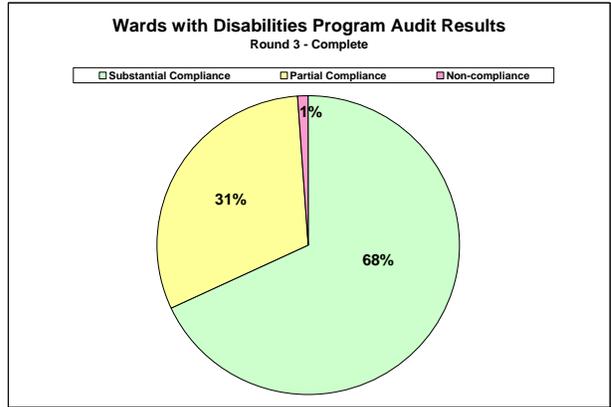
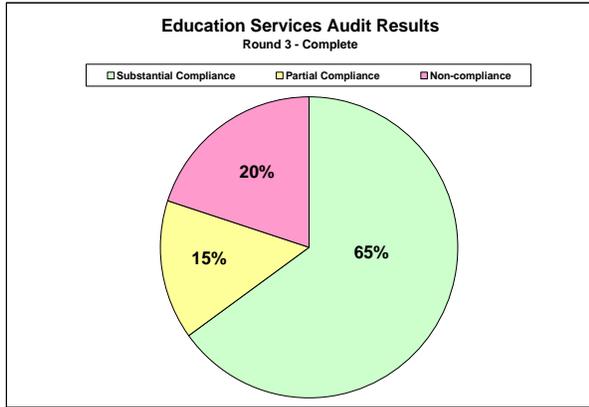
<b>SBTP</b>	<b># of Items Rated</b>	<b>Round 3</b> (in progress - 1 of 4 facilities)
Substantial Compliance	9	33%
Partial Compliance	12	44%
Non-compliance	6	22%
Total #		27
<b>EDUCATION</b>	<b># of Items Rated</b>	<b>Round 3</b> (complete)
Substantial Compliance	498	65%
Partial Compliance	112	15%
Non-compliance	151	20%
Total #		761
<b>WDP</b>	<b># of Items Rated</b>	<b>Round 3</b> (complete)
Substantial Compliance	418	68%
Partial Compliance	191	31%
Non-compliance	8	1%
Total #		617
<b>S &amp; W</b>	<b># of Items Rated</b>	<b>Round 1</b> (in progress - 6 of 7 facilities)
Substantial Compliance	89	26%
Partial Compliance	102	30%
Non-compliance	146	43%
Total #		337

<b>HEALTH CARE</b>	<b># of Items Rated</b>	<b>Round 1</b> (in progress - 5 of 6 facilities)
Substantial Compliance	2459	70%
Partial Compliance	79	2%
Non-compliance	979	28%
Total #	3517	
<b>MENTAL HEALTH</b>	<b># of Items Rated</b>	<b>Round 1</b> (in progress - partial HQ and facility items)
Substantial Compliance	27	30%
Partial Compliance	40	44%
Non-compliance	24	26%
Total #	91	
<b>FARRELL ROLL-UP</b>	<b># of Items Rated</b>	<b>As of July 31, 2008</b>
Substantial Compliance	3500	65%
Partial Compliance	536	10%
Non-compliance	1314	25%
Total #	5350	
<b>FARRELL ROLL-UP</b> Minus Health Care	<b># of Items Rated</b>	<b>As of July 31, 2008</b>
Substantial Compliance	1041	57%
Partial Compliance	457	25%
Non-compliance	335	18%
Total #	1833	

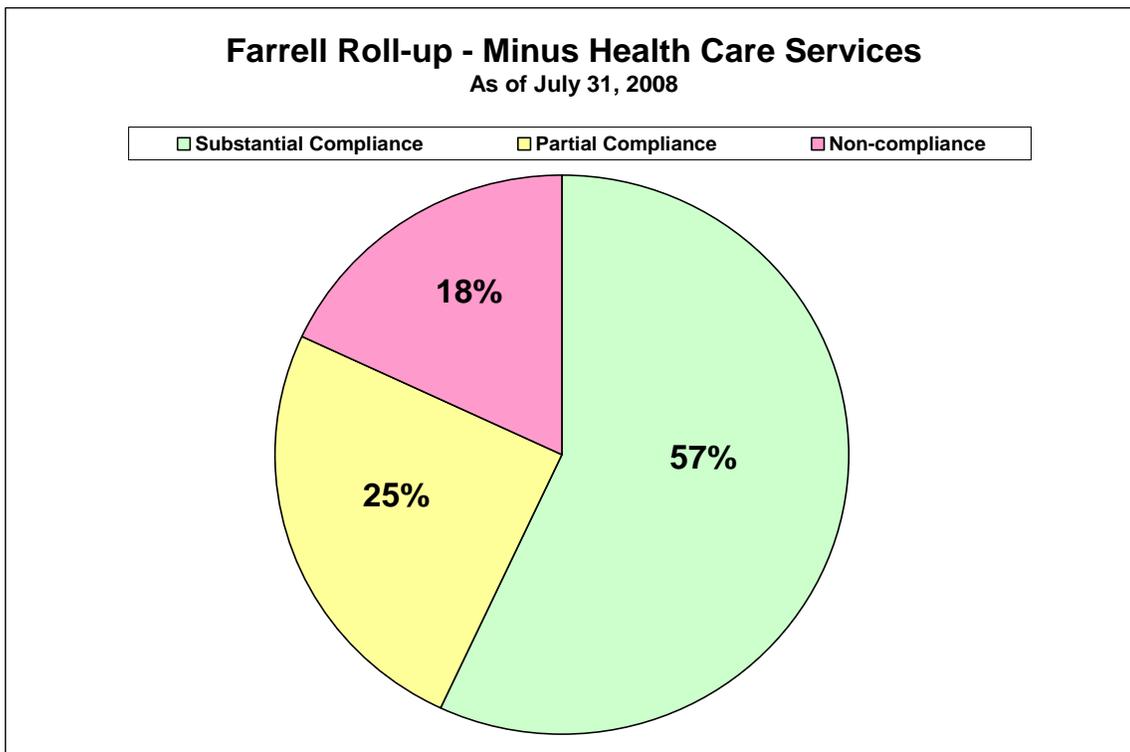
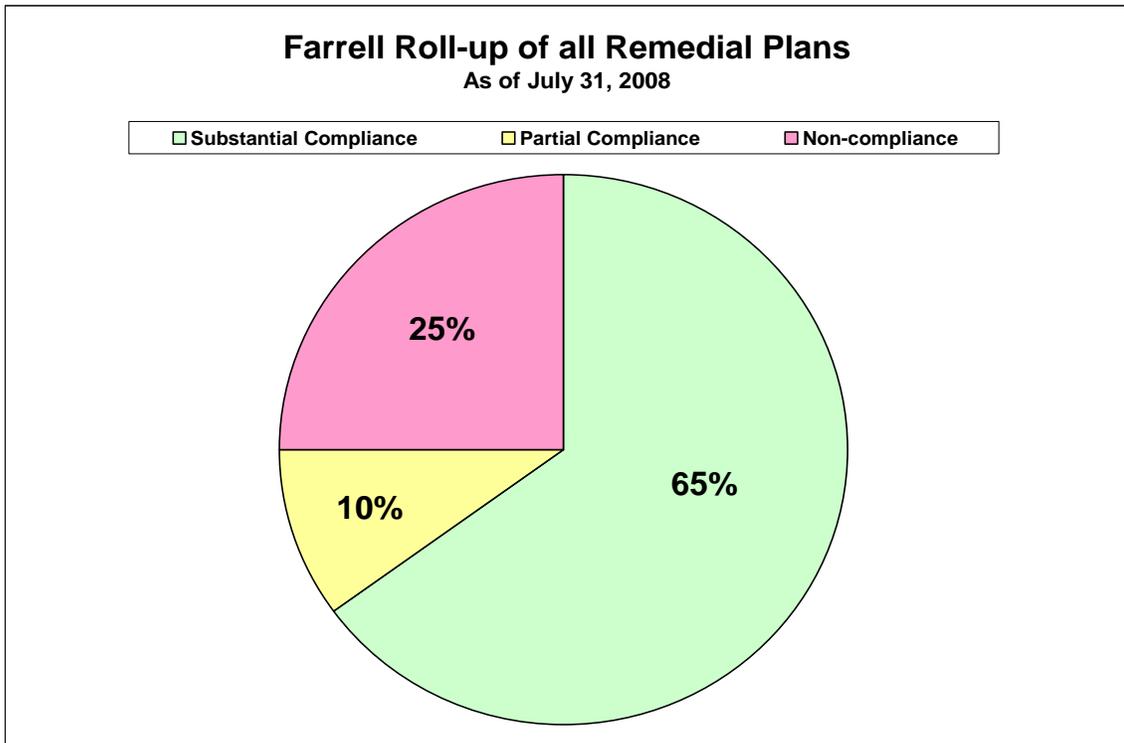
### 1.1.2 Remedial Plan Compliance Charts

The charts of the next page provide a visual of the compliance percentages for each of the six remedial plans. Sections in green identify Substantial Compliance, sections in yellow identify Partial Compliance and the red sections identify Non-compliance.

- “Farrell Roll-up” Substantial Compliance plus Partial Compliance is 75%
- “Farrell Roll-up: Minus Health Care” Substantial Compliance plus Partial Compliance is 82%
- Listing of Non-compliance percentage for each remedial plan from high to low:
  - Safety & Welfare – 43%
  - Health Care Services – 28%
  - Mental Health – 26%
  - Sexual Behavior Treatment Program – 22%
  - Education – 20%
  - Wards with Disabilities Program – 1%



**Figure 1: Remedial Plan Compliance Summaries**



**Figure 2: Farrell Roll-up Compliance Summaries**

## 2 PROGRESS

### 2.1 Education Services Remedial Plan Compliance Status

#### 2.1.1 Historical Audit Perspective

##### Court Filings

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

##### Audit Tool

The Education Services audit tool consists of a total of 115 different “action items.” Associated with these 115 action items were originally 920 “audit items.” The 920 total audit items were based on eight facilities (8 x 115 = 920). Since the filing of the Education Services Remedial Plan in 2005, DJJ has closed two of its facilities, the El Paso de Robles Youth Correctional Facility (“El Paso de Robles”) and the DeWitt Nelson Youth Correctional Facility (“DeWitt Nelson”). As a result, the total number of audit items will decrease in proportion with these closures. During their last round of audits, the Education Experts had already audited DeWitt Nelson prior to the announcement of its closure but had not audited El Paso de Robles. As a result, the total number of audit items for this last round of audits totals 805, down 115 from the 920 items of previous rounds.

A unique feature of the Education Services audit tool, unlike the other five *Farrell* audit tools, is that there are no headquarter-specific audit items.

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

##### Audit History

Because the Education Services Remedial Plan was one of the first 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 from the Education Experts.

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

- Round 1: September 2005 to April 2006
- Round 2: September 2006 to April 2007
- Round 3: October 2007 to March 2008

The chart below provides a more detailed listing of all of the education audits by facility.

	ROUND 1	ROUND 2		ROUND 3	
Facility	Date Audited	Date Audited	Time between Audits	Date Audited	Time between Audits
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

\* Not audited due to closure.

### **Future Audit Schedule**

The Education Experts have provided DJJ with the following audit schedule for their next round of audits:

- N.A. Chaderjian Youth Correctional Facility – October 20-22, 2008
- O.H. Close Youth Correctional Facility – October 23-24, 2008
- Heman G. Stark Youth Correctional Facility – December 10-12, 2008
- Preston Youth Correctional Facility – January 12-14, 2009
- Southern Youth Correctional Reception Center Clinic – February 9-11, 2009
- Ventura Youth Correctional Facility – March 16-18, 2009

## **2.1.2 Most Recent Audit Findings**

### **Audit Reports Received During Last Quarter**

DJJ received a draft copy of the Education Experts annual report on May 23, 2008. In previous Quarterly Reports, DJJ has used the compliance data from the Education Experts facility audit reports to report out on its educational progress. These facility audit reports provided timely feedback to DJJ and allowed DJJ to report out on the compliance progress as the information became available. However, these facility audit reports are not filed with the Court.

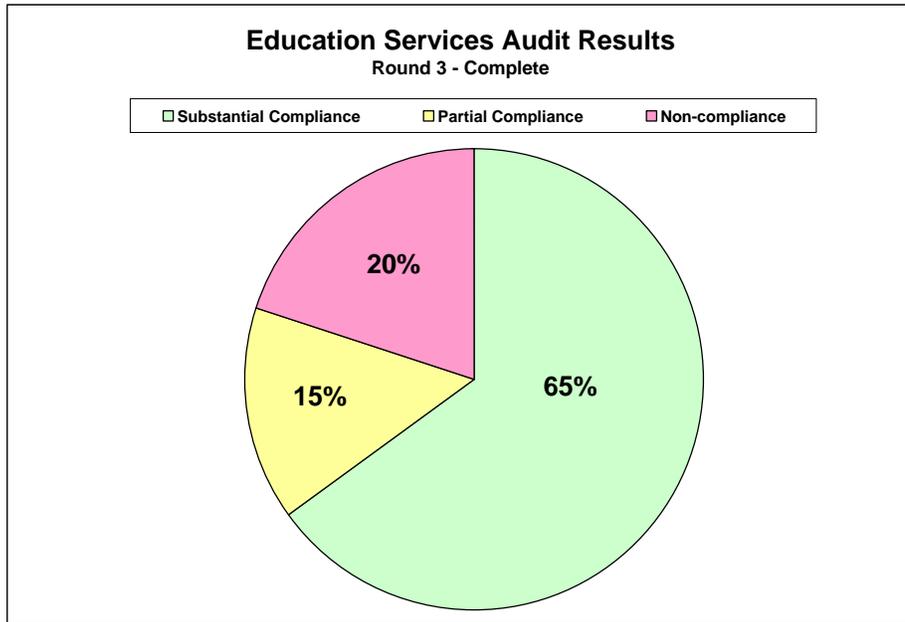
The Education Experts do produce an annual report that in essence summarizes and finalizes the findings from their latest round of auditing and this annual report is filed with the Court. Upon the review of this latest annual report, it was discovered that the compliance data from the facility audit reports differed slightly from that found in the annual report. This was also consistent with the previous two rounds of compliance data.

The major difference is that in the facility audit reports the Experts sometimes provide multiple compliance ratings to a single audit item. For example, an item may receive both an SC ("substantial compliance") rating and a NC ("non-compliance") rating. However, in the annual report, the Experts only use one compliance rating per audit item and the rating used is the lowest of the multiple ratings provided on that item. Because DJJ counts all the compliance ratings within a facility audit report and not just the lowest rating of an item with multiple ratings, its previous reports on compliance progress differs slightly with that of the Experts' annual reports but nonetheless are consistent with the Experts' facility audit reports.

To ensure further consistency with the information that the Experts provide to the Court, DJJ has reviewed and reconciled the previous compliance data for all three rounds of auditing using the Experts' annual reports as its compliance data source. Generally, this reconciliation has resulted in a slight decrease of Substantial Compliance from that which had been previously reported by 1% to 3%.

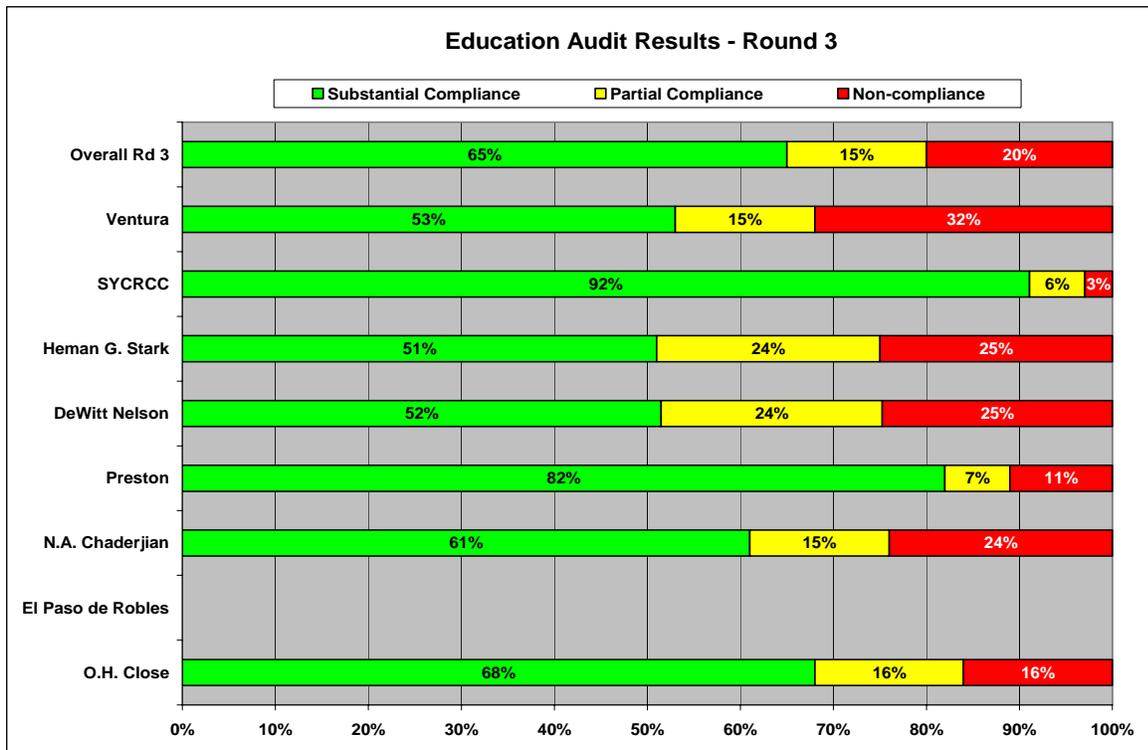
### **Overall Compliance Averages from Round 3**

The chart on the next page identifies the overall compliance averages for the seven facilities that were audited by the Education Experts during Round 3. For the Round 3 audits, the Education Experts found that DJJ was 65% in Substantial Compliance, 15% in Partial Compliance and 20% in Non-compliance.



**Figure 3: Education Services Audit Results: Round 3 - Complete**

**Overall Compliance Averages by Facility from Round 3**



**Figure 4: Education Audit Results - Round 3**

- The Southern Youth Correctional Reception Center-Clinic (“SYCRCC”) was found to be 92% in Substantial Compliance. Only three out of 111 rated action items were found to be in Non-compliance. To date, this is the highest rated audit of any facility for any plan.
- The Preston Youth Correctional Facility (“Preston”) also had a very positive audit with an 83% Substantial Compliance rate. This is the second highest compliance percentage of any facility for any plan to date.
- The Heman G. Stark Youth Correctional Facility (“Heman G. Stark”) had a 20% increase in their Substantial Compliance from Round 2 to Round 3.
- The Ventura Youth Correctional Facility (“Ventura”) was found to be 53% in Substantial Compliance, a decrease of 16% from Round 2 to Round 3. This situation was discussed in detail in the previous Quarterly Report, and the decrease was found to be due in large part to a recent change in the local educational administration and the administration’s lack of understanding on how to prepare for an audit.
- DeWitt Nelson was found to be 52% in Substantial Compliance, a decrease of 3% from Round 2 to Round 3. This situation was also discussed in the previous Quarterly Report.

### **2.1.3 Expert Feedback**

In their annual report for the school year 2007-2008, the Education Experts identify 30 “commendations” and 37 “recommendations” to assist DJJ in attaining full compliance with the Consent Decree requirements. The items below are examples of these commendations and recommendations, and the ones chosen are general examples of DJJ’s significant progress in given areas. In addition, they also identify more problematic issues that DJJ has encountered in implementing the Education Services reforms.

#### **Education Experts’ Noted Areas of Progress / Commendations from Round 3**

- “Implementation of the five period school day has been a significant step in providing a sufficient number of courses in content areas needed to meet the students’ graduation requirements.”
- “The development of High School Graduation plans at the majority of the sites is indicative of the progress being made in planning for students to meet graduation requirements.”
- “There is substantial progress in screening, identifying and providing services to English Learner students. Teachers are now SDAIE or CLAD certified.”
- “Progress continues to be made in hiring teachers that hold valid California teaching credentials and teach as highly qualified teachers in the appropriate fields.”
- “Each high school with a restricted program has a minimum of 2 psychologists.”
- “Significant progress has been made in requesting records and enrolling students into appropriate educational classes within four days of arrival.”

- “DJJ central office staff has made exceptional efforts to conduct special education training statewide and to maintain training records.”
- “Significant progress is noted in meeting special education timeline requirements.”
- “All students failing at least one part of the exam are being provided remediation through a test preparation class or enrollment in a course designed to review and specifically remediate deficit areas.”

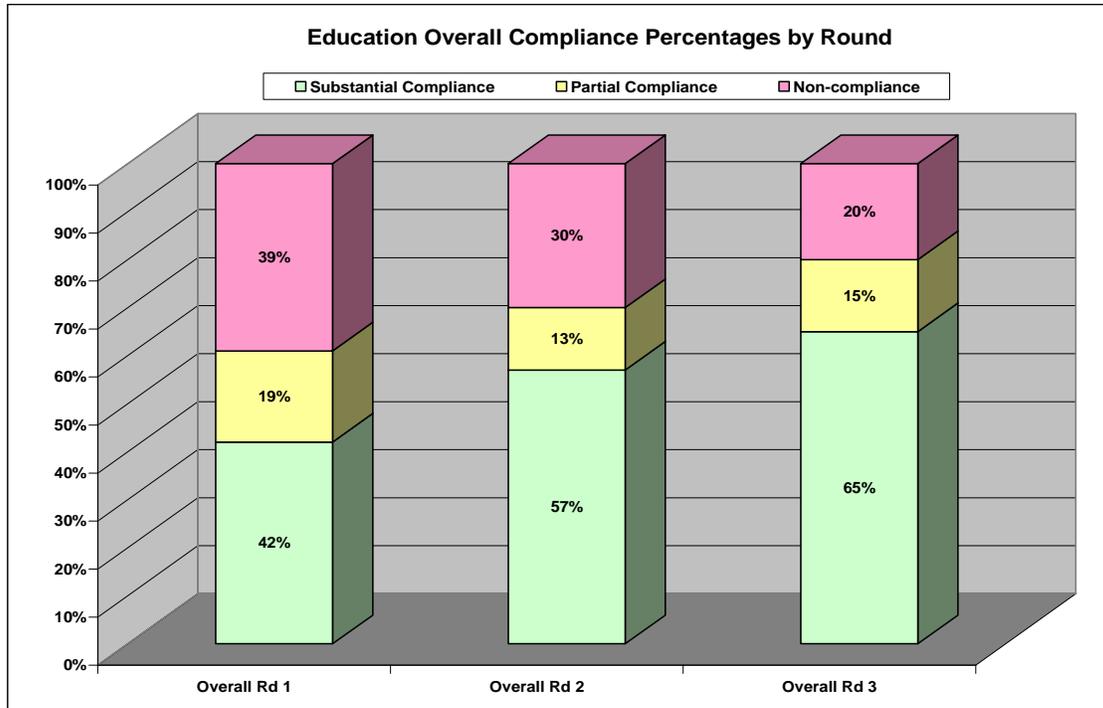
### **Education Experts’ Noted Areas of Concern / Recommendations from Round 3**

- “Additional substitute teachers are needed at some sites to prevent class cancellations due to teacher absences. Substitute teacher lists were often found to be inaccurate and did not reflect the number of substitute teachers actually available at the site.”
- “DJJ Central Office must reduce the time between education vacancies occurring and the position being filled.”
- “Student absentee rates are unacceptable at all sites. Strategies outlined in the remedial plan to improve school attendance must be fully implemented.”
- “Instructional programs for both regular and special education students in the restricted settings are inadequate. Staff and adequate instructional space must be identified and provided in order to ensure equal educational access for these students.”
- “All sites have excellent vocational facilities; however, student enrollment in vocational classes continues to be very low. Full utilization of these vocational resources should be provided to ensure that students receive the employment skills necessary to prepare them to re-enter the community.”
- “Distance learning technology must be provided to students on the restricted units. Technology must be used to increase educational service hours without compromising security for students segregated from the general population.”
- “A full continuum of services is not being offered to students on the special management units. Students continue to be denied access to a full educational day and compensatory services are less than adequate. All relevant parties must be involved in developing cooperative agreements for the provision of a full school schedule and required compensatory services. The integrity of the school day must be protected while providing for the safety and welfare of all individuals on these units.”
- “Compensatory services must be provided to eligible special education students. Student absences and pull outs create needs for compensatory services and must be addressed.”
- “All sites must provide a full range of alternatives for students to complete their education, including students on the restricted units.”

### 2.1.4 Cumulative Audit Findings

By conducting a cumulative analysis of all the facilities audited within a given round, DJJ believes that an objective pattern of progress may be demonstrated in the implementation of the Educational Services Remedial Plan. The chart below identifies the overall average compliance ratings for each of the three rounds of education audits to date.

#### Overall Compliance Averages by Round



**Figure 5: Education Overall Compliance Percentages by Round**

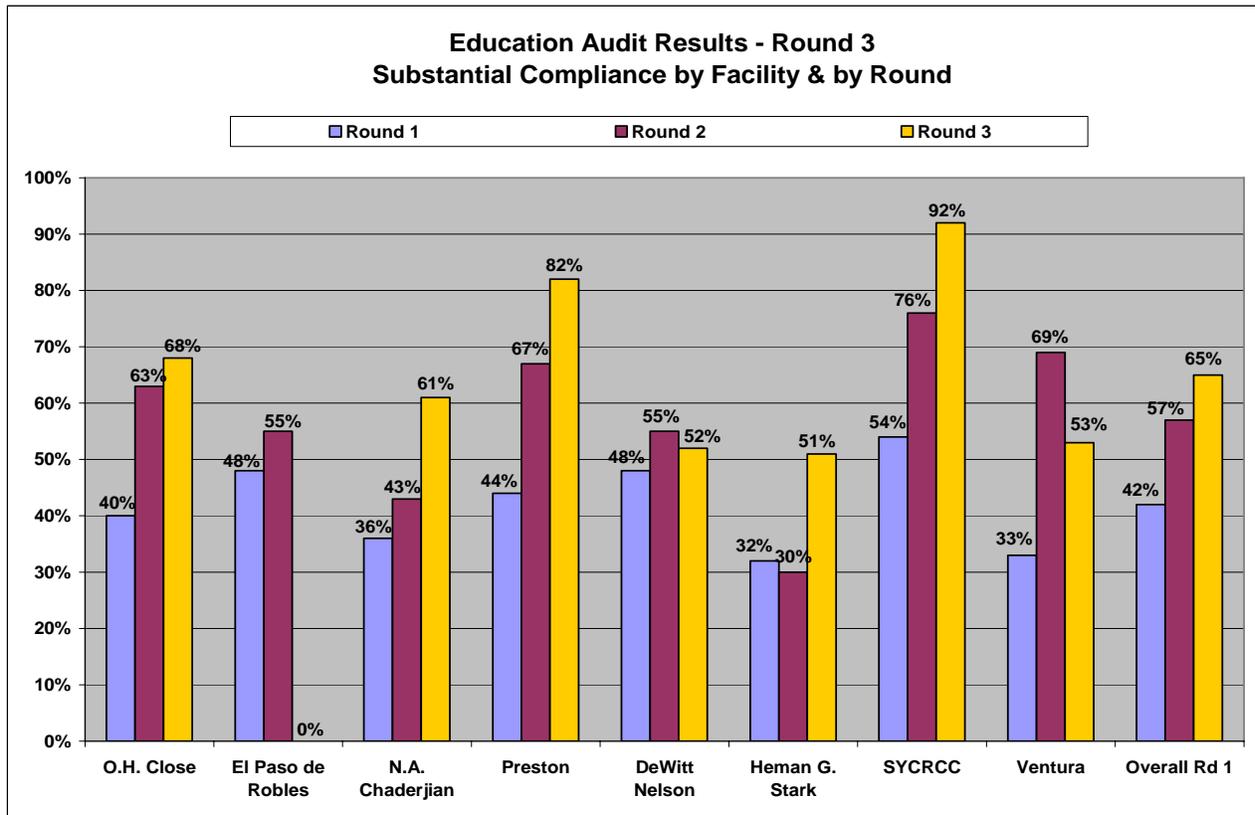
From Round 1 to Round 3, Substantial Compliance has increased from 42% to 65%, a 23% increase. Partial Compliance for the three rounds has remained within a range of 19% to 15%. Non-compliance has steadily decreased from a high in Round 1 of 39% to a low in Round 3 of 20%. Currently, there appears to be a general increase of approximately 10% in Substantial Compliance from one round of auditing to the next and approximately a 10% decrease in Non-compliance during these same time frames.

#### Substantial Compliance Percentages by Facility by Round

The graph on the following page identifies the Substantial Compliance percentages of each facility for each of the three rounds of auditing completed to date. Of the seven facilities that have received three rounds of compliance ratings, five of them have increased their Substantial Compliance percentage by 20% or greater from Round 1 to

Round 2. The five facilities that have experienced this increase in Substantial Compliance are as follows:

- Southern Youth Correctional Reception Center Clinic, with a 38% increase;
- Preston, with a 38% increase;
- O.H. Close Youth Correctional Facility (“O.H. Close”), with a 28% increase;
- N.A. Chaderjian Youth Correctional Facility (“N.A. Chaderjian”), with a 25% increase; and
- Ventura with a 20% increase.



**Figure 6: Education Audit Results Round 3: Substantial Compliance by Facility & by Round**

**Substantial + Partial Compliance Percentages by Facility by Round**

A Partial Compliance rating, while not the same as Substantial Compliance, does demonstrate that some progress and work effort have been achieved to move a given action item towards Substantial Compliance. The chart on the next page combines the Substantial and Partial Compliance percentage for each facility for all three rounds of audits.

DJJ’s overall average of Substantial plus Partial Compliance percentage is at 80%. All of the facilities are at 75% or above in their compliance percentage with the exception of Ventura (68%). Three facilities, O.H. Close, Preston, and SYCRCC, are at 80% or greater, with SYCRCC being the highest at 98%.

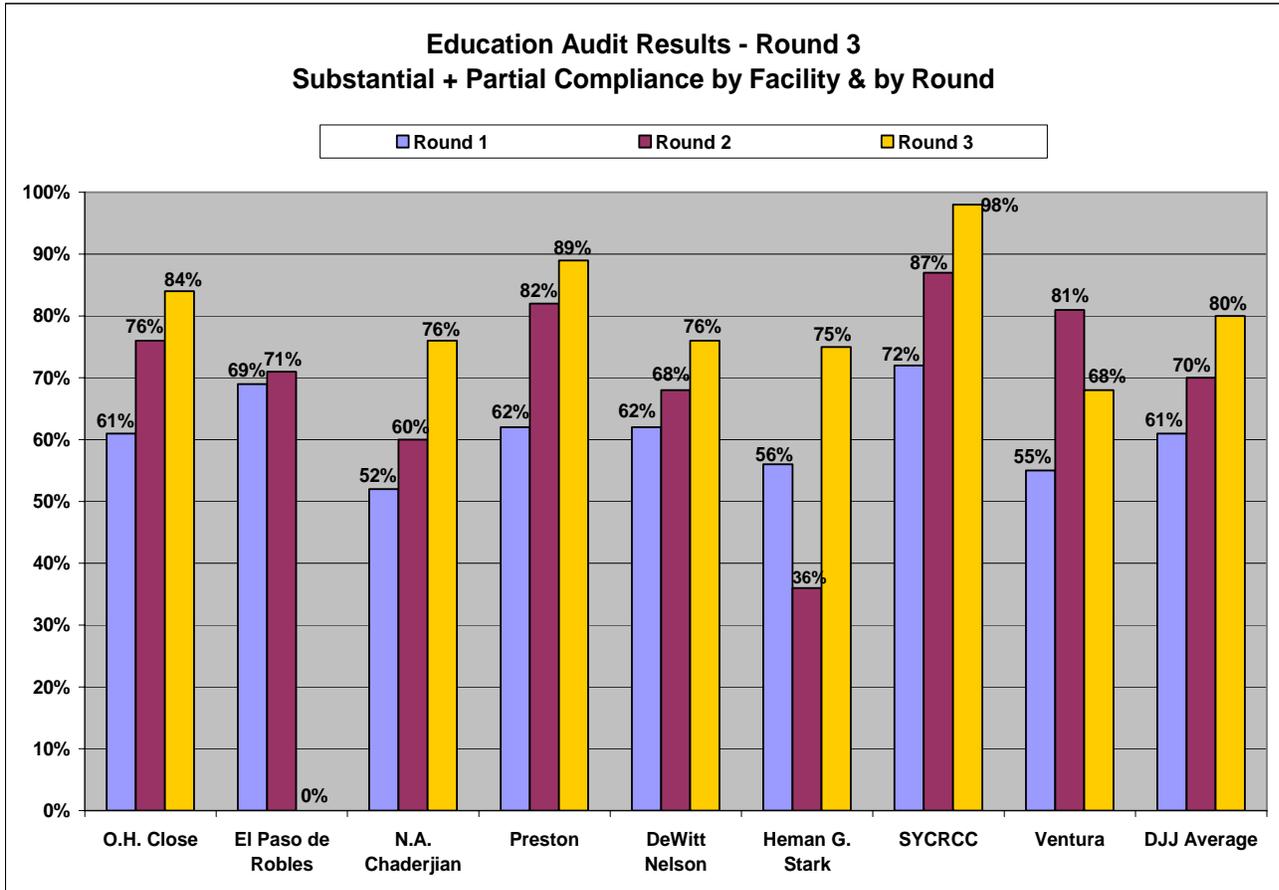


Figure 7: Education Audit Results Round 3: Substantial + Partial Compliance by Facility & by Round

### 2.1.5 Status of Specific Action Items

#### Relieved Items

The following chart identifies the 11 audit items that the Education Experts have deemed “relieved” from future independent monitoring as a result of continued Substantial Compliance ratings over a two year period. Although the Experts have removed these 11 items from future audits, DJJ is still responsible for and has committed itself to ensuring that these 11 items are maintained at their current level of compliance.

<b>Education Services Action Items “Relieved” from Future Independent Monitoring</b>			
<b>DJJ #</b>	<b>Item#</b>	<b>Action Item</b>	<b>Deadline</b>
2	1.2	<b>FACILITY ACTION ITEM</b> – 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	<b>FACILITY ACTION ITEM</b> – 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	<b>FACILITY ACTION ITEM</b> – 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	<b>FACILITY ACTION ITEM</b> – 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	<b>FACILITY ACTION ITEM</b> – Verify that the core academic guides are available to all staff electronically in December 2005.	<b>12/1/05</b>
63	4.5	<b>FACILITY ACTION ITEM</b> – Compare the number of textbooks and library books at each site with applicable standards.	N/A
64	4.6	<b>FACILITY ACTION ITEM</b> – Verify in August 2005 that the annual inventory and needs assessment has been conducted.	N/A
81	4.23	<b>FACILITY ACTION ITEM</b> – Verify that policies have been revised to reflect changes in operations.	N/A
108	6.1	<b>FACILITY ACTION ITEM</b> – 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	<b>FACILITY ACTION ITEM</b> – 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	<b>FACILITY ACTION ITEM</b> – Through student interviews and file reviews, verify that eligible students have appropriate opportunities to pass the state mandated exam.	N/A

**Items Removed from Relieved Status**

The Education Experts did not remove any audit items from its relieved status during this last round of audits.

**State-wide Substantial Compliance Items**

In addition to the 11 relieved action items, there are an additional 21 action items for which the Education Experts have provided Substantial Compliance ratings to each of the facilities for those 21 audit items. The chart on the following page lists these 21 action items. DJJ believes that, with continued diligence, the next set of relieved action items will come from this list.

<b>Education Services Action Items in State-wide Substantial Compliance - Round 3</b> ("Relieved" Items not Included)			
<b>DJJ #</b>	<b>Item#</b>	<b>Action Item</b>	<b>Deadline</b>
1	1.1	<b>FACILITY ACTION ITEM</b> – Verify WASC accreditation status at all school sites. Review WASC records at each site.	N/A
10	2.3	<b>FACILITY ACTION ITEM</b> – Review and evaluate the written recruitment plan and the qualifications and use of the 2 recruiters.	N/A
17	2.10	<b>FACILITY ACTION ITEM</b> – 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	<b>FACILITY ACTION ITEM</b> – Verify employment of 2 school psychologists at schools with restricted programs.	N/A
19	3.1	<b>FACILITY ACTION ITEM</b> – 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	<b>FACILITY ACTION ITEM</b> – 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	<b>FACILITY ACTION ITEM</b> – 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	<b>FACILITY ACTION ITEM</b> – Review and evaluate annual school calendar.	N/A
49	3.31	<b>FACILITY ACTION ITEM</b> – Review scheduling and utilization of the 44 student advising/case conference days per year.	N/A
71	4.13	<b>FACILITY ACTION ITEM</b> – Verify the use of annual surveys to provide vocational course planning by July 2005.	<b>7/1/05</b>
72	4.14	<b>FACILITY ACTION ITEM</b> – Verify the use of annual Career Technical job studies to determine the effectiveness of CTE programs.	N/A
80	4.22	<b>FACILITY ACTION ITEM</b> – Verify that the strategic plan and reading initiative are being implemented at each site.	N/A
82	4.24	<b>FACILITY ACTION ITEM</b> – Verify that policies are made available to staff electronically by June 2006.	<b>6/1/06</b>
83	5.1	<b>FACILITY ACTION ITEM</b> – 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.	<b>9/1/05</b>
92	5.10	<b>FACILITY ACTION ITEM</b> – Verify that the revised standards are established and that the timelines are being met.	N/A
102	5.20	<b>FACILITY ACTION ITEM</b> – 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	<b>FACILITY ACTION ITEM</b> – 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	<b>FACILITY ACTION ITEM</b> – Review quarterly site review reports.	N/A
111	6.4	<b>FACILITY ACTION ITEM</b> – 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	<b>FACILITY ACTION ITEM</b> – 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	<b>FACILITY ACTION ITEM</b> – 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
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**Items with Majority Ratings of Non-compliance**

The Expert 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 dependent on action items from other remedial plans being addressed, thus making them more challenging to implement in a timely manner. The chart below identifies 17 action items where the majority of compliance ratings given to that specific action item were for Non-compliance.

<b>Education Services Action Items with Majority of Ratings of "Non-compliance"</b>			
DJJ #	Item#	Action Item	Deadline
13	2.6	<b>FACILITY ACTION ITEM</b> – Document class cancellations due to teacher absences that are not covered by substitute teachers.	N/A
33	3.15	<b>FACILITY ACTION ITEM</b> – Review 10 or 10%, whichever is greater, student files to document school attendance for the last 30 school days.	N/A
34	3.16	<b>FACILITY ACTION ITEM</b> – 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	<b>FACILITY ACTION ITEM</b> – Review and evaluate quarterly corrective action plans for sites that have an absence rate of more than 7%.	N/A
38	3.20	<b>FACILITY ACTION ITEM</b> – 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	<b>FACILITY ACTION ITEM</b> – Verify the use of the alternative behavior management classroom at each site.	N/A
55	3.37	<b>FACILITY ACTION ITEM</b> – 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	<b>FACILITY ACTION ITEM</b> – 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	<b>FACILITY ACTION ITEM</b> – 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	<b>FACILITY ACTION ITEM</b> – Verify implementation and use of Global Classrooms distance learning.	<b>6/1/2006</b>
76	4.18	<b>FACILITY ACTION ITEM</b> – Verify use of distance learning in restricted settings by direct observation, lesson plan and transcript review.	N/A
79	4.21	<b>FACILITY ACTION ITEM</b> – Verify the practice of quarterly teacher observations by administrators using the revised rubric for Classroom Observation.	N/A

88	5.6	<b>FACILITY ACTION ITEM</b> – 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	<b>FACILITY ACTION ITEM</b> – 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	<b>FACILITY ACTION ITEM</b> – 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
95	5.13	<b>FACILITY ACTION ITEM</b> – Verify existence of collaborative agreements.	N/A
96	5.14	<b>FACILITY ACTION ITEM</b> – 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 past quarter. The Proof of Practice documents provide evidence of DJJ’s efforts to come into compliance with the specific audit items.

Education Services Proof of Practice Documents Submitted During the Last Quarter				
Log#	Section	Audit Item Description	Documents Submitted	Date
169	3.16	<i>“Cooperative agreements exist between education, custody and treatment to ensure students’ access to programs. Management teams will implement a program service schedule to allow service needs to be met during the work day/week without loss of mandatory instructional time.”</i>	A one page signed memo by Sandra Youngen and Doug McKeever dated May 30, 2008 to Principals, Health Care Managers and Superintendents with a subject line of, “Service Level Agreement.”	7/7/08

### 2.1.7 Summary and Application of Audit Findings

The Education Experts have provided DJJ with their third annual report, confirming the compliance data pertaining to their latest round of auditing. DJJ believes that these results provide evidence of the Division’s progress and continued efforts to fully implement the educational reforms. Although there is an established, objective pattern of progress, as identified by the Experts compliance data, DJJ is fully aware that it still has much work to do to attain full compliance. DJJ looks forward to continuing to work with the Education Experts and using their expertise to assist DJJ in overcoming the more complex and problematic issues within the Education Services Remedial Plan.

## 2.2 Sex Behavior Treatment Remedial Plan Compliance Status

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### 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 52 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 52 action items are 208 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.

None of the approximately 52 SBTP action items within the audit tool have a specific deadline for implementation.

#### **Audit History**

The SBTP Expert conducted her first round of audits in October 2005 at each of the four facilities that have a residential Sexual Behavior Treatment Program: O.H. Close, N.A. Chaderjian, Heman G. Stark, and SYCRCC. The SBTP Expert provided DJJ with her first comprehensive report addressing all four programs, in January 2006. This report was narrative in nature and did not use the matrix/spreadsheet audit model 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 for Partial Compliance (35%) and 17 were for Non-compliance (65%).

During the SBTP Expert’s second round of auditing, she did use 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 provided a single compliance rating for every facility for each of the different audit items. This resulted in all four facilities having the identical compliance percentages.

Presently, the SBTP Expert has completed her third round of audits and has provided DJJ with an audit report for O.H. Close. This audit report does contain site specific compliance ratings and comments. DJJ is very appreciative for the SBTP Expert to provide this kind of information. The level of detail these types of reports provide are valuable in that the information provided allows DJJ to objectively assess the progress of each facility’s SBTP program and identifies the issues that need further attention.

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

	ROUND 1	ROUND 2		ROUND 3	
Facility	Date Audited	Date Audited	Time between Audits	Date Audited	Time between Audits
<b>SYCRCC</b>	Oct. 25, 2005	July 26, 2007	21 months	May 21, 2008	10 months
<b>Heman G. Stark</b>	Oct. 24, 2005	July 27, 2007	21 months	May 22, 2008	10 months
<b>N.A. Chaderjian</b>	Oct. 21, 2005	May 25, 2007	19 months	April 29, 2008	11 months
<b>O.H. Close</b>	Oct. 20, 2005	May 24, 2007	19 months	Feb. 21, 2008	9 months

**Future Audit Schedule**

The SBTP Expert completed her third round of monitoring earlier this year and is in the process of completing her annual report. To date, the SBTP Expert has not provided DJJ with a schedule for her next round of audits.

***2.2.2 Most Recent Audit Findings***

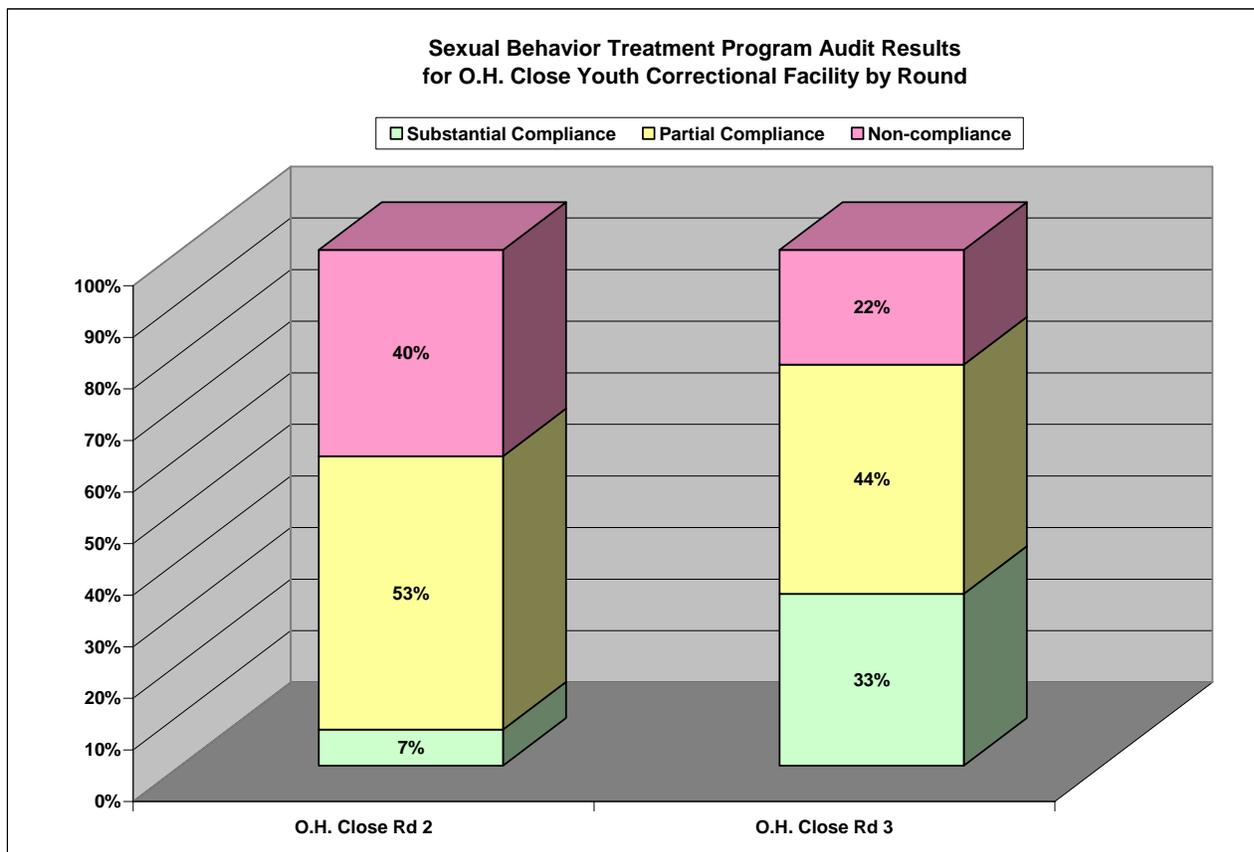
**Audit Reports Received During Last Quarter**

On April 23, 2008, DJJ received an informal audit report from the SBTP Expert entitled, “Report of Site Visit – February 21, 2008: O.H. Close and N.A. Chaderjian.” Although N.A. Chaderjian is listed in the title of this report, only O.H. Close was actually audited. The SBTP Expert rescheduled the N.A Chaderjian audit to April 29, 2008. As of this writing, DJJ is awaiting the Expert’s informal reports for N.A. Chaderjian, Heman G. Stark, and SYCRCC, as well as her formal annual report, which will ultimately be filed with the Court.

### Compliance Percentages from Audit Reports Received During the Last Quarter

The SBTP Expert's informal audit report on O.H. Close used the SBTP audit tool and provided compliance ratings and comments specific to that facility. This detailed and site-specific information is very beneficial to DJJ and assists DJJ in gauging the progress made in implementing the SBTP at each individual facility.

From Round 2 to Round 3, O.H. Close increased its Substantial Compliance percentage from 7% to 33% for an overall increase of 26%. O.H. Close also decreased its Non-compliance percentage by 18%, from 40% to 22%. Many of the SBTP audit items are currently undergoing development, and as a result, O.H. Close received a Partial Compliance rating of 44% for those particular items.



**Figure 8: SBTP Audit Results for O.H. Close Youth Correctional Facility by Round**

### Compliance Data for O.H. Close

- A 26% increase in its Substantial Compliance rating, from 7% to 33%.
- An 18% decrease in its Non-compliance rating, from 40% to 22%.

- An overall average compliance rating of 77% combining the Substantial Compliance and Partial Compliance percentages.
- The 33% Substantial Compliance rating is still low. One of the major barriers to fully implementing the SBTP has been the lack of a fully developed program curriculum.

### **2.2.3 Expert Feedback**

The SBTP Expert provided DJJ with her informal audit report for O.H. Close on April 23, 2008. In her report, the SBTP Expert made several positive comments regarding the Division's progress and provided five specific recommendations to assist DJJ in achieving Substantial Compliance in the future. These comments and recommendations are listed below:

#### **SBTP Expert's Noted Areas of Progress / Recognition for O.H. Close**

- "The day before my visit, I was notified that there was be [sic] a brief introductory meeting with various staff members chaired by Dr. Arguello. At this meeting I was delighted to learn that there had been three major DJJ accomplishments including 1.) the preparation of a rough draft of policies for the Mental Health Unit which will include the policies for the SBTP, 2) a policy in the final stage of development which will address the issues of confidentiality and informed consent and 3.) the submission of a policy on Section 1800 issues which addresses many of concerns expressed by myself and other Farrell experts."
- "Dr. Martin announced that staff are attending a variety of trainings, Dr. Bowlds informed me that she had recently been to an intensive training on Motivational Interviewing and one on Static-99 offered by Dr. Amy Pheonix [sic]. Dr. Martin is exploring an Internet credentialing program for juvenile sex offender treatment providers. Additionally a number of new staff have been hired and a number of these professionals have relevant experience."
- "I was actually overwhelmed by what a great job Dr. Bowlds and Supervising Casework Specialist Annette Herring had done in organizing evidence of compliance with the plan. I have attached an audit matrix which demonstrates compliance in whole or part with many of the factors. They have organized the files so that they are readable and auditable. Upon opening the main file one can instantly tell where in the program the youth is and what he needs to accomplish. The manner in which the staff at Close has organized the material can serve as an example for the rest of the units."

#### **SBTP Expert's Noted Areas of Concern / Recommendations for O.H. Close**

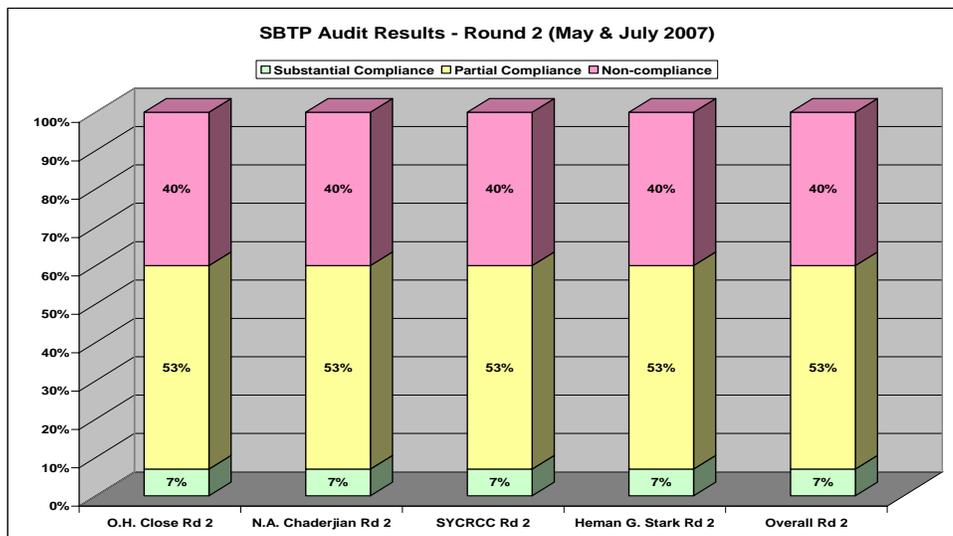
- "The other facilities should take a lesson from Close as to how to organize their files and how to present evidence of compliance with the plan."

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

### 2.2.4 Cumulative Audit Findings

Because the SBTP Expert’s Round 1 findings could not be applied to specific action items, DJJ does not have a basis for comparing progress made from Round 1 to Round 2. Round 2 was the first round where the SBTP Expert provided DJJ with compliance ratings for the specific audit items contained in the SBTP audit tool. Even though the SBTP Expert has completed her latest round of audits, she has not yet provided DJJ with her complete round of compliance findings. Therefore, to date, DJJ only has the Round 2 compliance data upon which to base its cumulative findings.

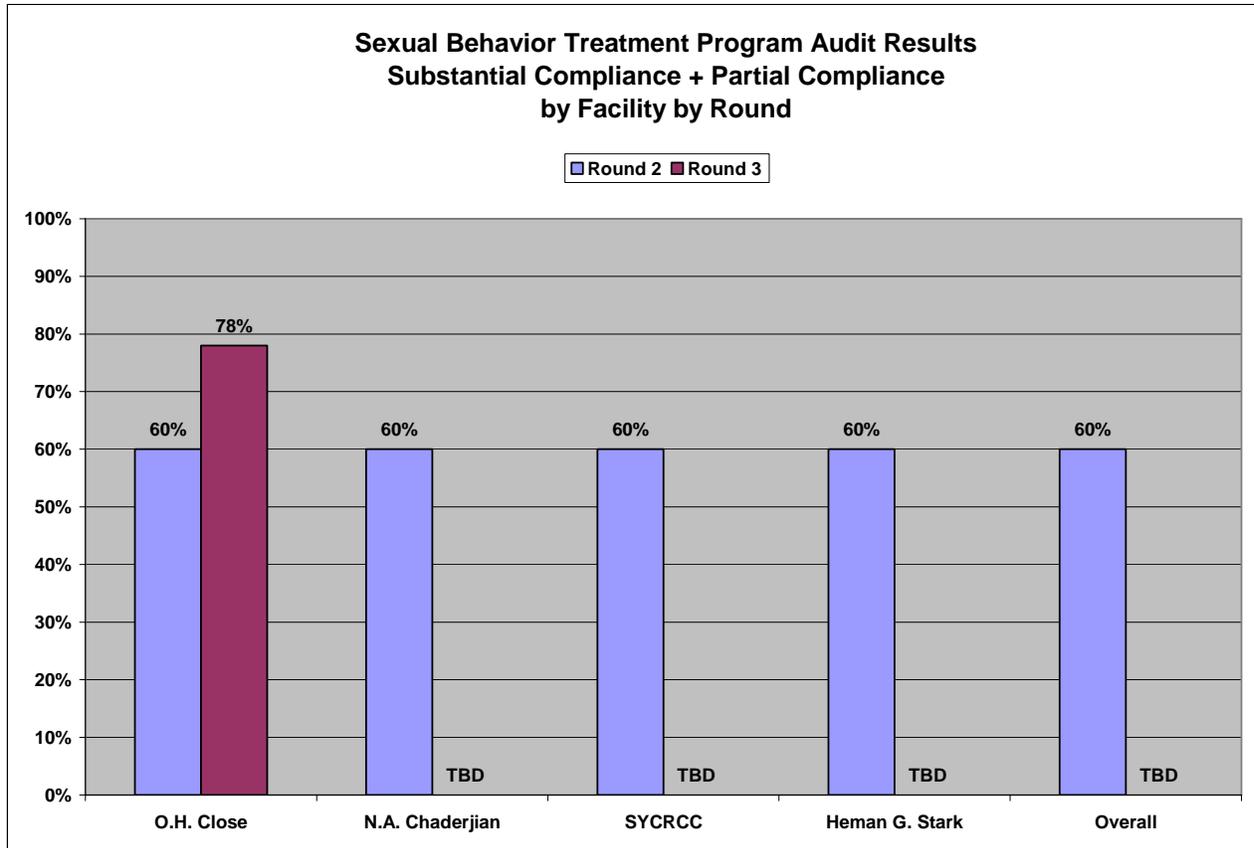
The graph below identifies the compliance ratings for all four residential Sexual Behavior Treatment Programs for Round 2, which were conducted in May and July of 2007. It should be noted that for this round of auditing, the SBTP Expert provided a single compliance rating to be applied broadly to each action item for each of the four residential Sexual Behavior Treatment Programs. Therefore, each of the facilities identified in the graph have identical compliance percentages



**Figure 9: SBTP Audit Results – Round 2 (May & July 2007)**

**Substantial + Partial Compliance Percentages by Facility by Round**

For Round 2, the Substantial Compliance combined with the Partial Compliance percentages for all four Sexual Behavior Treatment Programs was 60%. For Round 3, only O.H. Close has received compliance ratings to date and has a combined Substantial Compliance plus Partial Compliance percentage of 78%, an increase of 18% from the previous round.



**Figure 10: SBTP Audit Results – Substantial Compliance + Partial Compliance by Facility by Round**

***2.2.5 Status of Specific Action Items***

**Relieved Items**

To date, the SBTP Expert has not relieved any of the approximately 52 action items from further independent monitoring.

**Items Removed from Relieved Status**

This section does not apply as the SBTP Expert has not yet relieved any audit items.

**State-wide Substantial Compliance Items**

In Round 2, the SBTP Expert identified two action items being in state-wide Substantial Compliance. "State-wide" means that every applicable audit site for that specific action item received a rating of Substantial Compliance.

<b>SBTP Action Items in State-wide Substantial Compliance – Round 2</b>			
<b>DJJ #</b>	<b>Standard #</b>	<b>Action Item</b>	<b>Deadline</b>
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

**Items with Majority Ratings of Non-compliance**

In Round 2, the SBTP Expert identified 12 items where the majority of the ratings provided for that action item were for Non-compliance

<b>SBTP Action Items with Majority Ratings of "Non-compliance" – Round 2</b>			
<b>DJJ #</b>	<b>Standard #</b>	<b>Action Item</b>	<b>Deadline</b>
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 the efforts of DJJ to come into compliance with the specific audit items.

SBTP Proof of Practice Documents Submitted During the Last Quarter				
#	Section	Audit Item Description	Documents Submitted	Date
126	Std. 3	<i>“Appropriate screening and assessment tools are used to evaluate risk and treatment needs initially and on an ongoing basis. Included in the assessment protocol will be a evaluation of a participant’s substance abuse history. These screening and assessment tools have demonstrated reliability and validity.”</i>	A one page document titled, “STATIC-99 TRAINING” and another one page document titled, “STATIC 99 TRAINING LIST DJJ STAFF.”	5/21/08

### 2.2.7 Summary and Application of Audit Findings

DJJ is appreciative of the SBTP Expert’s latest informal audit report in which she provided DJJ with site-specific information and compliance assessments. DJJ was also encouraged to see an increase in its Substantial Compliance percentage from that of the previous round. However, much of the SBTP’s progress is dependent on the development and implementation of a program curriculum, and unfortunately, DJJ has experienced delays in this area. DJJ is currently reviewing the appropriate steps to remedy this situation in an effort to fully implement the program. DJJ is 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 successful implementation.

## 2.3 Wards with Disabilities Program

### 2.3.1 Historical Audit Perspective

#### Court Filings

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

#### Audit Tool

The WDP audit tool contains 122 different action items. Associated with those 122 action items are approximately 730 individual audited items. These 730 audited items are the total number of compliance ratings that DJJ is responsible for achieving compliance with during a round of auditing.

Of the 122 action items within the WDP audit tool, only 25 of the action items have a specific deadline for implementation.

#### Audit History

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

- Round 1: September 2005 to April 2006;
- Round 2: October 2006 to April 2007; and
- Round 3: September 2007 to May 2008.

The following chart provides a more detailed listing of all the WDP facility audits to date:

	ROUND 1	ROUND 2		ROUND 3	
Facility	Date Audited	Date Audited	Time between Audits	Date Audited	Time between Audits
<b>DeWitt Nelson</b>	Sep. 2005	Feb. 2007	17 months	Oct. 2007	8 months
<b>El Paso de Robles</b>	Oct. 2005	Dec. 2006	14 months	Apr. 2008	16 months
<b>Ventura</b>	Nov. 2005	Mar. 2007	16 months	Nov. 2007 & Mar. 2008	8 & 4 months
<b>SYCRCC</b>	Feb. 2006	April 2007	14 months	Jan. 2008 & May 2008	8 & 5 months
<b>Heman G. Stark</b>	Dec. 2005	Jan. 2007	13 months	Dec. 2007 & Mar. 2008	11 & 3 months

<b>N.A. Chaderjian</b>	Feb. 2006	Oct. 2006	8 months	Jan. 2008 & Apr. 2008	14 & 4 months
<b>O.H. Close</b>	Mar. 2006	Oct. 2006	7 months	Jan. 2008 & Apr. 2008	14 & 4 months
<b>Preston</b>	April 2006	Feb. 2007	10 months	Sept. 2007 & Apr. 2008	7 & 7 months

**Future Audit Schedule**

The WDP Expert has recently submitted a list of proposed audit dates for his next round of audits. DJJ is currently reviewing this proposed schedule and has objected to the Experts’ proposal to monitor the Pine Grove Youth Conservation Camp. The following is the WDP Expert’s proposed schedule:

- Preston Youth Correctional Facility – September 25, 2008 & January 8, 2009
- Pine Grove Youth Conservation Camp – September 26, 2008
- O.H. Close Youth Correctional Facility – October 22, 2008 & February 19, 2009
- N.A. Chaderjian Youth Correctional Facility–October 23, 2008 & February 20, 2009
- Southern Youth Correctional Reception Center Clinic – November 14, 2008 & February 12, 2009
- Heman G. Stark Youth Correctional Facility – December 9, 2008 & March 18, 2009
- Ventura Youth Correctional Facility – December 10, 2008 & March 19, 2009
- DJJ Headquarters – April 24, 2009

***2.3.2 Most Recent Audit Findings***

**Audit Reports Received During Last Quarter**

DJJ recently received a draft copy of the WDP Expert’s third annual report. When finalized, this report will be filed with the Court. Even though there is a chance that some of the compliance ratings could change slightly once the Expert’s annual report becomes final, DJJ believes that the compliance assessment for the third round is indicative of the overall progress that has been made in the implementation of the Wards with Disabilities Program Remedial Plan. If any compliance ratings are changed when the annual report is finalized, those changes will be reflected in this section of the next Quarterly Report.

The WDP Expert’s annual report provided DJJ with its first opportunity to see the compliance ratings for each of its facilities as well as Headquarters during the last round of audits. This was a different process from the previous two rounds during which the WDP Expert promptly provided DJJ with facility audit reports within 30 days of auditing a facility. Such reports were provided in addition to the filing of his annual report.

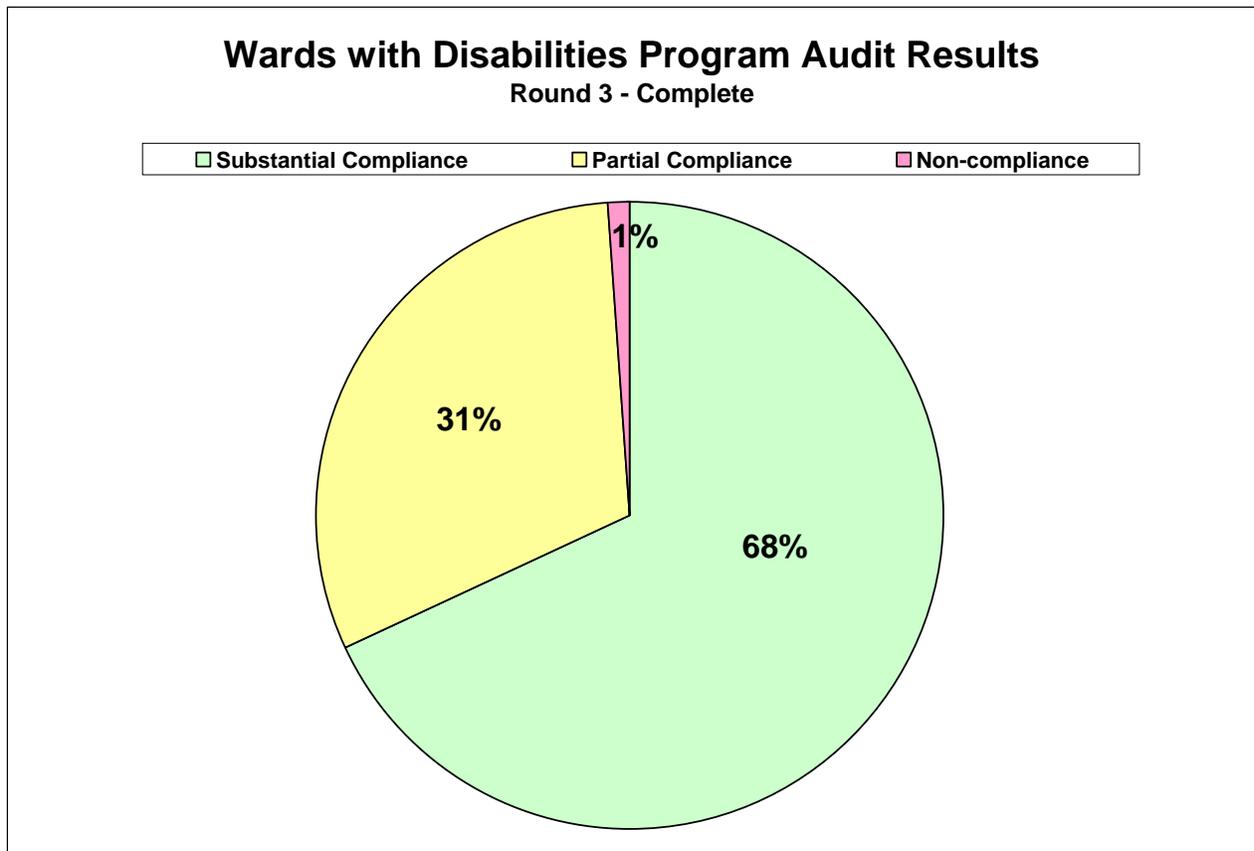
From DJJ’s perspective, there are both advantages and disadvantages to the WDP Expert’s new policy of providing DJJ with all of its compliance ratings from a round of audits only after the Expert drafts and finalizes his annual report. Further, the

information provided to DJJ did not contain site-specific information that would be helpful to DJJ in gauging its progress in achieving full compliance at each of the facilities.

In an effort to identify and mitigate any disadvantages in the current audit process, DJJ had a conference call with the WDP Expert on July 23, 2008, to discuss some of its concerns, mainly the desire for more site specific information on audit items for which the facility was not in Substantial Compliance. The conference call was productive, and several possible solutions were discussed. The WDP Expert seemed to understand the Division's desire for more site specific information and was amenable to providing this information in a yet-to-be determined manner.

### **Overall Compliance Averages for Round 3**

For the third round of auditing, the WDP Expert found 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 the third round. Of these 617 audit items, 418 received a Substantial Compliance rating, 191 received a Partial Compliance rating, and 8 audit items received a Non-compliance rating.



**Figure 11: Wards with Disabilities Program Audit Results: Round 3 - Complete**

### Overall Compliance Percentages by Site for Round 3

The graph on this page identifies the compliance percentages for each of the eight facilities, Headquarters, and the overall average of all of the compliance ratings after the completion of the Round 3 audits.

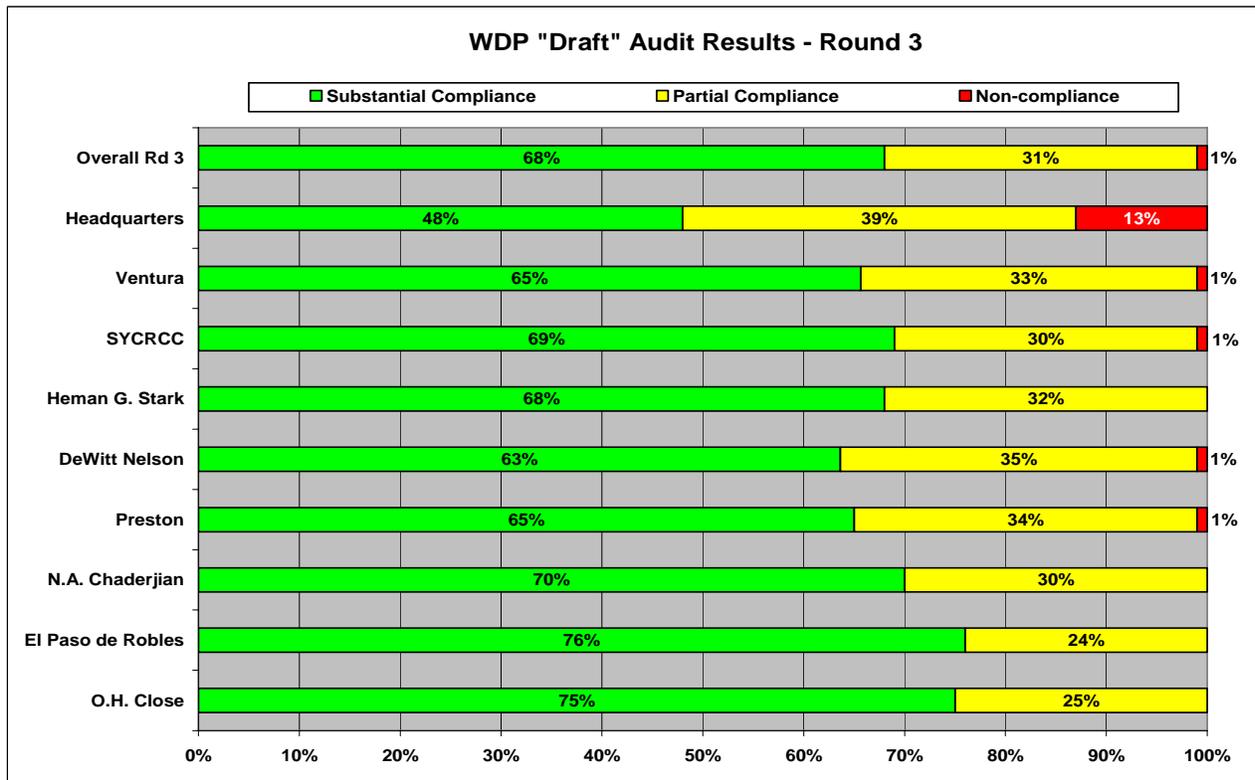


Figure 12: WDP "Draft" Audit Results – Round 3

### Compliance Data for Round 3

- Every facility increased its Substantial Compliance percentage with a range of 0.5% to 11.7%.
- Two facilities had an 11% increase or more in their Substantial Compliance percentage, Preston at 11.0% and Ventura at 11.7%.
- Two facilities are at or above 75% in Substantial Compliance (O.H. Close and El Paso de Robles).
- Four facilities did not have any item rated as being in Non-compliance (O.H. Close, El Paso de Robles, N.A. Chaderjian, and Heman G. Stark). The other four facilities had just a single item each that was rated as being in Non-compliance.
- The Substantial Compliance percentage for Headquarters is 48%.

- Heman G. Stark had minimal improvement in its Substantial Compliance percentage with a gain of only 0.5%.
- DeWitt Nelson had the lowest Substantial Compliance percentage of any facility at 63%.

### **2.3.3 Expert Feedback**

In addition to the actual compliance data that is provided in the WDP Expert's annual report, the Expert also provides narrative feedback that is useful to DJJ in assessing its progress as well as identifying areas and issues that require further effort and attention.

The following section contains noteworthy comments from the Expert's Annual Report and highlights the Division's progress in implementing the WDP Remedial Plan.

#### **WDP Expert's Noted Areas of Progress / Recognition for Round 3**

- "The WDP departmental and facility coordinators and staff members go about their tasks in different ways, but they have all demonstrated remarkable patience and skill in setting up processes and undertaking the necessary tasks."
- "As a result of the combined efforts of these coordinators, the WDP program has progressed steadily as an entity at all facilities. The execution of basic WDP tasks by these coordinators, such as overseeing the Staff Assistant teams, providing individualized assistance to wards with disabilities, and monitoring the disciplinary and grievance systems, continues to meet basic goals established by the plan."
- "It should also be noted that WDP staff has been receptive to specific recommendations from the Disabilities Expert for improving reports and activities, and this cooperation has been appreciated."
- "In addition, high-ranking supervisors at all facilities, usually Program Administrators or Treatment Team Supervisors, assist the WDP facility coordinators in procedural and operational matters, and many of these staff should also be commended for their commitment toward making the implementation of the plan filter into the various disciplines and departments."
- "DJJ has worked steadily to upgrade its computerized ward information and record-keeping system, referred to as the WIN system."
- "The WDP Remedial Plan requires that various types of information about wards with disabilities, including the nature of any disabling condition and any reasonable accommodations necessary to provide services and programs to a specific ward, be readily available to staff, and it appears that DJJ has made progress toward that end."
- "The facility management departments at all locations should be commended for the numerous architectural modifications undertaken during the past year to increase accessibility for wards with mobility impairments. As described in the Auditor's preliminary reports, there are many areas that are exemplary in their

design and in the appropriate incorporation of accessibility elements into the construction.”

- “It should be reported that significant strides in training activities have been made during the last half of the fiscal year. All WDP facility coordinators have completed Training for Trainers (called T for T) sessions and are actively involved in training activities at their facilities.”

The following section identifies the WDP Expert’s concerns and recommendations on audit items that require further effort.

### **WDP Expert’s Noted Areas of Concern / Recommendations for Round 3**

- “Proof of practice documentation of compliance efforts and activities as required by the remedial plan continue to progress, although it is clear that greater standardization and coordination among facilities and Headquarters is still needed.”
- “One issue that is of concern is the possibility that in the future, these coordinators may not be available full time to execute the duties required of them. The newly-instituted SSI assistance program is now also being handled by the WDP facility coordinators, and there has been some discussion regarding one or more of these coordinators taking on other responsibilities unrelated to the Wards with Disabilities Program.”
- “Full cooperation and coordination from all staff has been a major impediment to more significant progress. As will be described below, disability awareness and sensitivity has progressed significantly during the fiscal year, and more staff are becoming better acclimated to the program, and acceptance has increased accordingly. However, many DJJ staff are still not aware of how WDP Remedial Plan requirements relate to their department’s activities.”
- “During the third round of visits, the various facilities used different methods and achieved differing results in attempts to identify, classify, and assign appropriate accommodations to wards with disabilities. This was mainly due to the fact that the WIN computerized identification system had not yet been fully implemented at the facilities at the time of the audit. During this fiscal year, there was still a lack of clear direction from Headquarters on these processes, although WDP staff at all facilities used their best efforts to prepare appropriate documentation of wards with disabilities and their reasonable accommodations. A full implementation of WIN system reporting should allow for a more definitive monitoring of the effectiveness of these identification procedures.”
- “In their facility reports for this fiscal year, the educational experts have cited improvement on the issue of school participation and the number of hours of instruction for these wards, but they also still cite the need for further improvement at most facilities. Since many wards with disabilities are housed in special treatment or restrictive programs, this situation tends to negatively affect educational services for these wards to a significant degree. I would recommend

that remedial strategies developed by the educational experts continue to be implemented to improve the number of hours of direct and integrated instruction for these wards.”

- “The form (Disability Referral / Evaluation Form) has many excellent features, yet it is not yet clear that the form will serve the intended purposes of the remedial plan....It is recommended that the form remain in use with no revisions throughout the next fiscal year, so that its proper usage and effectiveness can be further monitored and evaluated by the Disabilities Auditor and WDP staff.”
- “The Disabilities Auditor attended a meeting on September 4, 2007, with most of the staff who would be involved in these activities (coordination with special study groups). Subsequent to that meeting, I prepared a memorandum, dated October 17, 2007, describing the discussions of the meeting and recommended follow-up actions, and transmitted the memo to WDP staff on several occasions throughout the year. To date, I have received no substantive information on any progress on these activities.”

## Cumulative Audit Findings

### Overall Compliance Averages by Round

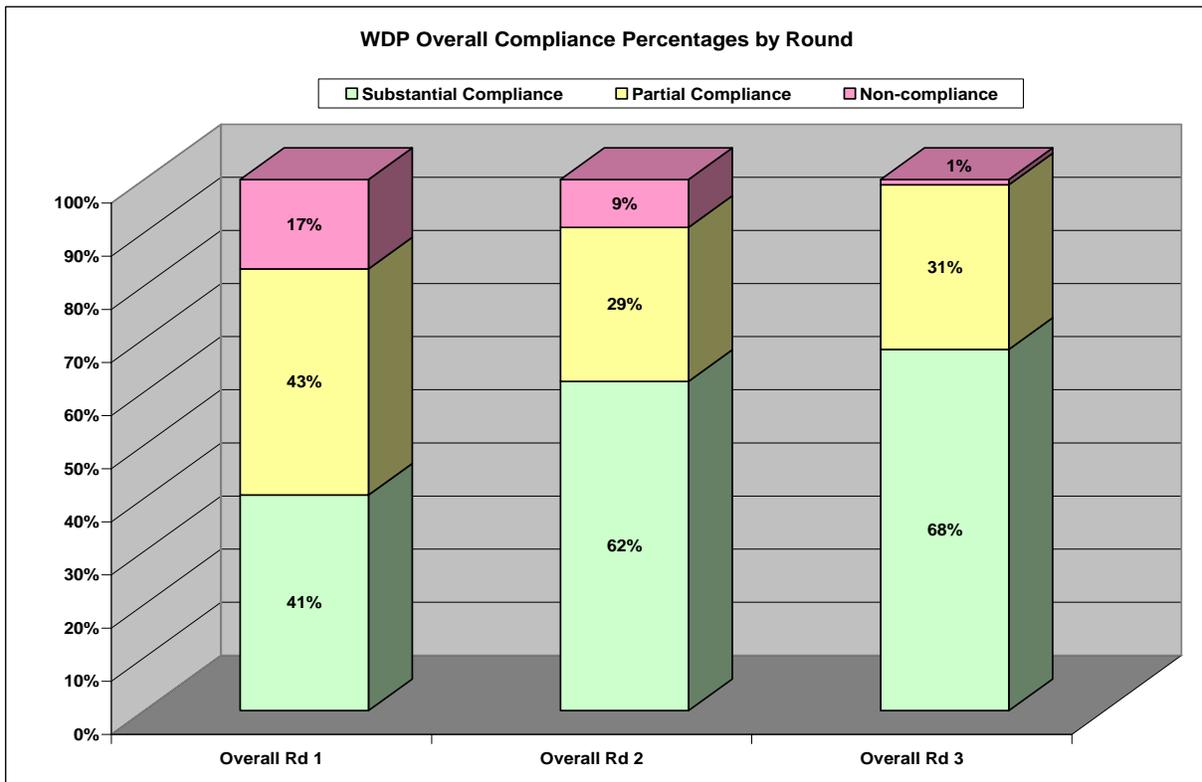


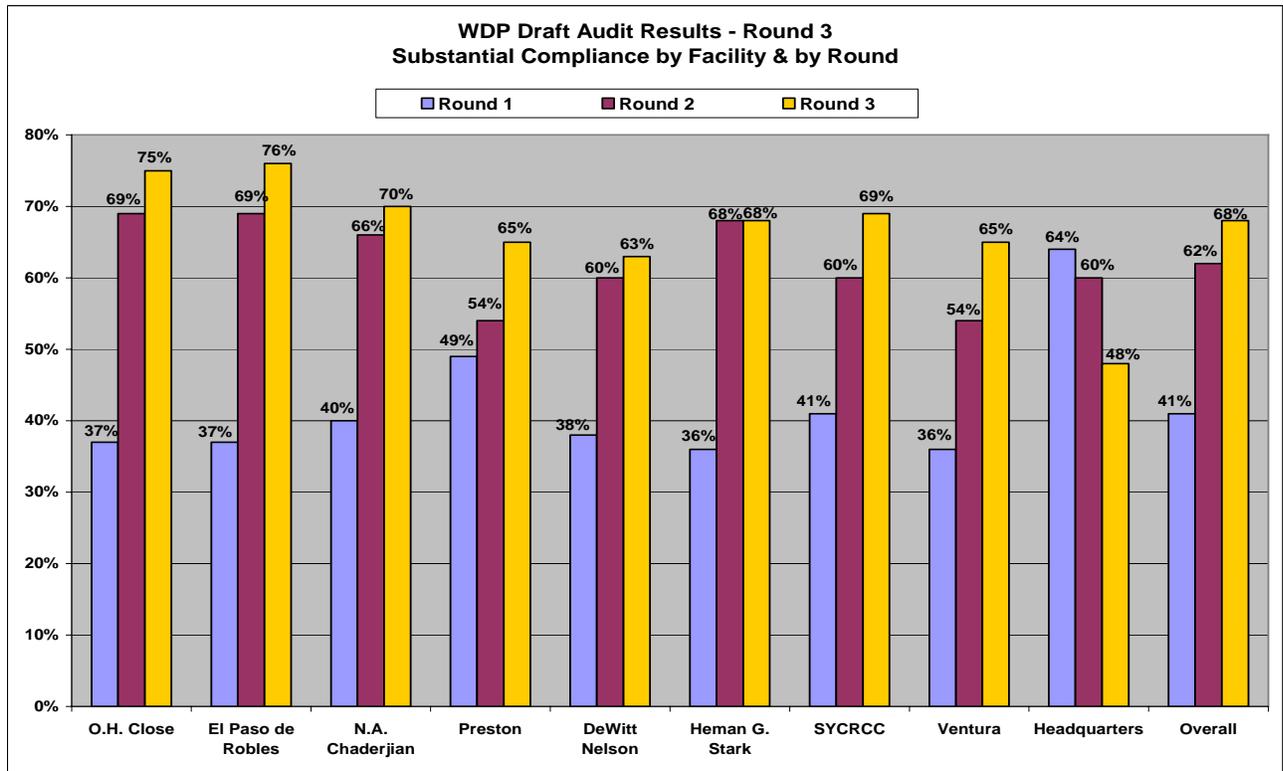
Figure 13: WDP Overall Compliance Percentages by Round

The graph on the previous page identified the composite average for each round of auditing to date. From Round 1 to Round 3, there has been a consistent increase in the Substantial Compliance percentage and a steady decrease in the Non-compliance percentage. The overall Substantial Compliance percentage for Round 3 increased 6% from Round 2 and is now at 68%. The Non-compliance percentage decreased 8% from Round 2 and is now at an overall average of 1% for Non-compliance.

**Substantial Compliance Percentages by Facility by Round**

The graph below shows the Substantial Compliance for each facility for each of the three rounds of audits. Some noteworthy aspects that can be gleaned from the graph include the following:

- Every facility increased its Substantial Compliance percentage after each round of auditing (Heman G. Stark increased 0.5% in Round 3).
- The facilities with the highest Substantial Compliance, 76% at El Paso de Robles, and the lowest Substantial Compliance, 63% at DeWitt Nelson with 63%, have since been closed.
- An area of concern for DJJ is the pattern of decline for Headquarters Substantial Compliance from Round 1 (64%) to Round 3 (48%).

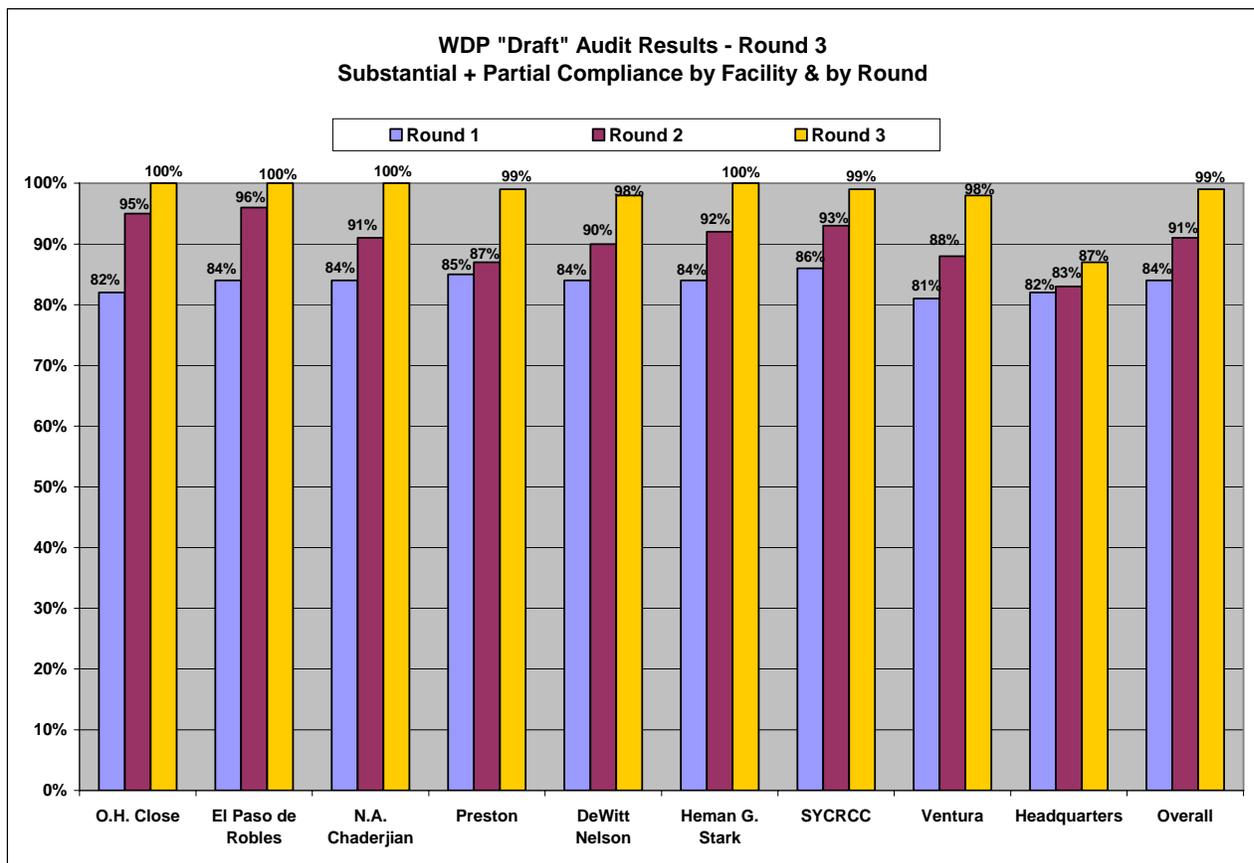


**Figure 14: WDP Draft Audit Results – Round 3: Substantial Compliance by Facility & by Round**

**Substantial + Partial Compliance Percentages by Facility by Round**

The graph on the following page depicts the sum of the Substantial Compliance percentage and the Partial Compliance percentage for each site for each of the three rounds of auditing. Highlights include:

- That, when adding the Substantial Compliance and Partial Compliance percentages together for each facility, the totals range from a high of 100% (four facilities) to a low of 98%;
- That Headquarters’ combined percentage is 87%; and
- That the overall average for all the sites is 99%.



**Figure 15: WDP “Draft” Audit Results – Round 3: Substantial + Partial Compliance by Facility & by Round**

DJJ has much work left to do to fully implement all the reforms in the WDP Remedial Plan. However, DJJ believes that these percentages demonstrate an objective pattern of progress that speak to DJJ’s efforts to fully implement this 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.

### 2.3.4 Status of Specific Action Items

#### Relieved Items

In the WDP Expert's annual report, he identifies a total of 22 action items that are relieved from future independent monitoring. As stated on the WDP audit tool, these 22 action items meet the criteria of a "[s]econd 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 that are relieved from future independent monitoring in comparison to the previous round of auditing.

The following chart identifies the 22 relieved action items.

<b>WDP Actions Items "Relieved" from Future Independent Monitoring</b>			
<b>DJJ #</b>	<b>Section</b>	<b>Action Item</b>	<b>Deadline</b>
1	<b>Directorate</b>	<b>HQ ACTION ITEM</b> – Maintain a current copy of the Wards with Disabilities Program Remedial Plan in the Director's Office.	N/A
3	<b>Departmental Ward Disability Coordinator &amp; Functions</b>	<b>HQ ACTION ITEM</b> – Ensure duty statement encompasses all Departmental WDP Coordinator duties as defined in the WDP Remedial Plan.	N/A
5		<b>FACILITY ACTION ITEM</b> -Establish and maintain full-time WDP Coordinators at each facility by February 2006.	<b>2/1/06</b>
18	<b>Headquarters Policies</b>	<b>HQ ACTION ITEM</b> – 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.	<b>12/1/05</b>
19		<b>HQ ACTION ITEM</b> – 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
20		<b>HQ ACTION ITEM</b> – The Education Branch working committee shall also study the need to include a wider variety of individualized accommodations in IEP's.	N/A
27	<b>Headquarters Policy</b>	<b>HQ &amp; RECEPTION CENTER ACTION ITEM</b> – The CYA shall develop a provisional form that contains a written advisement of ADA Rights Notification in simple English and Spanish by August 2005.	<b>8/1/05</b>
28	<b>Headquarters Programs / Screening</b>	<b>HQ &amp; FACILITIES ACTION ITEM</b> – Maintain a contract for sign language interpreter services, as well as a record of the use of this service.	N/A
30		<b>HQ ACTION ITEM</b> – 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.	<b>12/19/04</b>
32	<b>Superintendent</b>	<b>FACILITY ACTION ITEM</b> – Maintain a current copy of the Wards with Disabilities Program Remedial Plan in the Superintendent's Office.	N/A

44	<b>Facility Policies</b>	<b>FACILITY ACTION ITEM</b> – 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		<b>FACILITY ACTION ITEM</b> – Distribute and post reports, brochures, treatment, and education materials in a manner that is accessible to wards with disabilities.	N/A
66		<b>FACILITY ACTION ITEM</b> – 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	<b>Disciplinary Decision Making System</b>	<b>FACILITY ACTION ITEM</b> – 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		<b>FACILITY ACTION ITEM</b> – 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	<b>Grievance Procedures</b>	<b>FACILITY ACTION ITEM</b> – 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		<b>FACILITY ACTION ITEM</b> – 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	<b>Reception Center and Clinic Functions</b>	<b>RECEPTION CENTER ACTION ITEM</b> – 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	<b>Removal of Architectural Barriers</b>	<b>FACILITY ACTION ITEM</b> – 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.	<b>6/30/06</b>
117		<b>FACILITY ACTION ITEM</b> – 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.	<b>6/30/06</b>
119		<b>FACILITY ACTION ITEM</b> – 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.	<b>7/15/05</b>
120		<b>FACILITY ACTION ITEM</b> – 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.	<b>9/30/06</b>

**Items Removed from “Relieved” Status**

Of the nine previously relieved action items from Round 2, the WDP Expert has 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 WDP positions as they become vacant, DJJ informed the expert that it objects to this auditing methodology.

The chart below identifies the two action items that the Expert has recently removed from relieved status and are once again to be monitored by the Expert during his audit rounds.

<b>WDP Actions Items Removed from “Relieved” Status</b>					
<b>DJJ #</b>	<b>Section</b>	<b>Action Item</b>	<b>Deadline</b>	<b>Current Rating</b>	<b>Expert Comments</b>
4	<b>Departmental Ward Disability Coordinator &amp; Functions</b>	<b>HQ ACTION ITEM</b> –The WDP Coordinator shall perform the oversight functions as set forth in the WDP Remedial Plan.	N/A	<b>SC</b>	Sandi Becker is believed to be performing the required oversight functions.
36	<b>Facility Wards with Disabilities Coordinator</b>	<b>FACILITY ACTION ITEM</b> –Maintain WDP Coordinators at each facility.		<b>SC</b>	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).

**State-wide Substantial Compliance Items**

In addition to the 22 relieved action items, DJJ was found to be in state-wide Substantial Compliance for 37 action items for Round 3. “State-wide” in this case refers to the situation in which an action item receives a Substantial Compliance rating for every applicable site related to that action item. The chart on the next page identifies these 37 action items.

<b>WDP Action Items in State-wide Substantial Compliance – Round 3</b> (“Relieved” Items not Included)			
DJJ #	Section	Action Item	Deadline
2	<b>Departmental Ward Disability Coordinator &amp; Functions</b>	<b>HQ ACTION ITEM</b> – 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.	<b>10/1/05</b>
4		<b>HQ ACTION ITEM</b> - The WDP Coordinator shall perform the oversight functions as set forth in the WDP Remedial Plan.	N/A
5		<b>FACILITY ACTION ITEM</b> – Establish and maintain full-time WDP Coordinators at each facility by February 2006.	<b>2/1/06</b>
11		<b>HQ ACTION ITEM</b> – 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.	<b>11/30/05</b>
13	<b>Headquarter Policies</b>	<b>HQ ACTION ITEM</b> – The CYA shall procure two wheelchair assessable vans to transport wards with disabilities by July 2006.	<b>7/1/06</b>
15		<b>HQ ACTION ITEM</b> – 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		<b>HQ ACTION ITEM</b> – 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	<b>Headquarters Programs / Screening</b>	<b>HQ ACTION ITEM</b> - 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	<b>Superintendent</b>	<b>FACILITY ACTION ITEM</b> – 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	<b>Facility Wards with Disabilities Coordinator</b>	<b>FACILITY ACTION ITEM</b> – Maintain WDP Coordinators at each facility.	<b>2/1/06</b>
37		<b>FACILITY ACTION ITEM</b> – Ensure duty statement encompasses all facility WDP Coordinator duties as defined in the WDP Remedial Plan.	N/A
38		<b>FACILITY ACTION ITEM</b> – The facility WDP Coordinator shall perform the oversight functions as set forth in the WDP Remedial Plan.	N/A
39		<b>FACILITY ACTION ITEM</b> – Within six months of the court approval and adoption of this plan, the facility Ward Disability Program Coordinators will receive a higher level of training provided by qualified trainers/consultants from outside the Department as recommended in Section 5.1 of the Experts report.	<b>11/30/05</b>
40		<b>FACILITY ACTION ITEM</b> – The facility WDP Coordinators shall submit monthly reports to the Department WDP Coordinator.	N/A
42		<b>FACILITY ACTION ITEM</b> – 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	<b>Facility Policies</b>	<b>FACILITY ACTION ITEM</b> – Wards with hearing disabilities shall be provided use of a Telecommunications Device for the Deaf (TDD).	N/A

47		<b>FACILITY ACTION ITEM</b> – The Principal shall ensure students with disabilities are trained in the proper use of electronic equipment.	N/A
50		<b>FACILITY ACTION ITEM</b> – Provide for and implement the four exceptions to the graduation standards for students with disabilities, as listed in the remedial plan.	N/A
52		<b>FACILITY ACTION ITEM</b> – 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
54		<b>FACILITY ACTION ITEM</b> – 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		<b>FACILITY ACTION ITEM</b> – 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		<b>FACILITY ACTION ITEM</b> – 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	<b>Disciplinary Decision Making System</b>	<b>FACILITY ACTION ITEM</b> – Disposition chairperson shall be trained to communicate with wards that have disabilities.	N/A
70		<b>FACILITY ACTION ITEM</b> – 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		<b>FACILITY ACTION ITEM</b> – 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	<b>Grievance Procedures</b>	<b>FACILITY ACTION ITEM</b> – 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		<b>FACILITY ACTION ITEM</b> – 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		<b>FACILITY ACTION ITEM</b> – 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		<b>FACILITY ACTION ITEM</b> – 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	<b>Reception Center-Clinic Functions</b>	<b>RECEPTION CENTER ACTION ITEM</b> - 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		<b>RECEPTION CENTER ACTION ITEM</b> - 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		<b>RECEPTION CENTER ACTION ITEM</b> - Credentialed education staff shall complete educational assessment within 50 calendar days.	N/A
111	<b>Residential Programs</b>	<b>FACILITY ACTION ITEM</b> – 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		<b>FACILITY ACTION ITEM</b> – 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		<b>FACILITY ACTION ITEM</b> – 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
114	<b>Developmental Disabilities</b>	<b>FACILITY ACTION ITEM</b> – No outward signs of identification or labeling will be posted for wards involved in the developmental disabilities program.	N/A
118	<b>Removal of Architectural Barriers</b>	<b>FACILITY ACTION ITEM</b> – 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.	<b>7/1/08</b>

**Items with Majority Ratings of Non-compliance**

The chart below identifies the four action items for which the majority of compliance ratings received were for Non-compliance.

<b>WDP Action Items with Majority Ratings of Compliance Ratings – Round 3</b>			
<b>DJJ #</b>	<b>Section</b>	<b>Action Item</b>	<b>Deadline</b>
9	<b>Departmental Ward Disability Coordinator &amp; Functions</b>	<b>FACILITY ACTION ITEM</b> - 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	<b>Headquarter Policies</b>	<b>FACILITY ACTION ITEM</b> - 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.	<b>11/30/05</b>
24		<b>FACILITY ACTION ITEM</b> – 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.	<b>12/1/06</b>

86	<b>Reception Center-Clinic Functions</b>	<b>RECEPTION CENTER ACTION ITEM</b> - 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
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### 2.3.5 Proof of Practice

The following chart identifies the WDP-related Proof of Practice documents that were sent to the WDP Expert and the Special Master during the last quarter. Proof of Practice documents provide evidence of DJJ efforts to come into compliance with the audit items of a specific remedial plan.

<b>WDP Proof of Practice Documents Submitted During the Last Quarter</b>				
#	Section	Audit Item Description	Documents Submitted	Date
155	I - C	<i>"In conjunction with the Health Care Transition Team, Medical Experts and Disabilities Expert, (1) prepare an "action plan" for wards with mobility or other physical impairments to integrate with the general population as soon as medical issues are resolved, including determining the most physically accessible locations available and making the barrier removal improvements required on a timely basis."</i>	<u>Draft</u> of the "Action Plan" for youth with mobility or other physical impairments. DJJ is respectfully requesting the WDP Expert's feedback by July 7, 2008.	6/20/08
170		<i>"The CYA shall procure two wheelchair accessible vans to transport wards with disabilities by July 2006"</i>	# 1 - Invoice No. 46138, dated 3/24/2008 for 2008 El Dorado AeroElite 290, ParaTransit package. Total Amount: \$ 102,269.53. # 2 – Invoice No. 46554, dated 4/4/2008, for 2008 El Dorado AeroElite 290, ParaTransit package. Total Amount: \$ 101,020.53.	7/7/08
174	4-1	<i>"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 schedule for June 30, 2006."</i>	A two page memo dated March 20, 2008 to the Superintendent of El Paso de Robles YCF from Richard L. Traversi, Jr., Architect, from CDCR Design Standards and Services regarding the removal of architectural barriers. The subject line of the memo is, "El Paso De Robles Youth Correctional Facility – Americans with Disabilities Act Modifications.	7/11/08
	4-2	<i>"The Department committed, at a minimum, to have one fully accessible shower and/or lavatory area at each facility. Each of these fully accessible shower and/or lavatory areas must be in close proximity to the renovated accessible cells due to be completed by June 30, 2006."</i>		

	4-3	<i>"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."</i>		
	4-5	<i>"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."</i>		
	4-6	<i>"The second category of projects, which involve projects that will require substantial funding, will be completed by September 30, 2008."</i>		
175	4-1	<i>"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."</i>	A two page memo dated April 3, 2008 to the Superintendent of DeWitt Nelson YCF from J.H. Linan, Architect, from CDCR Design Standards and Services regarding the removal of architectural barriers. The subject line of the memo is, "DeWitt Nelson Youth Correctional Facility – Americans with Disabilities Act – Compliant Ward Room and Shower Renovation at Lassen and Modoc."	7/11/08
	4-2	<i>"The Department committed, at a minimum, to have one fully accessible shower and/or lavatory area at each facility. Each of these fully accessible shower and/or lavatory areas must be in close proximity to the renovated accessible cells due to be completed by June 30, 2006."</i>		
176	4-1	<i>"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 schedule for June 30, 2006."</i>	#1 - A two page memo dated June 18, 2008 to the Superintendent of DeWitt Nelson YCF from Howard G. Taylor, Architect, from CDCR Design Standards and Services regarding the removal of architectural barriers. The subject line of the memo is, "DeWitt Nelson Youth Correctional Facility – Americans with Disabilities Act Modifications #2 - A three page spreadsheet attachment with a header of "ADA Projects.	
	4-2	<i>"The Department committed, at a minimum, to have one fully accessible shower and/or lavatory area at each facility. Each of these fully accessible shower and/or lavatory areas must be in close proximity to the renovated accessible cells due to be completed by June 30, 2006."</i>		
	4-3	<i>"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."</i>		
	4-5	<i>"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."</i>		
	4-6	<i>"The second category of projects, which involve projects that will require substantial funding, will be completed by September 30, 2008."</i>		

177	4-1	<i>"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 schedule for June 30, 2006."</i>	A two page memo dated June 26, 2008 to the Superintendent of Heman G. Stark YCF from J.H. Linan, Architect, from CDCR Design Standards and Services regarding the removal of architectural barriers. The subject line of the memo is, "Heman G. Stark Youth Correctional Facility – Americans with Disabilities Act – Modifications Out Year Budget Change Proposal (BCP) 1, 2, and 3."	
	4-2	<i>"The Department committed, at a minimum, to have one fully accessible shower and/or lavatory area at each facility. Each of these fully accessible shower and/or lavatory areas must be in close proximity to the renovated accessible cells due to be completed by June 30, 2006."</i>		
	4-3	<i>"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."</i>		
	4-5	<i>"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."</i>		
	4-6	<i>"The second category of projects, which involve projects that will require substantial funding, will be completed by September 30, 2008."</i>		
178	I-C	<i>"In conjunction with the Health Care Transition Team, Medical Experts and Disabilities Expert, (1) prepare an "action plan" for wards with mobility or other physical impairments to integrate with the general population as soon as medical issues are resolved, including determining the most physically accessible locations available and making the barrier removal improvements required on a timely basis."</i>	Second draft of the "Action Plan" for youth with mobility or other physical impairments that has incorporated feedback from the WDP Expert and additional DJJ Health Care Services input. DJJ is respectfully requesting the WDP Expert's feedback by July 18, 2008.	7/11/08
182	4-1	<i>"The Department committed, at a minimum, to have one fully accessible shower and/or lavatory area at each facility. Each of these fully accessible shower and/or lavatory areas must be in close proximity to the renovated accessible cells due to be completed June 30, 2006."</i>	A two page memo dated July 8, 2008 to the Superintendent of Heman G. Stark YCF from J.H. Linan, Architect, from CDCR Design Standards and Services regarding the removal of architectural barriers. The subject line of the memo is, "Heman G. Stark Youth Correctional Facility – Americans with Disabilities Act – Renovate Showers at Units A, B, C and D."	7/11/08
	4-2	<i>"The Department committed, at a minimum, to have one fully accessible shower and/or lavatory area at each facility. Each of these fully accessible shower and/or lavatory areas must be in close proximity to the renovated accessible cells due to be completed by June 30, 2006."</i>		

### **2.3.6 Summary and Application of Audit Findings**

DJJ believes that it has made substantial progress to date in implementing the WDP Remedial Plan, and this belief is corroborated by the last round of compliance data. Much of this progress is the result of the WDP Expert and the DJJ Departmental WDP Coordinator working closely together. DJJ will continue to look to the WDP Expert for his expertise and his guidance as the Department attempts to get to the next plateau of successfully implementing the WDP Plan.

## 2.4 Health Care Services Remedial Plan Compliance Status

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### 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 made up of a series of questions and screens.

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

Screens on the other hand are random file reviews to ensure that proper procedures and documentation are being followed and completed. 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; 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 14,116 audit items when first designed. Because the Experts have the flexibility to review a range of the number of files for a given screen, 14,116 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, in practice, in regards to the five 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 1.

The Health Care audit tool is vastly 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. Also, due in large part to the time involved in auditing all of the items in the Health Care Services audit tool, the Health Care Experts may not necessarily be able to complete an audit for all 18 facility categories at one time.

The list of 20 categories includes:

- 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, there are a few deadlines that are noted in the Health Care Services Remedial Plan.

**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 this current round of audits. Due to their announced closures, the Health Care Experts did not audit DeWitt Nelson or El Paso de Robles during this last round of monitoring. The only facility that DJJ has not yet received an audit report on is O.H. Close, which was audited June 2 through June 4, 2008.

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

	ROUND 1	ROUND 2		ROUND 3	
Facility	Date Audited	Date Audited	Time between Audits	Date Audited	Time between Audits
Ventura	Dec 5-7, 2007	N/A	N/A	N/A	N/A
SYCRCC	Jan. 29-31, 2008	N/A	N/A	N/A	N/A
Heman G. Stark	Oct. 31-Nov. 2, 2007	N/A	N/A	N/A	N/A

N.A. Chaderjian	Feb. 25-29, 2008	N/A	N/A	N/A	N/A
O.H. Close	June 2-4, 2008	N/A	N/A	N/A	N/A
Preston	Sept. 5-7, 2007	N/A	N/A	N/A	N/A

**Future Audit Schedule**

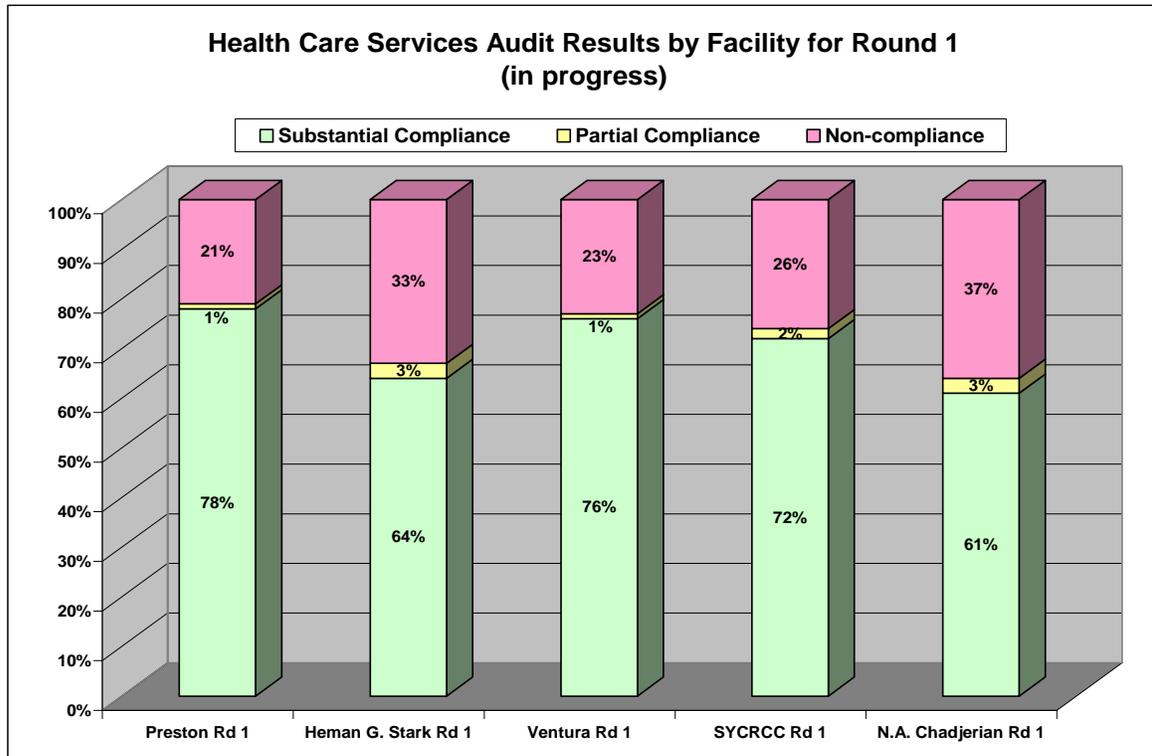
The Health Care Experts have not yet provided DJJ with a schedule for their second round of auditing.

**2.4.2 Most Recent Audit Findings**

**Audit Reports Received During Last Quarter**

DJJ has not received any Health Care Services audit reports during the last quarter. DJJ anticipates receiving the audit report for O.H. Close in the very near future and the Health Care Expert’s annual report later on in the quarter. All of the compliance data for this section remains the same from what was reported in the last Quarterly Report.

**Audit Results by Facilities for Round 1 (in progress)**



**Figure 16: Health Care Services Audit Results by Facility for Round 1 (in progress)**

Based on the compliance data from each of the five facility audits performed so far, as demonstrated by the graph above, the following are apparent:

- Substantial Compliance percentage for the five facilities covers a range of 61% to 78%.
- Non-compliance percentage covers a range of 37% to 21%.
- Partial Compliance percentage covers a range of 1% to 3%.
- Three of the five facilities have a Substantial Compliance percentage of 72% or greater.
- Preston has the highest Substantial Compliance percentage to date at 78% while N.A. Chaderjian has the lowest percentage at 61%.

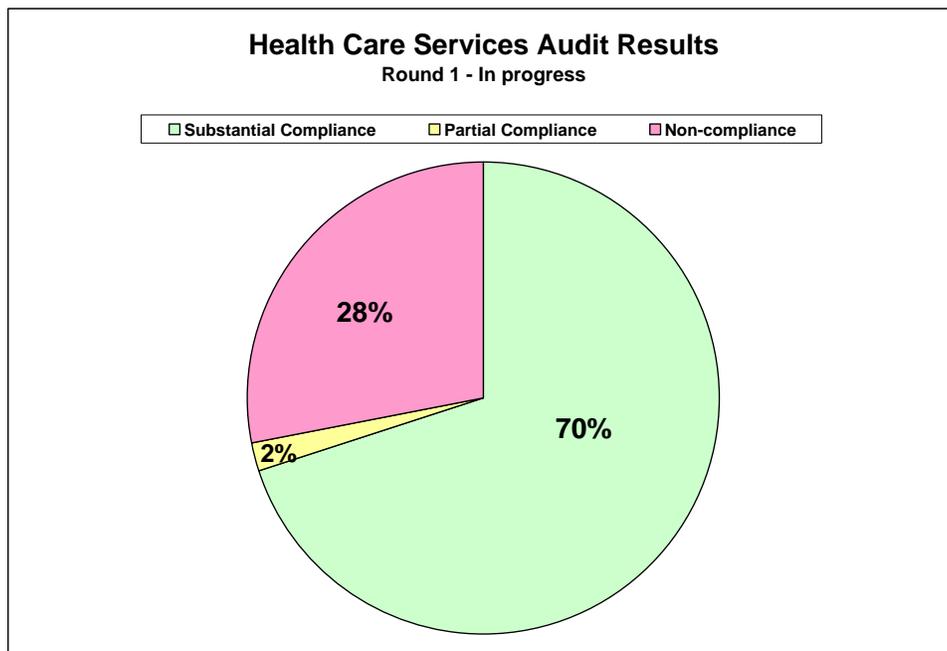
### 2.4.3 Expert Feedback

The Health Care Experts have not provided DJJ with an audit report since the last Quarterly Report.

### 2.4.4 Cumulative Audit Findings

To date, five of the six applicable facilities have been audited for Round 1. The chart below identifies the cumulative compliance data of these five facilities.

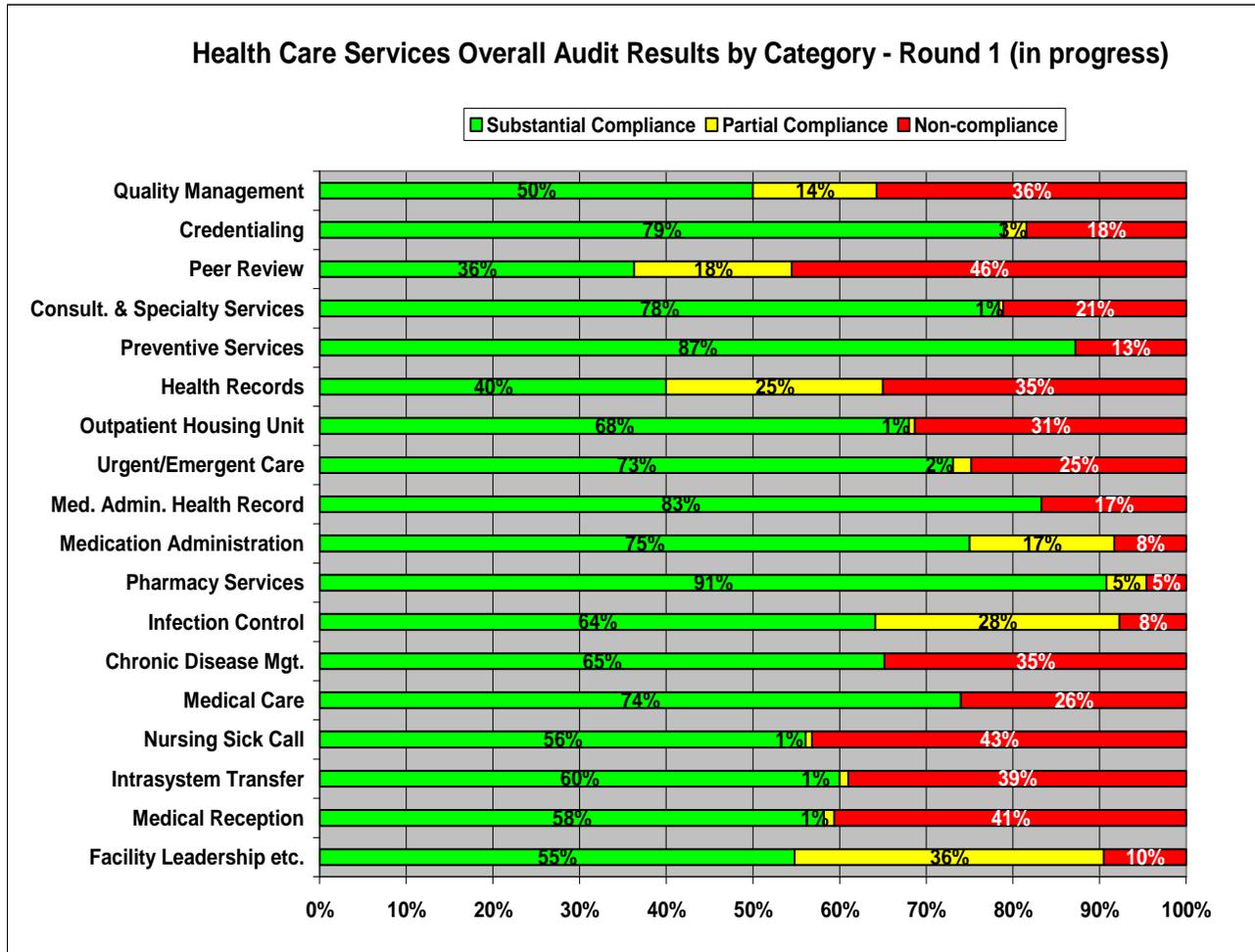
#### Overall Compliance Averages for the Last Round of Auditing



**Figure 17: Health Care Services Audit Results: Round 1 – In progress**

As the chart on the previous page indicates, DJJ is currently averaging 70% for Substantial Compliance, 2% for Partial Compliance, and 28% for Non-compliance.

**Overall Compliance Averages by Category for Round 1 (In progress)**



**Figure 18: Health Care Services Overall Audit Results by Category – Round 1 (in progress)**

- Overall, DJJ is averaging 73% or more in Substantial Compliance in eight of the 18 facility categories.
- Three of the 18 facility categories are averaging 83% or more in Substantial Compliance with “Pharmacy Services” averaging the highest at 91%.
- Eight of the 18 facility categories had a Substantial Compliance percentage of 73% or greater.
- 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 being put in place.

### 2.4.5 Status of Specific Action Items

The Health Care Services Experts are currently in their first round of monitoring. As such, DJJ is not yet eligible to have any of the action items within the Health Care Services audit tool relieved from further independent monitoring by the Health Care Services Experts. Neither is DJJ able to identify audit items that are in state-wide Substantial Compliance across every facility nor items for which the majority of ratings are for Non-compliance. Identification of where these audit items can occur only when a complete round of auditing has concluded and the data is provided to DJJ.

### 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 the Department's efforts to come into compliance with the identified action items within each remedial plan.

<b>Health Care Services Proof of Practice Documents Submitted During the Last Quarter</b>				
#	Section	Audit Item Description	Documents Submitted	Date
179	Nursing Sick Call	Numerous audit items within each of the four categories identified above. Due to the wide scope of these trainings, there may be other audit items addressed in other categories other than what are listed above.	A packet of training sign-in sheets with an attached coversheet entitled, "Nursing Services, Health Care Services Training Classes completed April 2008. The coversheet identifies the type of training provided, where the training was conducted, the duration of the training, and the dates the training was provided. The packet contains forty-one total pages, including the coversheet	7/11/08
	Infection Control			
	Chronic Disease Management			
	Urgent/Emergent Care			
180	Nursing Sick Call	Numerous audit items within each of the three categories identified above. Due to the wide scope of these trainings, there may be other audit items addressed in other categories other than what are listed above.	A packet of training sign-in sheets with an attached coversheet entitled, "Nursing Services, Health Care Services Training Classes completed May 2008. The coversheet identifies the type of training provided, where the training was conducted, the duration of the training, and the dates the training was provided. The packet contains twelve total pages, including the coversheet.	7/11/08
	Medication Administration			
	Health Records			
181	Nursing Sick Call	Numerous audit items within each of the five categories identified above. Due to the wide scope of these trainings, there may be other audit items addressed in other categories other than what are listed above.	A packet of training sign-in sheets with an attached coversheet entitled, "Nursing Services, Health Care Services Training Classes completed June 2008. The coversheet identifies the type of training provided, where the training was conducted, the duration of the training, and the dates the training was provided. The packet contains nineteen total pages, including the coversheet.	7/11/08
	Chronic Disease Management			
	Urgent/Emergent Care			
	Infection Control			
	Health Records			

183	Nursing Sick Call	Numerous audit items within each of the two categories identified above. Due to the wide scope of these trainings, there may be other audit items addressed in other categories other than what are listed above.	A packet of training sign-in sheets with an attached coversheet entitled, "Nursing Services, Health Care Services Training Classes completed March 2008." The coversheet identifies the type of training provided, where the training was conducted, the duration of the training, and the dates the training was provided. The packet contains eight total pages, including the coversheet.	7/11/08
	Medication Administration			
184	Nursing Sick Call	Numerous audit items within each of the two categories identified above. Due to the wide scope of these trainings, there may be other audit items addressed in other categories other than what are listed above.	A packet of training sign-in sheets with an attached coversheet entitled, "Nursing Services, Health Care Services Training Classes completed February 2008." The coversheet identifies the type of training provided, where the training was conducted, the duration of the training, and the dates the training was provided. The packet contains 14 total pages, including the coversheet.	7/11/08
	Medication Administration			
185	Nursing Sick Call	Numerous audit items within each of the three categories identified above. Due to the wide scope of these trainings, there may be other audit items addressed in other categories other than what are listed above.	A packet of training sign-in sheets with an attached coversheet entitled, "Nursing Services, Health Care Services Training Classes completed January 2008." The coversheet identifies the type of training provided, where the training was conducted, the duration of the training, and the dates the training was provided. The packet contains 20 total pages, including the coversheet.	7/11/08
	Medication Administration			
	Urgent/Emergent Care			
186	Nursing Sick Call	Numerous audit items within each of the three categories identified above. Due to the wide scope of these trainings, there may be other audit items addressed in other categories other than what are listed above.	A packet of training sign-in sheets with an attached coversheet entitled, "Nursing Services, Health Care Services Training Classes completed from July to December 2007." The coversheet identifies the type of training provided, where the training was conducted, the duration of the training, and the dates the training was provided. The packet contains 21 total pages, including the coversheet.	7/11/08
	Medication Administration			
	Urgent/Emergent Care			

### **2.4.7 Summary and Application of Audit Findings**

DJJ is currently awaiting receipt of the Health Care Experts' audit report on O.H. Close and their annual report, which should also include compliance ratings for Headquarters-specific audit items. In the next Quarterly Report, an additional component will be included in this Health Care Services section that will provide information from the Dental Expert's preliminary assessment of the Division's dental services. A complete and separate dental audit tool is currently being field tested. Once this audit tool is fully approved and implemented, this will provide another means with which to measure the Division's progress of providing mandated and quality services to the youth under its care.

### **2.5 Safety & Welfare Remedial Plan Compliance Status**

## **2.5.1 Historical Audit Perspective**

### **Court Filings**

The Safety & Welfare (“S & W”) Remedial Plan was filed with the court on July 10, 2006. The audit tool (Standards & Criteria) was filed with the court on October 31, 2006.

### **Audit Tool**

The S & W 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.”

The 227 action items associated with the S & W Remedial Plan represent the most for any *Farrell* audit tool. However, in terms of audit items, the S & W Remedial Plan has only the third most, with the Health Care Services and Education Services Remedial Plans having more. There are 790 audit items connected to the 227 action items.

There are two unique aspects to the S & W audit tool that are also shared with the Mental Health audit tool, but there are also aspects which make it vastly different from the other four remedial plans’ respective audit tools. One main difference is the fact that the S & W audit tool may contain staggered deadlines within a specific action item. This accounts 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 action items within these two audit tools.

In the S & W audit tool, either the S & W 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. However, despite the fact that the delegation of monitoring duties is fairly clear, there still appears to be some confusion. To date, DJJ has received compliance ratings from parties not assigned as the monitor for those particular items. Too, DJJ has also received conflicting ratings from different sets of monitors for the very same action item. Confusion has also been created in getting compliance ratings at sites not identified in the audit tool as required to be monitored; for instance, a Headquarters-only action was recently audited at the facility level. These issues make it very difficult for DJJ to accurately quantify the compliance data.

The S & W audit tool is a complex document, but it clearly identifies who is required to monitor what, where, and for the most part, what the specific deadline is. For each item, it would be very useful to DJJ if the various parties required to monitor the S & W Remedial Plan would adhere to the audit tool that was filed with the court or, conversely, if the auditors have suggestions as to better meet the goals of the Remedial Plan, work cooperatively with DJJ to develop a more standardized and collaborative approach that

will better enable them to carry out their monitoring duties and compliance reporting, and keep DJJ better apprised of what will be monitored and by whom.

**Audit History**

Since the filing of the audit tool in October 2006 through November 2007, the S & W Expert made five facility site visits to a total of three facilities: Heman G. Stark (3 site visits), N.A. Chaderjian, and Preston. The Expert submitted a narrative report dated September 7, 2007, pertaining to these visits and also reported findings at meetings held at DJJ Headquarters. However, in that report, the S & W Expert did not provide specific compliance ratings to specific action items; therefore, DJJ could not quantify the information in an objective manner. Since then, the S & W Expert has used the S & W audit tool starting with his audit of El Paso de Robles in November 2007. To date, DJJ has received audit reports for all of its facilities with the exception of Heman G. Stark. The S & W Expert did not audit DeWitt Nelson due to its announced closure.

In reviewing the S & W audit reports received so far, DJJ would appreciate clarification from the S & W Expert on some of the audit items that did not receive Substantial Compliance regarding what exactly is required from DJJ to come into Substantial Compliance on these audit items and/or a clearer understanding of the methodology used to determine their compliance level rating.

As discussed above in the “Audit Tool” section, there are parties other than the S & W Expert responsible for auditing certain specific S & W action items. The Office of the Special Master has provided several accounts within her quarterly reports that provide compliance ratings for different action items, and the Mental Health Experts have also provided several compliance ratings for the items they are responsible for monitoring within the Safety & Welfare audit tool.

The chart below provides a more detailed schedule of the audits conducted to date or which have been scheduled by the S & W Expert.

	ROUND 1	ROUND 2		ROUND 3	
Facility	Date Audited	Date Audited	Time between Audits	Date Audited	Time between Audits
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 15-16, 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

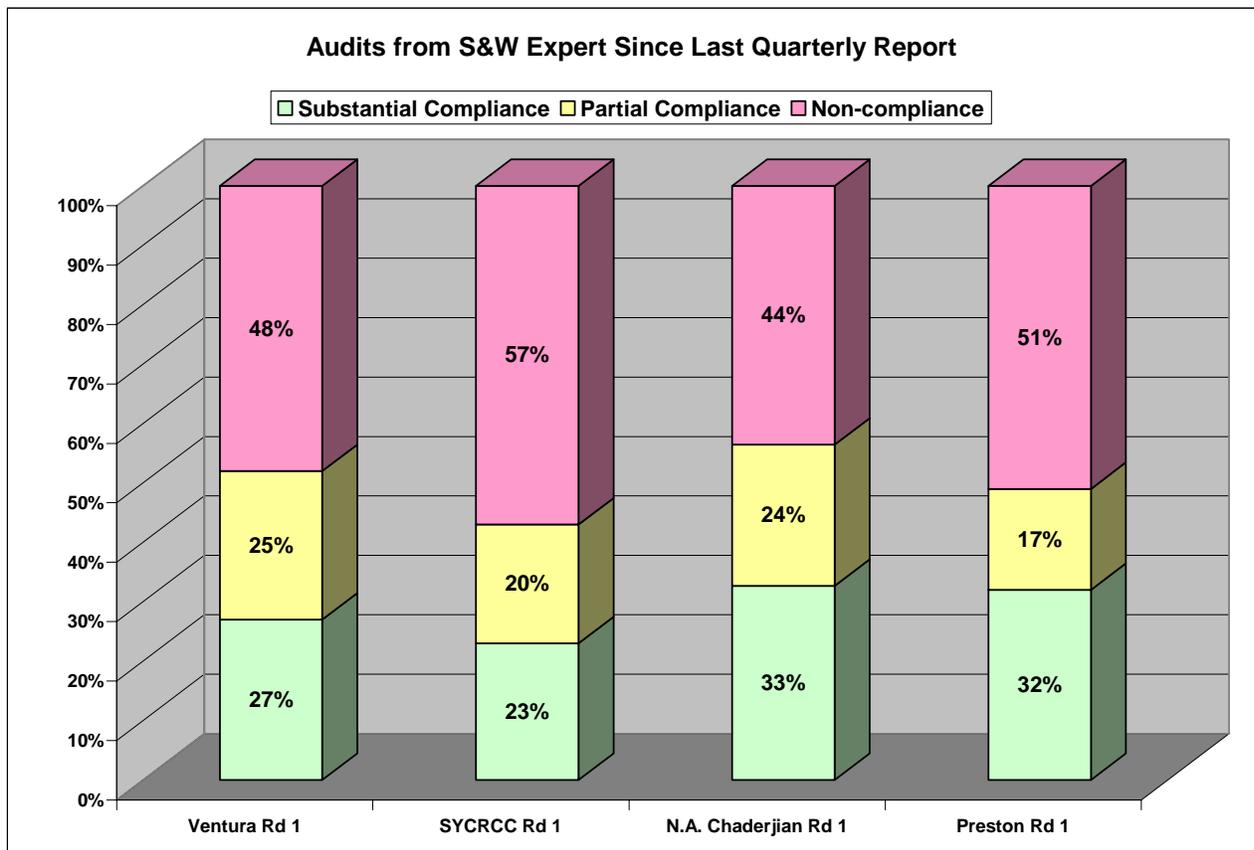
## Future Audit Schedule

The S & W Expert has not yet provided DJJ with an audit schedule for his second round of audits.

### **2.5.2 Most Recent Audit Findings**

#### Audit Reports Received During Last Quarter

Since the last Quarterly Report, the S & W Expert has provided DJJ with four facility audit reports: one each for Ventura, SYCRCC, N.A. Chaderjian, and Preston. The compliance percentages for each of these facilities are identified in the graph below.



**Figure 19: Audits from S & W Expert Since Last Quarterly Report**

What this graph demonstrates are the following:

- Substantial Compliance ratings, ranging from 33% to 23%;
- Partial Compliance ratings, ranging from 17% to 25%;
- Non-compliance ratings, ranging from 44% to 57%; and

- N.A. Chaderjian having the highest Substantial Compliance percentage at 33% and SYCRCC the lowest at 23%.

### **2.5.3 Expert Feedback**

#### **S & W Expert's Noted Areas of Progress / Recognition for Ventura**

- “Chaired by Ms. Brown, this committee includes a cross-section of staff. They meet regularly and review shift reports along with PbS and Com[S]tat data. The committee does look at trends as well as individual cases and develops opportunities for violence reduction strategies.” (RE: *Create Violence Reduction Committees at each facility*)

#### **S & W Expert's Noted Areas of Concern / Suggestions for Ventura**

- “Ventura is using a Use of Force (UOF) policy that was distributed in Dec. 2007. Like most facilities, Ventura is awaiting an updated UOF policy. Currently UOF reports are reviewed by the Watch Commanders, the Chief of Security and the Superintendent. The Institutional Force Review Committee (IFRC) meets twice a month and has minimum of five members, usually as many as 12 members. The minutes from these meetings tend to focus on individual cases, with less emphasis on trend or structural issues. A cursory review of two recent UOF committee reports suggests that the group takes seriously its assignment and does point out lapses in performance as per policy. There did appear to be more than a few instances of UOF employed in situations in which the youth was “defying staff instructions” as opposed to responding to violent incidents. There were also cases in which “spit masks” were employed – rare at other DJJ facilities. There seemed cases in which girls were sprayed in the face with chemicals from three feet away. My impression is that the facility staff do not think that they have a problem with UOF. Given the potential high level of UOF in mental health units, I believe that this matter requires more in-depth analysis. I have asked Headquarters for a 10% sample of all UOF cases from Ventura because I have concerns about excessive and inappropriate force.”

**DJJ Response:** As a result of the concerns from the S & W Expert, the Chief Deputy Undersecretary of DJJ assembled a multidisciplinary team with 120 years of youth correctional experience to visit Ventura from June 3 to June 5, 2008, to assess the facility's use of force incidents. A confidential 52 page report, dated June 23, 2008, on the findings of this assessment was provided to the S & W Expert and the Special Master on June 26, 2008. After receiving the report, the Safety and Welfare Expert complimented DJJ on the quality of the report, especially its executive summary, its interviews with youth, its efforts to capture the Expert's concerns relative to the use of force practices and the recommendations that were made as a result of the assessment.

### **S & W Expert's Noted Areas of Progress / Recognition for SYCRCC**

- “Despite an aging and dilapidated physical plant, SYCRCC is one of the better run DJJ facilities.”
- “The Supt. has begun a very innovative Peace and Unity Campaign that is reminiscent of the principles of Normative Culture. The Supt. Has set the standard that this facility will be safe and gang free.”
- “The youth and the staff talk about safety and respect issues, and they celebrate daily achievements in terms of being incident free. Many youth proudly show off watches that signify a year without any serious DDMS infractions.”
- “My interviews with the youth suggest that the youth feel safe and that there is very good communication with most staff.”
- “During my site visit we observed most youth out of their rooms and involved in group sports.”
- “The Supt. encourages events to celebrate the peaceful nature of the facility. These events include parents and have even included the USXC [sic] marching band.”
- “The facility also gets donations of dress clothes from a local store and the youth are taught dressing skills to help in job interview.”
- “I think that many of the efforts being tried at SYCRCC should get very positive recognition from DJJ management staff and that there are ample opportunities to replicate these efforts elsewhere.”

### **S & W Expert's Noted Areas of Concern / Suggestions for SYCRCC**

- “The administrator for the Sex Behavior Treatment Program is not filled yet. Current program administrator has been on sick leave for an extended period.”
- “According to staff every institution had to make up its own scoring system and there is lots of variability among facilities. The staff seems unclear about how the classification system is supposed to work. Training to date has been limited. The process in the past has been cumbersome, requiring manual tracking of changes. They are looking forward to the classification process being handled by WIN Exchange.”
- “None organized so far. The first one will occur on April 19, 2008. The staff attempt ongoing family counseling but the clinical staff is not around on the weekends with the visits occur. The YCC's do call the parents to discuss individual treatment plans.” (RE: *Family visiting days organized*)
- “The person assigned to this job has not been trained. They are involved in other assignments and are not really function [sic] in this role.”

### **S & W Expert's Noted Areas of Progress / Recognition for N.A. Chaderjian**

- “Youth still reported some safety concerns but far less than in the past.”

- “Joan Loucraft leads this effort at Chad with the assistance of Maria Compos. Training on PbS has been helpful and implementation seems to be going well.” (RE: *Establish PbS Site Coordinator at each Facility*)
- “Accomplished as planned, CHAD staff received excellent training by Doreen Nylund.” (RE: *Male youth classified as high risk for institutional violence separates from low risk youth based on initial classification analysis*)
- “Many activities for A phase wards. There is some attempt to include B phase youth in some of these activities. A’s are encouraged to invite a [sic] B youth to these activities. The staff are giving games and candy to youth in lockup that are showing positive behavior. “Day on the Green” with all youth out for sports activities. They have had a pre-release fair and invited Peace Corps, Americorps, US Army and Books Not Bars to have booths at this fair. (RE: *Volunteer/positive incentive coordinators*)
- “TD is hardly ever used except for court cases. There were two youth in TD on the day of my visit.” (RE: *Each facility maintains electronic log of TD use as specified in interim plan*)

#### **S & W Expert’s Noted Areas of Concern / Suggestions for N.A. Chaderjian**

- “I raised issues about the fact that Chad youth in SMP were wearing jump suits that said “CDCR Prisoner.”
- “There is still uncertainty as to exactly when Chad will become a virtually dedicated Mental Health and Sex Offender facility.”
- “Staff have still not been fully trained and involved in the conversation [sic] from the “Old” Chad that was a very violent and gang-involved facility to one that will be 100% Mental Health or Sex Offender treatment.”
- “There will soon be a transition in management at Chad and there is concern that this issue be resolved quickly.”
- “There is uncertainty as to when the Mental Health unit from Preston will come to Chad.”
- “Meetings once a month, chaired by Rick Flynn. Various staff attend. There are a mix of people involved, including youth residents of CHAD. The biggest issue that has surfaced is the need for more activities and that there is still quite a bit of “dead time” for the youth. No real clear guidance from Headquarters on how this Committee should function. Minimal use of data to inform these deliberations.” (RE: *Create Violence Reduction Committees at each facility*)

#### **S & W Expert’s Noted Areas of Progress / Recognition for Preston**

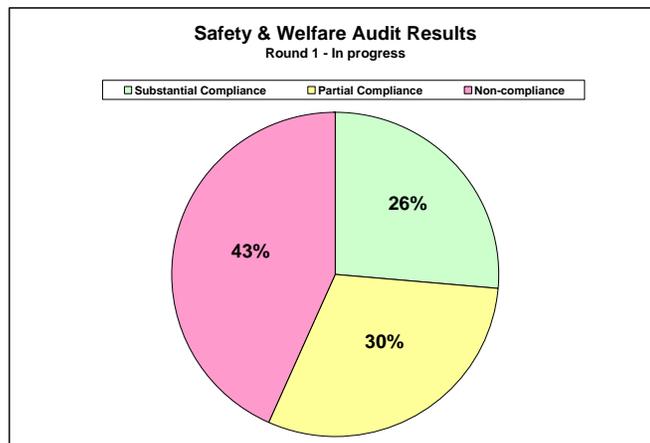
- “On the positive side, staff morale remains high despite the big increase in violence.”
- “The school program gets praise for the youth.”
- “The Crisis Resolution Teams seem to be functioning well and the Impact program is well received by youth and staff.”

- “The staff like the idea of becoming an IBTM facility and look forward to implementing the new Behavior Treatment Programs to help address the violence issues at Preston.”

### **S & W Expert’s Noted Areas of Concern / Suggestions for Preston**

- “The facility has been beset with high levels of violence as youth from closed facilities have been transferred here. The population has gone up providing even greater challenges to staff. The limited living unit options creates other challenges. The school remains the locus of much of the institution[s] violence. You[th] routinely expressed their concern to me about safety issues.”
- “We learned that security staff were denying some youth access to Chapel services even though these youth are attending school together and living in dorms together. I raised this with the Superintendent who promised to fix the situation.”
- “Youth also complained about not getting enough food and being hungry.”
- “In general the staff appear to be somewhat detached from the youth. The youth rarely told me that they talked to staff to help them work through personal issues. Staff at Preston need a heavy dose of training to increase the positive interaction with youth. The young residents also complained that the WGS is not working to help solve problems.”
- “Preston has been ‘on hold’ for some time in which its core mission was not defined. Mental Health units that were to be shifted to CHAD are still at Preston and there has been uncertainty as to whether the institution would be closed.”

### **2.5.4 Cumulative Audit Findings**

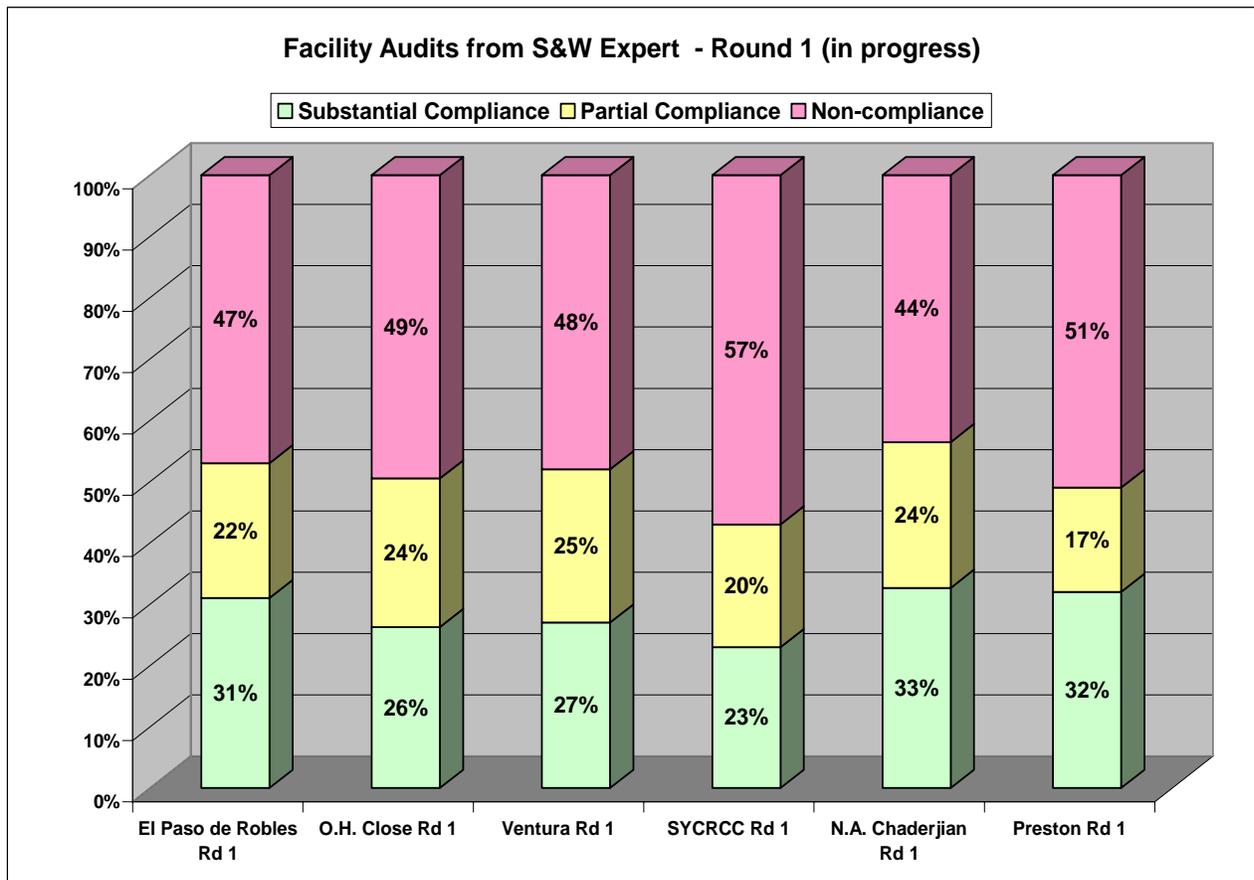


**Figure 20: Safety & Welfare Audit Results: Round 1 – In progress**

To date, according to all of the compliance ratings received from the S & W Expert, the Office of the Special Master and the Mental Health Experts, DJJ is currently at 26% in Substantial Compliance, 30% in Partial Compliance, and 43% in Non-compliance.

**Facility Audit Results from the S & W Expert for Round 1 (in progress)**

To date, DJJ has received six facility audit reports from the S & W Expert. DJJ is still awaiting the S & W Expert’s report on Heman G. Stark. The graph on the following page identifies the compliance percentages for each of the six audited facilities.

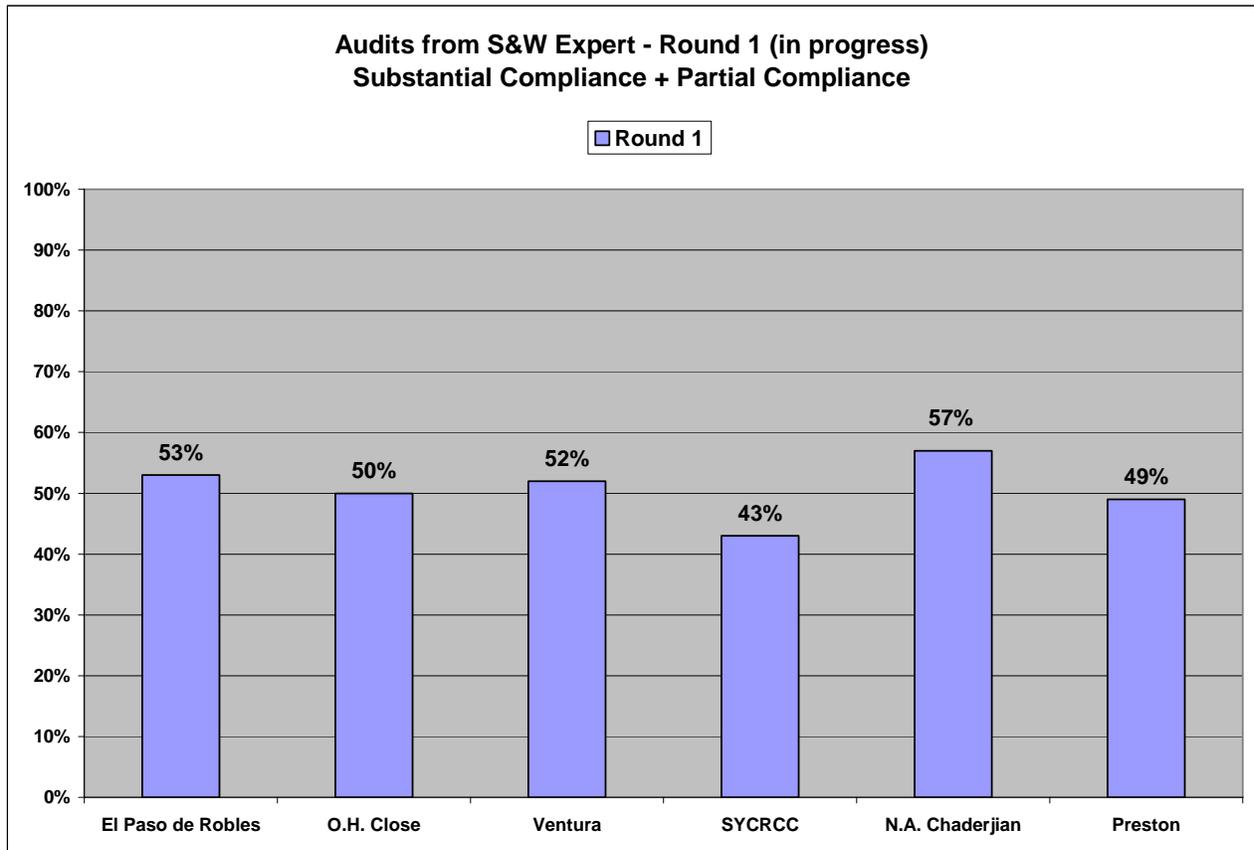


**Figure 21: Facility Audits from S & W Expert – Round 1 (in progress)**

- Substantial Compliance percentage ranges from 33% to 23%.
- Partial Compliance percentage ranges from 25% to 17%.
- Non-compliance percentage ranges from 57% to 44%.
- 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.

### **Substantial + Partial Compliance Percentages by Facility by Round**

The graph below shows the cumulative percentage for both Substantial Compliance and Partial Compliance for each of the six audited facilities to date.



**Figure 22: Audits from S & W Expert – Round 1 (in progress): Substantial Compliance + Partial Compliance**

- The combined Substantial Compliance and Partial Compliance for each facility ranged from 43% to 57%.
- Four of the six facilities had a combined percentage of 50% or greater.
- N.A. Chaderjian has the highest combined percentage at 57% and SYCRCC has the lowest at 43%.

### ***2.5.5 Status of Specific Action Items***

The S & W Expert has completed his first round of facility audits but has not yet provided DJJ with the audit reports for either Heman G. Stark or Headquarters or his annual report. Because this is only the first round of auditing, DJJ is not yet eligible to have any of the action items in the S & W audit tool relieved from further independent monitoring, nor is

DJJ able to identify audit items that are in state-wide Substantial Compliance across every facility or items where the majority of ratings are for Non-compliance. These determinations may not be made until a complete round of auditing has been completed and the data provided to DJJ.

### 2.5.6 Proof of Practice

The following chart identifies the S & W-related Proof of Practice documents that have been sent to the S & W 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 identified action items within the S & W Remedial Plan.

<b>S &amp; W Proof of Practice Documents Submitted During the Last Quarter</b>				
<b>#</b>	<b>Section</b>	<b>Audit Item Description</b>	<b>Documents Submitted</b>	<b>Date</b>
125	2.2-1	"Produce central office organization chart."	10 Central Office organization charts.	5/21/08
128	2.-4a	"Youth informed of changes as appropriate"	A one page memo dated 7/10/07 from Sandra Youngen titled "Policies and Procedures – Notification to Youth."	5/21/08
129	2.-4a	"Master table of contents completed for DJJ policy manual."	A six page document titled "CDCR DJJ PPP&R Unit – The Master Table of Contents."	5/21/08
132	9.1-3	"Consolidated report on SMP use prepared by HQ and sent to S & W expert, Plaintiff's Counsel and Special Master."	Monthly SMP Report for March 2008. As part of the Standards and Criteria, these documents will also be sent to the Plaintiff's Counsel and the Special Master	5/5/08
133	9.1-3	"Consolidated report on SMP use prepared by HQ and sent to S & W expert, Plaintiff's Counsel and Special Master."	Monthly SMP Report for April 2008. As part of the Standards and Criteria, these documents will also be sent to the Plaintiff's Counsel and the Special Master	5/20/08
134	Consent Decree	"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)	A one page email from "Williamsborough Public" dated 4/8/08 advertising SPAR training for Headquarters staff.	5/20/08
135	9.1-5	"Staff trained on new SMP policy."	An email string (last email dated 4/9/08) identifying the status of staff training on the new SMP policy at each facility.	5/21/08
136	8.3-3	"Family visiting days organized"	A one page CDCR "News Advisory" advertising a Family Reunification Concert scheduled for April 19, 2008 at the Ventura Youth Correctional Facility	5/21/08
137	5–5b	"Establish/modify job classifications for treatment team staff – Case Managers"	1.) A three page signed memo dated March 12, 2008 to Superintendents from Sandra Youngen and Amy Seidlitz identifying the duties and responsibilities of hiring the case manager positions. 2.) A three page duty statement for the Casework Specialist (Working title: CASE MANAGER) position.	7/16/08
138	2.2-3	"Designate facility compliance monitors and schedule."	1.) A one page memo from Sandra Youngen to the Superintendents dated 3/17/08 instructing them to designate someone in their facility as the Facility Compliance Monitor(s). 2.) A one page memo from	5/21/08

			Sandra Youngen to Bob Moore dated 4/3/08 identifying the Facility Compliance Monitors at each facility.	
139	4-1b	<i>"Provide training in use of risk/needs tool."</i>	A two page memo from Amy Seidlitz to Superintendents and Parole Regional Administrators dated 4/25/08 with a subject title of "Risk Needs Assessment Training." This memo identifies the initial training sessions in the Risk Needs Assessment.	5/21/08
140	3-4b	<i>"Crisis management training for direct care staff at two facilities."</i>	<b>1.)</b> A one page "Acknowledgement Cover Sheet memo from Bernard Warner dated 1/15/08 with a subject title of "Direct Care Staff Training in Safe Crisis Management (JKM, Training). <b>2.)</b> A three page memo from Amy Seidlitz to Chief Medical Officers, Superintendents, Principals, Regional Parole Administrators and Hearing Officers dated 1/15/08 with a subject title "Direct Care Staff Training in Safe Crisis Management (JKM, Training). <b>3.)</b> A one page spreadsheet identifying the DJJ certified instructors in JKM – Safe Crisis Management.	5/21/08
141	5-4g	<i>"Hire or train trainers – Other programs adopted by DJJ."</i>	<b>1.)</b> A one page memo from Bernard Warner to DJJ Division Heads dated 11/14/07 with a subject title "Staff Training in Aggression Replacement Training (ART). <b>#2.)</b> A one page memo from Bernard Warner to Superintendents dated 11/14/07 with a subject title "Staff Training in Aggression Replacement Training (ART). <b>3.)</b> A three page memo from Amy Seidlitz to Superintendents dated 4/28/08 with a subject title of "Aggression Replacement Training Group Facilitator Certification. FYI -Aggression Replacement Training is a component of the Integrated Behavior Treatment Model.	7/16/08
143	5-4d	<i>"Hire or train trainers – Motivational Interviewing."</i>	<b>1.)</b> A four page memo from Bernard Warner to Chief Medical Officers, Superintendents, Principals, Regional Parole Administrators and Hearing Officers date 11/8/07 with a subject line "Motivational Interviewing (MI) Executive Summit. <b>2.)</b> A one page cover sheet for the "Motivational Interviewing Executive Summit" which identifies the agenda for this meeting. <b>3.)</b> A "Acknowledgement Cover Sheet" from Bernard Warner to DJJ Executive Management Team dated 11/28/07 with a subject line of "Staff Training in Motivational Interviewing (MI). <b>4.)</b> A three page memo from Bernard Warner to Superintendents, Chief Medical Officers, Chief Psychologists, Principals, Regional Parole Administrators, and Supervising Parole Agents dated 11/28/07 with a subject line of "Staff Training in Motivational Interviewing (MI).	7/16/08
	6-7d	<i>"Complete training – Motivational Interviewing."</i>		
144	8.4-7a	<i>"Steps to promote participation in Ward Incentive Plan"</i>	<b>1.)</b> A one page memo from Sandra Youngen to Superintendents dated 5/22/08 with a subject line "Youth Incentive Newsletter." <b>2.)</b> A seven page (colored) issue of the Youth Incentive News, volume 1, Issue 1.	5/22/08
147	2.2-3	<i>"Designate facility compliance monitors and schedule"</i>	<b>1.)</b> A one page memo dated June 3, 2008, from Sandra Youngen to Superintendents with a subject line of "Facility Compliance Monitors." <b>2.)</b> "Compliance Self Assessment Template" (3 pages).	6/11/08
148	2.1-4a	<i>"Youth informed of changes as appropriate"</i>	A one page memo dated June 3, 2008, from Sandra Youngen to Superintendents with a subject line of "Youth Notification of Policy Changes."	6/11/08

150	8.7-1c	<i>"Education Services controls budget and manages purchases"</i>	A one page memo dated June 11, 2008, to Jan Krueger, SSMII, Budget Management Branch, from Lisa Goodwill Program Administrator/Business Manager, DJJ with a subject line of "Budget Allotment Change."	6/12/08
151	8.7-7	<i>"Staff trained on access to courts and law library"</i>	<p>1.) A five page document entitled, "Legal Research, in a nut shell." This document lists the table of contents for this book. Please note that all of the law librarians that attended the training received this book in its entirety, not just the table of contents. 2.) An 81 page document displaying the PowerPoint slides that were used in the law librarian training that was presented by two Sacramento County Public law librarians on March 14, 2007. 3.) A one page listing of the "California Gilmore List, 53060.11." Please note that DJJ is currently reviewing this list to ascertain which reference material appropriately applies to DJJ youth. For example, reference material regarding the death penalty would not apply to DJJ youth. 4.) A one page (front and back) document entitled "Select Bibliography of Juvenile-related Materials at the Sacramento County Public Law Library, March 2007. This document was given to the law librarians. 5.) A one page document entitled, "Juvenile Justice Online Links, March 2007. This document was given to the law librarians. 6.) A two page email string which identifies the law library subjects covered in the March 14, 2007 training. 7.) A two page training sign-in sheet for the law library training held on March 14, 2007. One page is the sign-in of the law librarians from the southern schools and the other is for the law librarians from the northern schools.</p>	6/12/08
152	9.1-3	<i>"Consolidated report on SMP use prepared by HQ and sent to S &amp; W expert, Plaintiff's Counsel and Special Master."</i>	Monthly SMP Report for May 2008. As part of the Standards and Criteria, these documents will also be sent to the Plaintiff's Counsel and the Special Master.	6/16/08
153	3-3b	<i>"Create Violence Reduction Committees at each facility"</i>	A three page Violence Reduction Quarterly Report from O.H. Close dated April 15, 2008 from Yvette Marc-Aurele to Jeff Plunkett.	6/17/08
154	8.7-1c	<i>"Education Services controls budget and manages purchases"</i>	<p>1.) Purchase Order # 61613 dated 5/23/07 (one page) with Attachment A (one page) and Attachment B (two pages). This Purchase Order was for law publications for the sum of \$143,115.76. 2.) Purchase Order # 61614 dated 5/23/07 (one page) with Attachment A (one page) and Attachment B (one page). This Purchase Order was for law publications for the sum of \$224,048.00.</p>	6/18/08
158	8.3-2a	<i>"Family phone contact facilitated w/in 24 hrs of commitment"</i>	A report entitled, "O.H. Close Youth Correctional Facility SB 518, AB 1300, and Safety and Welfare Remedial Plan Item 8.3 Compliance Assessment February 8, 2008"	7/8/08
	8.3-2b	<i>"Ongoing family phone contact facilitated"</i>		
159	8.3-2a	<i>"Family phone contact facilitated w/in 24 hrs of commitment"</i>	A report entitled, "DeWitt Nelson Youth Correctional Facility SB 518, AB 1300, and Safety and Welfare Remedial Plan Item 8.3 Compliance Assessment February 8, 2008."	7/8/08
	8.3-2b	<i>"Ongoing family phone contact facilitated"</i>		
160	8.3-2a	<i>"Family phone contact facilitated w/in 24 hrs of commitment"</i>	A report entitled, "Southern Youth Correctional Reception Center and Clinic SB 518, AB 1300, and Safety and Welfare Remedial Plan Item 8.3 Compliance Assessment May 7, 2008."	7/8/08
	8.3-2b	<i>"Ongoing family phone contact"</i>		

		<i>facilitated'</i>		
161	8.3-2a	"Family phone contact facilitated w/in 24 hrs of commitment"	A report entitled, "Preston Youth Correctional Facility SB 518, AB 1300, and Safety and Welfare Remedial Plan Item 8.3 Compliance Assessment June 11, 2008."	7/8/08
	8.3-2b	"Ongoing family phone contact facilitated"		
162	8.3-2a	"Family phone contact facilitated w/in 24 hrs of commitment"	A report entitled, "Heman G. Stark Youth Correctional Facility SB 518, AB 1300, and Safety and Welfare Remedial Plan Item 8.3 Compliance Assessment March 25, 2008."	7/8/08
	8.3-2b	"Ongoing family phone contact facilitated"		
163	8.3-2a	"Family phone contact facilitated w/in 24 hrs of commitment"	A report entitled, "N.A. Chaderjian Youth Correctional Facility SB 518, AB 1300, and Safety and Welfare Remedial Plan Item 8.3 Compliance Assessment March 13, 2008."	7/8/08
	8.3-2b	"Ongoing family phone contact facilitated"		
164	8.3-2a	"Family phone contact facilitated w/in 24 hrs of commitment"	A report entitled, "Ventura Youth Correctional Facility SB 518, AB 1300, and Safety and Welfare Remedial Plan Item 8.3 Compliance Assessment May 1, 2008."	7/8/08
	8.3-2b	"Ongoing family phone contact facilitated"		
165	7.0	This is general information regarding DJJ's attempts to contract for its female population. This information was provided to Dr. Krisberg at his request during a meeting at DJJ HQ on June 19, 2008.	#1 – Two page document entitled, "Female Offender Request for Proposal Chronology", #2 – Request for Proposal, DJJ.06023, "Secure Residential Placements for Female Youthful Offenders", #3 – Request for Proposals, DJJ.07059, "Secure Residential Placement and Treatment Services for Female Youthful Offenders", #4 – One page document entitled, "Secure Residential Placement and Treatment Services for Female Youthful Offenders – Evaluators List." <b>PLEASE NOTE:</b> This information was provided to Dr. Krisberg on June 19, 2008 at DJJ HQ during a meeting on DJJ's female population. DJJ will forward an electronic copy of this information to Dr. Krisberg as well as sending both a hard copy and electronic copy to the Office of the Special Master.	7/8/08
167	8.3-11b	"Grievance coordinators trained for duties"	Two pages of sign-in sheets for facility youth grievance coordinator training conducted on June 10 & 11, 2008.	6/30/08
171	3-4b	"Crisis management training for direct care staff at two facilities"	#1 – A one page colored graph entitled, "Number of Staff Trained by Subject Area Through June 2008." #2 – An eight page spreadsheet entitled, "Farrell Related Training Data – Training Attendance Report – Aggression Replacement Training." #3 – A nine page spreadsheet entitled, "Farrell Related Training Data – Training Attendance Report – Crisis Intervention and Conflict Resolution." #4 – A 22 page spreadsheet entitled, "Farrell Related Training Data – Training Attendance Report – Motivational Interviewing." #5 – A six page spreadsheet entitled, "Farrell Related Training Data – Training Attendance Report – Training by ORBIS Partners." #6 – An 11 page spreadsheet entitled, "Farrell Related Training Data – Training Attendance Report – Safe Crisis Management." #7 – A 10 page spreadsheet entitled, "Farrell Related Training Data – Training Attendance Report – Understanding and Preventing Suicide."	7/8/08
	3-4c	"Crisis management training for remaining direct care staff"		
	6-7a	"Complete Training: DJJ Integrated Behavior Treatment Model"		
	6-7b	"Complete Training: Risk/Needs Assessment"		
	6-7d	"Complete Training: Motivational Interviewing"		
6-7g	"Complete Training: 'Other key treatment components'"			
172	2.4-1	"Program Manager(s)"	A two page spreadsheet identifying Safety & Welfare positions at each facility.	7/7/08
	2.4-2	"Volunteer Services/Positive Incentive Coordinator"		
	2.4-3	"Vocational Specialists"		
	2.4-4	"Victim Services/Restitution Specialists"		
	2.4-5	"Training Officer"		

	2.4-6	"Conflict Resolution Team(s)"		
	2.4-7	"Work Assignment Coordinator"		
	2.4-8	"Facility Administrator for operations and business services"		
	6-3	"Facility Administrator of Programs"		
173	5-3h	"Establish interim training schedules for motivational interviewing, <b>normative culture</b> , and interactive journaling"	Request for Proposal (RFP) for "Normative Culture." <b>PLEASE NOTE:</b> DJJ is requesting guidance from the Safety and Welfare Expert on this item.	7/16/08
	5-4e	"Hire or train trainers: Normative Culture"		
	6-7e	"Complete training: Normative Culture"		
187	3-5	"Develop and use databases to track violence and use of force"	Eleven packets of COMPSTAT, 1 <sup>st</sup> Quarter, 2008 information. #1 – Roll-up (11 pages), #2 – Preston (13 pages), #3 – DeWitt Nelson (14 pages), #4 – Ventura (12 pages), #5 – SYCRCC (13 pages), #6 – N.A. Chaderjian (13 pages), #7 – Heman G. Stark (13 pages), #8 – O.H. Close (14 pages), #9 – El Paso de Robles (14 pages), #10 – Counting Rules (10 pages), and #11 – Instructions for Staff (11 pages). <b>NOTE</b> – Number of pages excludes coversheets.	7/17/08
188	3-5	"Develop and use databases to track violence and use of force"	PbS Outcome Measure Comparisons for April, 2008 data collection period for DJJ facilities. #1 – O.H. Close Youth Correctional Facility (114 pages), #2 – Heman G. Stark Youth Correctional Facility (114 pages), #3 – Ventura Youth Correctional Facility (114 pages), #4 – Preston Youth Correctional Facility (114 pages), #5 – Southern Youth Correctional Reception Center-Clinic (114 pages), #6 – N.A. Chaderjian Youth Correctional Facility (114 pages).	7/18/08
	3-6a	"Record PbS safety outcome measures 2-4, 11, 12 for every day of year. (Injuries to youth per 100 days youth confinement, injuries to staff per 100 days staff employment, injuries to youth by other youth per 100 days youth confinement, assaults on youth per 100 days youth confinement, assaults on staff per 100 days youth confinement)"		
	3-10b	"Twice yearly reports on staff and youth safety concerns"		
189	9.1-3	"Consolidated report on SMP use prepared by HQ and sent to S & W expert, Plaintiff's Counsel and Special Master."	Monthly SMP Report for June 2008. As part of the Standards and Criteria, these documents will also be sent to the Plaintiff's Counsel and the Special Master	7/18/08

### 2.5.7 Summary and Application of Audit Findings

DJJ is grateful for the S & W Expert's site-specific audit reports because they provide DJJ with valuable information on the progress of each site as the implementation of the Safety & Welfare reforms move forward. This first round of audit data helps to establish a baseline foundation for compliance, and DJJ is committed to demonstrating a pattern of progress much like that achieved by the Education Services and Wards with Disabilities Remedial Plans.

By the same token, DJJ would greatly benefit from a better understanding of the methodology and standards that the S & W Expert relies upon in assessing the compliance ratings of the audit items. This understanding will help to clearly identify what DJJ needs to do to be in Substantial Compliance.

It would also be helpful for all the parties responsible for monitoring the S & W Remedial Plan to coordinate their auditing schedules and develop protocols that address some of the problems currently experienced by DJJ in tracking its S & W compliance.

For example, what is the protocol when DJJ receives two different compliance ratings from two different sets of monitors for the same audit item? The audit tool identifies which set of monitors are responsible for auditing certain audit items; thus, to what degree is this to be followed? What is the expectation for Expert comments on audit items that are rated less than Substantial Compliance?

These are just a few issues that if addressed, would assist DJJ in moving forward with its implementation and its ability to accurately track its compliance progress for 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 was filed with the court on August 25, 2006 and 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 227 audit items associated with the 118 action items. The 227 audit items are the number of compliance ratings DJJ will receive in a typical cycle 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 (227) in relation to the 118 action items.

#### Audit History

The Mental Health Experts recently completed their first facility audit, using the Court-filed audit tool at Preston on July 17 and 18, 2008. DJJ has not yet received the Experts' audit report based on this visit; therefore, any compliance data in this section is the same as reported in the last Quarterly Report. That compliance data was collected via audits of Headquarters-only items by the Mental Health Experts and the Special Master. During these Headquarters audits, the Mental Health Experts and the Office of the Special Master have been able to assign compliance ratings to certain facility audit items based on the information and documentation provided to them during the Headquarters audits.

The chart below is a list of the Mental Health Experts' facility audit schedule to date. In future reports, this chart will also reflect the audit schedule of both the Mental Health Experts as well as the Office of the Special Master for Headquarters.

Facility	ROUND 1	ROUND 2		ROUND 3	
	Date Audited	Date Audited	Time between Audits	Date Audited	Time between Audits
Ventura	NA	NA	NA	NA	NA
SYCRCC	NA	NA	NA	NA	NA
Heman G. Stark	NA	NA	NA	NA	NA
N.A. Chaderjian	NA	NA	NA	NA	NA
O.H. Close	NA	NA	NA	NA	NA
Preston	July 17-18, 2008	NA	NA	NA	NA

### **Future Audit Schedule**

The Mental Health Experts have recently provided DJJ with their audit schedule for their first round of facility audits.

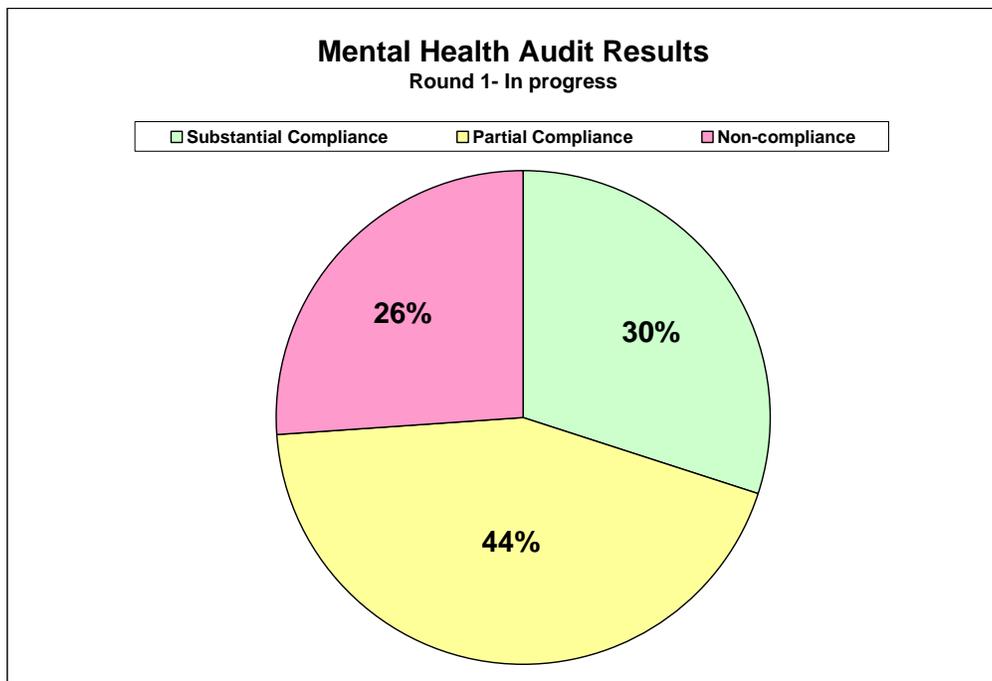
- Ventura Youth Correctional Facility – September 19, 2008
- O.H. Close Youth Correctional Facility – October 16, 2008
- N.A. Chaderjian Youth Correctional Facility – October 17, 2008
- Heman G. Stark Youth Correctional Facility – November 21, 2008
- Southern Youth Correctional Reception Center-Clinic – December 12, 2008

### **2.6.2 Most Recent Audit Findings**

The Mental Health Experts have not provided DJJ with an audit report since the last Quarterly Report.

### **2.6.3 Cumulative Audit Findings**

Even though the Mental Health Experts have not provided DJJ with a facility specific audit report, they, along with the Office of the Special Master, have provided some compliance ratings via Headquarter audits. The graph below identifies the current compliance ratings for the Mental Health Remedial Plan received to date.



**Figure 23: Mental Health Audit Results: Round 1 – In progress**

### 2.6.4 Status of Specific Action Items

The Mental Health Experts have just begun their first round of facility audits under the Mental Health Remedial Plan. As such, DJJ is not yet eligible to have any of the action items within the Mental Health audit tool relieved from further independent monitoring by the Mental Health Experts. Nor is DJJ able to identify audit items that are in state-wide Substantial Compliance across every facility or items where the majority of ratings are for Non-compliance. Such determinations cannot be made until a complete round of auditing has been completed and such data is provided to DJJ.

### 2.6.5 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.

<b>Mental Health Proof of Practice Documents Submitted During the Last Quarter</b>				
#	Section	Audit Item Description	Documents Submitted	Date
125	3-1	"Central office organization chart – incl MH chain of command."	10 Central Office organization charts.	5/21/08
130	3-3	"Establish dispute resolution protocol"	A two page signed memo dated 12/14/07 titled "Protocol for Handling Disagreements Between Facility and Health Care Staff."	5/21/08
134	Consent Decree	"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)	A one page email from "Williamsburgh Public" dated 4/8/08 advertising SPAR training for Headquarters staff.	5/20/08
145	5-3	"Develop & implement policy regarding forensic evaluations"	1.) Draft policy copy of the "Forensic Evaluation – WIC 1800/1800.5 (21 pages). 2.) "WIC 1800 Referral Form" (1 page). and, 3.) "Forensic Evaluation Summary" (1 page).	6/10/08
146	8-1b	"Coordinate psychopharmacological policy with HC Services Plan"	1.) Policy draft of the "Treatment Guidelines in Psychopharmacology (21 pages), 2.) Appendix A (2 pages), 3.) – Appendix B (2 pages), 4.) Appendix C (2 pages) and 5.) "Course of Treatment Consent for: Attention Deficit Hyperactivity Disorder" form (2 pages).	6/10/08
149	4-7	"Develop and implement structured clinical assessment for psychosis"	Psychosis Screening Questionnaire	6/11/08
156	8-1b	"Coordinate psychopharmacological policy with HC Services Plan"	A one page form entitled, "Abnormal Involuntary Movement Scale (AIMS)"	6/20/08
166	12-1	"Add or appoint senior administrator for plan implementation"	A one page memo dated June 18, 2007 from Ed Morales, M.D., with a subject line of, "New Administrative Lead for Farrell Implementation Plan."	7/3/08

168	5-20	<i>“Collaborate with DMH to expedite transfers and facilitate transitions”</i>	Two sets of documents entitled, “Record of Meeting Joint DJJ/DMH Quarterly Meeting.” One set is dated January 30, 2007 and the other set is dated August 28, 2007.	7/3/08
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**2.6.6 Summary and Application of Audit Findings**

DJJ is looking forward to receiving the Mental Health Experts facility audit reports. These reports will provide valuable information that DJJ can use to better meet the requirements established in the Mental Health Remedial Plan. The Division’s Mental Health team and the Mental Health Experts have worked closely as of late on such important policies as the WIC 1800/1800.5, SPAR, and Psychopharmacology. The Division’s Mental Health leadership has enjoyed a positive working relationship with the Mental Health Experts and will work to strengthen that relationship and work collaboratively as it moves forward in implementing the Mental Health reforms.

### 3 COMPLIANCE WITH DATES

#### 3.1.1 Section Purpose

This section documents progress achieved during the reporting period in completing the action items within the six *Farrell* Remedial Plans by the agreed-upon due dates. The following table indicates the total number of action items per plan and the total number of action items that have due dates:

Remedial Plan	Number of Action Items	Number of Action Items with Due Dates
Education Services	115	12
Sex Behavior Treatment Program	52	0
Wards with Disabilities Program	122	25
Health Care Services	205	0
Safety and Welfare	227	225
Mental Health	118	118
<b>Totals</b>	841	380

#### 3.1.2 Managing the Due Dates

In the April 2008 Quarterly Report, this section (Section 2) contained an evaluation of the action item due dates provided for in each of the six *Farrell* Remedial Plans. The evaluation found that a significant percentage of the remedial plan items were linked with due dates and estimated that the action item would be completed within 18 months from the related plan filing date. The evaluation explained that many of the original due dates were established

. . . at a time when it is acknowledged that DJJ lacked the administrative capacity to create the changes outlined in these plans and lacked the project management tools necessary to accurately predict project completion dates. As a consequence, most of the due dates were extremely optimistic and often unrealistic.

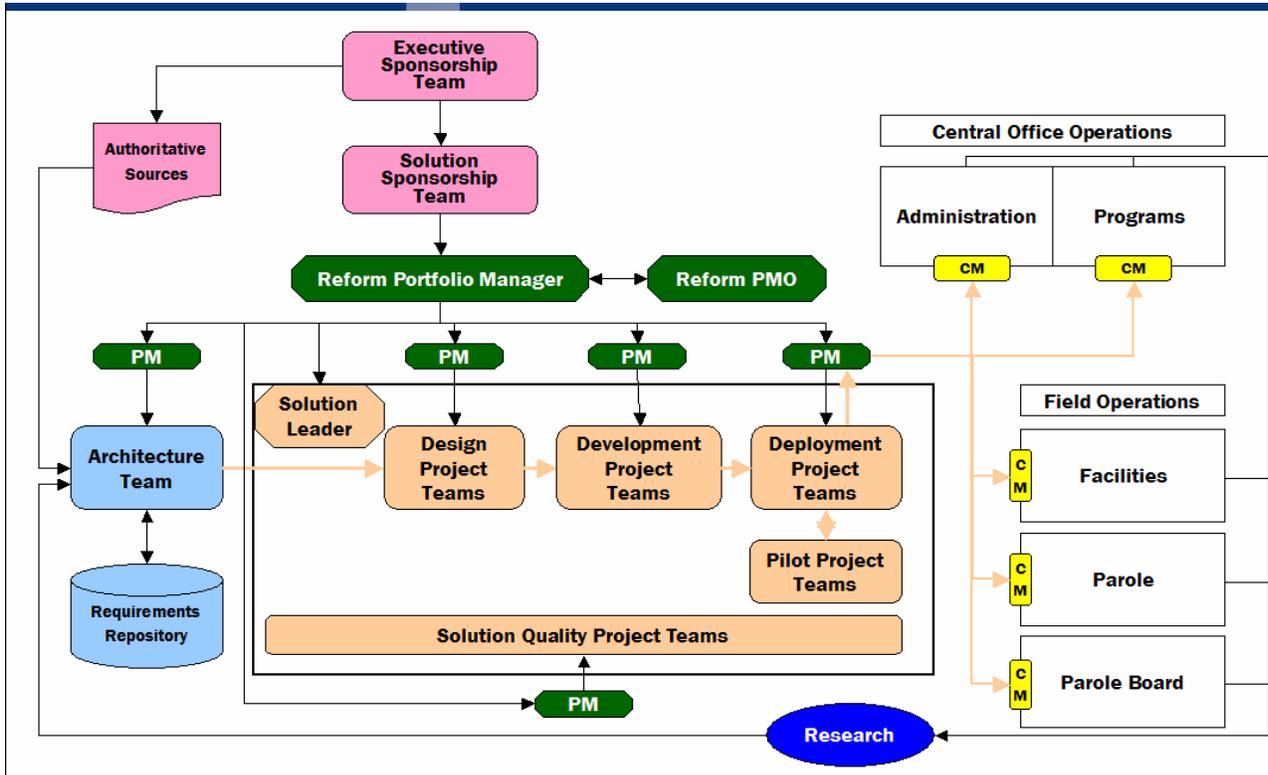
As reported last quarter, the DJJ Management team worked to estimate new dates for a number of high priority items using an estimation model. Several of the identified priority items were subsequently completed and transitioned to the audit review and verification of compliance stages. Additionally, DJJ Management “. . . committed to performing a full project planning process,” resulting in a structured planning process to guide completion of all action items. The electronic schedules for the formal planning process are in place but are not yet populated with all the work that have been identified for the completion of all action items.

During this quarter, DJJ initiated efforts to establish a process to revise due dates that have not yet been met and provide amended due dates based on the structured project planning process. However, thus far, this date-revision process is not yet in place; therefore, no target completion dates have been reset for any of the items identified in the six *Farrell* Remedial Plans.

The structured planning process has been designed and significant effort is now underway to make sure that all the action items are traced to planned work. Though the creation of the integrated schedule is not yet complete, the structure of the schedule is designed to ensure that the status of action items defined in the remedial plans are capable of being reported on. A more complete explanation of the structure and the method by which we will be able to report on action item status once the plan is completed is included in section 2.2.

### **3.1.3 Explanation of Schedule Structure**

The schedule of planned work, also known as the Master Portfolio Schedule, is designed to include all the tasks and deliverables that are required to complete implementation of all *Farrell*-related action items. The schedule allows for other work to be included so that DJJ can confirm that it has the necessary resources and staff to accomplish the work. In order to explain how the structure supports the *Farrell* Action Item status, a background explanation of the structure is required. A diagram of the project management structure is on the next page.



**Figure 24: Project Management Structure**

To create an integrated plan, all the action items (841 total from all six *Farrell* Remedial Plans, known as the Farrell Remediation Requirements) are being identified as a set of Authoritative Sources. The Architecture Team reviews the source items (inclusive of the action items) to extract requirements and then groups the related requirements into solution projects through a process called “architecture.” The architecture process entails the following:

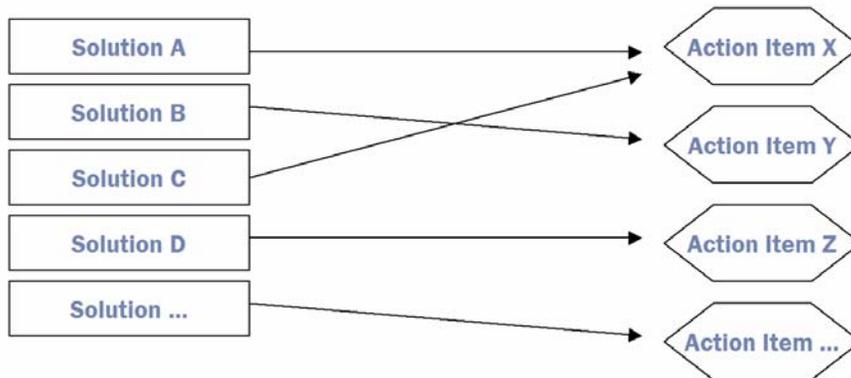
1. **ASSESSES** how each requirement should be implemented;
2. **IDENTIFIES** which requirements are similar and should be implemented at the same time;
3. **COLLECTS** and **COLLATES** the requirements together into related groups so that the implementation can be more efficient; and
4. **ORGANIZES** these groups into “Solution Projects”, defining and documenting the needed solution in a Solution Charter.

The Solution Charter provides the team with information defining the scope and purpose of the Solution Project and specifically identifies the source requirements that will be fulfilled with the completion of the project. The Solution Charter is then given to and used

by DJJ staff assigned to implement the solution project (the Solution Team), led by a Solution Leader. The team uses the Solution Charter information to design the solution. The Solution may include work such as creating, updating, or revising a policy or procedure; creating an information technology solution; hiring staff; adding or updating training; or issuing a contract to support the requirements. The team then continues to perform the required work in order to complete the development of the items designed. It also prepares tasks in anticipation for the deployment and implementation of the solution into the targeted environment. Change Managers serve the role of keeping the process smooth. The Solution Quality team ensures that the requirements are met throughout the design, develop, and deployment cycle. In some cases, a pilot project may be executed to test the steps and planned processes before it is implemented in all facilities.

In the Master Portfolio Schedule, each solution project is included with the tasks and deliverables that must be performed to complete the solution. Any project dependencies that may exist, which requires one project to be completed before another begins, are also reflected in this schedule.

Each action item identified in the six *Farrell* Remedial Plans (for a total of 841) has also been added to the schedule as a milestone task for tracking purposes. Each of these action item milestones is to be linked as a successor task to all the solution projects that must be completed in order to implement the action item. This structure allows for any one action item to be dependent on one or more solutions within the overall plan. For example, in the following diagram, Action Item X requires Solutions A and C to be complete, while Action Item Z is only dependent on Solution D. Therefore, Action Item X will not be marked complete until both Solution A and Solution C are complete.



**Figure 25: Solution Diagram**

DJJ can use this structure to identify when a particular action item should be complete based on the latest completion date of all the solutions it is dependent on. For example, if Solution A will be complete in November 2008, but Solution C will not be complete until

May 2009, then we can say that Action Item X will not be complete until May 2009, the later of the two due dates.

Tracing back through this linking structure identifies the work required to implement any action item. For example, to know what work is required to implement Action Item Y, one can trace the dependency to see that Solution B is the only work required.

## 4 ACTIONS TAKEN

### 4.1 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 implementing the Education Services Remedial Plan during the reporting period include:

- **Education Managers and School Principals Meeting** (*Education Services Standards & Criteria (all)*)

On June 2 and 3, 2008, the Education Managers and School Principals held a meeting/training in conjunction with the Education Experts. The purpose of the meeting was to review, item-by-item, the *Education Standards & Criteria* (audit tool) to ensure consistency across all DJJ schools in the data collected and prepared for submission to the Education Experts at site audits. Consensus was achieved, ensuring that all school sites will present the Education Experts with uniform Proof of Practice information which will be collected, organized, and formatted consistently. Future meetings will be scheduled as needed.

- **Access to (Hardcopy) Law Library** (*Safety and Welfare Standards and Criteria, Item 8.7.1b, 8.7.1c, 8.7.2, 8.7.5, 8.7.6a, 8.7.7*)

All school sites have law books and Nolo Press self-help editions available on shelves in the facility's hardcopy library. All school sites posted signs within this reporting period to notify youth of the law library resources and their location. These tasks were completed on June 30, 2008 and confirmed via emails and telephone calls by all principals to Education Headquarters on July 3, 2008.

- **Teacher Monitoring Standards & Criteria Item(s)** (*Education Services Standards & Criteria Item 4.2*)

DJJ Education's past practice was to monitor and assess each individual teacher's performance on an annual basis. The Principal's Monthly Reports also reported critical incidents and other concerns that may have occurred unexpectedly. When teacher performance was at issue, action by Education

management was taken to insure DJJ and education standards were met.

As the Education Services Remedial Plan requires quarterly formal teacher monitoring and assessment, during the meetings of managers and principals on June 2 and 3, 2008, Education management directed all school principals to develop a schedule and to consistently conduct quarterly classroom observations based on a rubric aligned with the California Standards for the Teacher Profession (CSTP). Education management will monitor compliance with this directive via the Principal's Monthly Report.

- **Cooperative Agreements to Ensure Students' Attendance – Headquarters** (*Education Services Standards & Criteria Item 3.16*)

On May 31, 2008, a cooperative agreement addressing student attendance was signed by both the Director of Programs and the Director of Facilities. It was settled that, in cases in which disagreement arises over educational access between Facility Superintendents, Principals, and/or the Chief Medical Officers, the following protocol will be followed:

1. The Superintendent, the Principal, and the Chief Medical Officer shall meet to resolve the issue;
2. The meeting will take place within one (1) business day. If the Superintendent, Principal, or Chief Medical Officer is absent, the Acting person(s) will meet; and
3. If the parties cannot resolve an educational access issue, it will be sent to the Director of Facilities and the Director of Programs at Headquarters for resolution.

Within this agreement, direction to resolve educational access issues is authorized to site Superintendents, Principals and Chief Medical Officers. As this overarching agreement is all that is needed to resolve this issue at the facility level, it is not necessary to have specific individual site agreements.

- **Behavior Management System in all Classrooms** (*Education Services Standards & Criteria, Section III, Item 3.33*)

The Education Services Remedial Plan requires a written policy, procedure, and practice to provide a structured positive behavior management system in each classroom statewide. The Safety and Welfare Remedial Plan mandates a Ward Incentives Plan, which incorporates positive incentives for acceptable behavior and participation in education and rehabilitation programming. To comply with these requirements, DJJ staff developed the Youth Incentive Program as the designated structured positive behavior management system

that will be used in all classrooms, facility programs, and custody operations.

The policies and procedures supporting the Youth Incentive Program are scheduled for Executive review in August 2008. After Executive approval, training of DJJ staff for the implementation of the program is projected to begin during the next reporting period.

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

Under the direction of DJJ Education Headquarters, the Alternative Behavior Learning Environment (ABLE) will be staffed and operational at all youth correctional school sites when the school-year resumes in August 2008.

Currently, all schools, except N.A. Chaderjian High School and Lyle Egan High School (Heman G. Stark), are ready to implement ABLE Classrooms. Emails from N.A. Chaderjian HS on June 18 and Lyle Egan HS on June 20, 2008, confirmed that their ABLE Classroom will be staffed and operational as directed.

The Mentor Teachers, composed of representatives from all DJJ schools, developed the program design for ABLE. The Mentor Teachers, working closely with the ABLE Teachers, provide training and consultation. The Mentor Teachers present information on the ABLE process at site staff meetings as needed. The Mentor Teachers will evaluate ABLE data in the fall of 2008, then, based on this evaluation will revise the program as needed and subsequently provide training at each school.

## 2. Items In Progress

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

Interviews were conducted for the Superintendent of Education position in July 2008. Background checks are being completed for two potential candidates.

- **Access to Electronic Law Library** (*Safety and Welfare Standards and Criteria, Item 8.7.1b, 8.7.1c, 8.7.2, 8.7.5, 8.7.6a, 8.7.7*)

DJJ Education is awaiting approval of a memo sent on June 11, 2008, to the CDCR Budget Management Office requesting that \$150,000 be transferred from the Facilities budget to the Education budget for the management of the electronic law library. Due to year-end fiscal management constraints, the project timeframe of completion of the budget transfer is August 2008.

DJJ is reviewing its budget to determine if there is sufficient funding to both keep the hardcopy library up-to-date and purchase an electronic law library system. DJJ management is currently working to address this issue.

Education staff met with representatives from LexisNexis on July 7, 2008, and with Westlaw on July 8, 2008. Multiple electronic communication solutions were discussed, including DVD stand-alone, server-based over the Wide Area Network (WAN), or the Internet. By July 20, 2008, both LexisNexis and Westlaw submitted quotes which included amounts for various solution options.

Seeking a three-quote option, Education staff had also invited Academy Computer Services, Inc., to present their electronic law library solutions. When they did not respond to their original invitation, Education sent a second request but, to date, has not received a response.

DJJ is reviewing and updating the list of materials needed in its law libraries. Once DJJ finalizes a list of law materials, Education will be able to finalize their electronic law library cost estimates. Education will continue to research possible electronic solutions and, once all vendors have had the opportunity to present their respective products and services, will submit a recommendation for EIS review.

As some of the electronic library software accesses legal information through the Internet, downloading of a CD, or utilizing a portable hard drive, the potential for unauthorized access to the Internet by youth continues to pose security issues. DJJ will be working with the IT security staff within EIS to ensure the recommended electronic library solution meets CDCR-DJJ security and access criteria and is not labor intensive to maintain. EIS will evaluate suggested electronic law library solutions to ensure all security issues are addressed and resolved. No solution will be purchased without the approval of EIS. Once an electronic law library solution is identified which meets Legal, cost, EIS, and IT Security criteria, a recommendation will be submitted for Executive review and approval.

- **Distance Learning Courses – Instructional Education** (*Education Services Standards & Criteria, Section IV, Item 4.16, 4.17, 4.18*)

Distance Learning (DL) courses for high school graduation meet Content Standards for California Public Schools. DJJ education courses must meet content standards for credits to be issued. DJJ's lessons, as designed and taught, provide learning activities that comply with content standards for California public schools.

All schools are able to connect, with limited bandwidth, to DJJ Headquarters. Currently, the DL network could potentially use all the available bandwidth connecting a DJJ facility's network, risking the facility's network performance. To prevent loss of network performance for essential functions such as, email, WIN, and other network services, the DL systems resources were limited to running at a lower than optimal bandwidth.

These limitations result in poor quality video performance and the capacity to conduct only one class at a time. It also restricted which schools could participate in the DL class.

Resolution of bandwidth and configuration of the T-1 lines are still needed. DJJ and EIS are working together to increase the bandwidth of the WAN to provide for more classes. The T-1 lines have been installed, and EIS is also installing DS-3 lines that will provide increased bandwidth.

Increasing the bandwidth will allow more classes to run at the same time and the video quality will be enhanced.

## 4.2 Health Care Services Accomplishments

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### 1. Health Care Services Significant Accomplishments

Significant accomplishments in implementing the Health Care Services Remedial Plan include the following:

- **Medical Care** (*Health Care Services Standards and Criteria, p. 16*)

Based upon the request of the Health Care Experts, DJJ contracted with a Dental Expert, Dr. Donald Sauter, to assist in assessing the dental services within DJJ. A draft audit tool was developed and the Dental Expert conducted the first audit-testing of the draft Dental Audit Tool at the NCYCC from June 3 through June 5, 2008. DJJ Health Care Services staff, in consultation with the Dental Expert and the Health Care Experts, are reviewing the Dental Audit Tool in reference to the test findings.

- **Health Care Organization, Leadership, Budget, and Staffing** (*Health Care Services Standards and Criteria, p. 1*)

Health Care Experts completed their audit of Health Care Management (headquarters) June 4 and 5, 2008. DJJ anticipates that the Health Care Annual Report will be released within the next reporting period.

- **Quality Management** (*Health Care Services Standards and Criteria, p. 37*)

Through their respective Quality Management Committees, all facilities developed Corrective Action Plans (CAPs) based on the results of their facility audits.

- **The Physical Assessment, Nursing Process and Documentation Course** (*Health Care Services Standards and Criteria, p. 14*)

Nursing Physical Assessment classes were developed and commenced in April 2008. The classes include basic physical assessment, nursing process, documentation, and patient education. This course is for all DJJ Registered Nurses (RNs). The class is a week-long didactic and practical course that is taught by DJJ Nurse Instructors and is based on the adaptation of the CDCR Physical Assessment course, which includes adolescent health assessment and correctional medical management issues. The physical assessment class teaches nurses to conduct a general physical examination at a level that is appropriate for RNs that practice in a primary care setting. The RNs learn

assessment practices in order to yield a determination of an abnormal health problem that requires higher level assessment and diagnosis by a physician or nurse practitioner. The course also includes training on nursing standards of practice for the provision and documentation of nursing care based on the Problem Oriented Medical Record methodology.

As of June 30, 2008, 49 of the 115 RNs in all DJJ youth correctional facilities, or 43% of all RNs, have completed the full Nursing Physical Assessment Training Course.

## **2. Items in Progress**

Items in process toward in implementation of the Health Care Services Remedial Plan include:

- **The Physical Assessment, Nursing Process and Documentation Course** (*Health Care Services Standards and Criteria, p. 14*)

As of July 1, 2008, 66 of the 115 RNs in all DJJ youth correctional facilities, or 65%, have yet to complete the full Nursing Physical Assessment Training Course. The classes are intensive and require small class sizes taught by DJJ Nurse Instructors and the Nurse Consultant; therefore, not all RNs will complete the course until the end of 2008 or the first quarter of 2009.

Further training will be provided as identified for follow-up audits of nursing practice and documentation, as conducted by the Supervising Registered Nurses and the Statewide Director of Nursing. It is planned that newly hired RNs will receive training from the same course once each quarter, beginning the second quarter of 2009. These courses will assess nurse competence in basic skills and physical assessment as well as the nursing process and documentation requirements of DJJ.

A potential barrier to completion is delays in the authorization of the State Budget Act, which limits DJJ's ability to incur operating costs, including travel expenses for the sake of attending training.

- **Nursing Protocols** (*Health Care Services Standards and Criteria, p.6, 14*)

A meeting was held between the Health Care Experts and Health Care Services regarding how to best implement the nursing protocols required by the Remedial Plan. Further meetings are anticipated during the third quarter.

- **Vision Testing and Eyeglass Procurement Policy** (*Health Care Services Standards and Criteria, p. 10*)

The draft Vision Testing and Eyeglass Procurement Policy includes the

process of having a patient read far and near vision charts, then sending those that demonstrate vision problems for an exam to determine the appropriateness and need for prescribed glasses. It also includes the procedure for ordering the glasses. The policy has been drafted and forwarded to DJJ's Policy, Procedures, Programs, and Regulations Unit (PPPRU) for initial formatting and approval.

Policy that was developed by the Director of Nursing was returned from the PPPRU to the Director of Nursing with a number of requested revisions. Once the revisions were incorporated, the policy draft was returned to the PPPRU on July 10, 2008.

There appear to be no barriers to completion at this time. Some of the next steps are for the PPPRU to review and forward the revised policies for the vetting process.

## 4.3 Mental Health Remedial Plan Accomplishments

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### 1. Mental Health Remedial Plan Significant Accomplishments

The Mental Health Remedial Plan, the last to be filed with the Court, was filed on August 25, 2006, and the related standards and criteria document was filed on December 14, 2006. Significant accomplishments in the implementation of the *Farrell* Mental Health Remedial Plan during the 2<sup>nd</sup> quarter of 2008 include:

- **Suicide Prevention Assessment and Response (SPAR) Policy & Implementation; Staff Trained on New Policies; Youth Informed of Changes as Appropriate.** (*Mental Health Standards and Criteria Items, 6.1; 8.1a4.; 8.1a5*)

The SPAR Policy was reviewed by the Mental Health Experts, Health Care Services, and DJJ Legal Services in June 2008.

Discipline-specific SPAR Pilot training developed for facility staff and for mental health staff was provided. Training was provided at DJJ Headquarters to a target audience of Headquarters Peace Officer Classifications, Medical and Mental Health Clinical Staff and Education Managers on April 22 and 23, 2008. A make-up session was also held on May 8, 2008. All staff having direct contact with youth at Chaderjian was provided formal training before implementation of Phase I of the SPAR Pilot program. Although dates for these trainings are not available, mental health staff provided multiple, informal ad hoc training sessions in the facility.

Youth affected by the pilot program were provided training during the pre-scheduled Large Group Meetings during March and April 2008.

Phase I of the SPAR Policy Pilot Program was conducted at N.A. Chaderjian from April 1 through June 2, 2008.

Multidisciplinary meetings to review the progress of the pilot, provide additional training, and initiate changes in policy or procedures when needed, were held on April 8, 22, 23, 25, and 30, May 3, May 13, and June 17, 2008.

Meetings between Information Technology Services and Mental Health occurred on May 14 and May 19, 2008. A plan to develop a Mental Health Tracking System that will include SPAR documentation and tracking was discussed.

Mental Health Experts conducted an on-site visit at N.A. Chaderjian on June 6, 2008. Data from the Phase I SPAR Pilot Tracking Log were provided to them at that time.

Meetings were held with DJJ contractors, Delegata and the Strategic Management Center of Excellence on June 10, 11, 12, 24, and 25, 2008, to review progress on the SPAR Project Management Plan. Additional meetings have also been scheduled.

Phase II of the SPAR Pilot Program began on June 2, 2008, and is anticipated to end on July 15, 2008. During this phase, an evaluation of Phase I will be conducted, policy and/or procedures will be revised, and the forms and logs will be updated to support the changes.

A teleconference occurred between Mental Health Services and the Mental Health Experts on June 23, 2008, wherein policy and procedure revisions were discussed, and agreement was reached on a new statewide SPAR Policy implementation date of February 2009.

Multidisciplinary meetings to define “Lessons Learned from Phase I of the SPAR Pilot Program” occurred June 29, 2008.

Meetings have been scheduled with Information Technology Services on July 3 and 10, 2008, in order to improve WIN Exchange support for documentation and information tracking required by the policy.

Phase III of the pilot program is in the early stages of development. During this phase, the revised SPAR Policy will be implemented during a short-term pilot program in anticipation of the statewide implementation.

The policy will be submitted to all relevant Bargaining Units for review and comment when the revisions are complete.

The SPAR Policy is on track for statewide implementation in February 2009.

- **Organization Charts for each Facility** (*Mental Health Standards and Criteria Item, 3.2*)

The organizational chart addressing the facility Mental Health chain of command was approved by the Director of Programs on May 30, 2008. In addition, a template was developed and sent to the facilities by Health Care Services to complete an organizational chart at each facility.

- **Automated Mental Health Tracking System** (*Mental Health Standards and Criteria Items, 4.1 and 6.4*)

Mental Health tracking data, developed in collaboration with the Office of the Special Master and the Mental Health Experts, continues to be collected manually and provided according to timelines established.

In meetings on May 14 and 19, 2008, Mental Health Services provided Information Technology Services with a specific, prioritized list of IT support needs required for the collection of data and development of reports. A meeting is scheduled for July 1, 2008, to discuss Information Technology Services' budget and staffing requirements to develop a Mental Health tracking system.

- **Outpatient Mental Health Staffing Consistent with Plan; Hiring Outpatient Psychologists and Psychiatrists** (*Mental Health Standards and Criteria Items, 5.11 and 6.3*)

All funded and allocated psychiatrist positions remain filled. Limited term restrictions on psychologist positions have been lifted. Interviews began on June 23, 2008, at N.A. Chaderjian and will continue throughout July 2008 to hire for the psychologist positions.

A meeting between Mental Health Services and DJJ Operations Support Services occurred on June 26, 2008, to determine the number of allotted psychologists' positions available. A follow-up meeting was scheduled for July 3, 2008.

Facility closures were completed on June 30, 2008. Reallocation of staff and reclassification of limited term positions are in the early stage of finalization.

- **Psychopharmacology Policy** (*Mental Health Standards and Criteria Item, 6.5*)

The final draft of the Guidelines for Treatment with Psychopharmacologic Agents policy was completed in April 2008 and is being reviewed by Health Care Services and the Mental Health Experts. Comments will be addressed and the policy submitted to the Wards with Disabilities Program expert and Medical experts for comment before executive review and approval. Curriculum development will be scheduled when all reviews are complete.

- **Development of Mental Health Policies and Procedures** (*Mental Health Standards and Criteria Item, 6.6*)

Mental Health policies have been prioritized for development according to the Mental Health Policy and Procedures Table of Contents approved by the Mental Health Experts. Priority I policies are on track for completion for development by December 2008, Priority II policies by June 2009, and Priority III policies by June 2010.

- **Policy/Process to Receive and Share Mental Health Information with Counties; Consultation with Local Government Entities** (*Mental Health Standards and Criteria Items, 4.2, 4.2a, 4.3*)

A newly developed Summary of Care form was provided to Parole Services for review and comment by Parole Services and county facilities on July 3, 2008. One hundred percent of the Mental Health records of youth arriving at DJJ are currently being reviewed by the Chief of Mental Health.

- **MAYSI-2** (*Mental Health Standards and Criteria Item, 4.5*)

As of June 2008, all youth are being given the MAYSI-2 on intake with results available to clinicians within 24 hours.

- **Develop and Implement Structured Tool for Clinical Assessment of Psychosis** (*Mental Health Standards and Criteria Item, 4.7*)

The Psychosis Screening Tool was accepted by the Mental Health Experts in June 2008. Screening for psychosis will be started when the Integrated Assessment Policy is implemented. The date for implementation of this policy is June 30, 2010.

- **Analyze Efficacy Of Screening And Assessment Tools** (*Mental Health Standards and Criteria Item, 4.8*)

All proposed initial screening tools have been nationally validated or accepted by the Mental Health Experts for use. Youth Assessment Screening Inventory (YASI) has recently been developed and will be validated.

- **Develop Treatment Hierarchy** (*Mental Health Standards and Criteria Item, 5.2*)

- A Treatment Hierarchy has been developed and has had an initial review by the Mental Health Experts. Finalization of the Treatment Hierarchy is ongoing.

- **Develop and Implement Policy Regarding Forensic Evaluations** (*Mental Health Standards and Criteria Item, 5.3*)

The Forensic Policy - WIC 1800/1800.5 Policy and all required forms have been developed by Mental Health Services and were submitted to the Mental Health Experts, Juvenile Parole Board, and Health Care Services for review in June 2008. Final revisions are underway and implementation is on track for March 2009.

- **IBTP Treatment Program** (*Mental Health Standards and Criteria Item, 5.13b*)

One additional Intensive Behavior Treatment Program (IBTP) has been developed at Heman G. Stark. Opening of the unit is awaiting negotiations with the Bargaining Units. Training for new staff has been developed.

- **Further Reduce Size of Mental Health Treatment Units** (*Mental Health Standards and Criteria Item, 5.15*)

On June 30, 2008, the maximum census for Intensive Treatment Programs (ITP), Special Counseling Program (SCP), and Intensive Behavior Treatment Program (IBTP) units were restricted to a population of 24, 24, and 16 youth respectively. The actual census will be reduced by attrition rather than through discharge of the youth. On June 30, 2008, the census on the IBTP unit was at or below the 2008/2009 census. Three of five ITP mental health units and four of five SCP mental health units were at or below the 2008/2009 census.

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

The Quarterly meeting with the Department of Mental Health (DMH) was held in May 2008, with emails between DJJ Mental Health and DMH administrators on May 23, 25 and 29, 2008. The purpose of these meetings was to collaborate and expedite transfers and facilitate transitions.

- **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; 5.24*)

All northern California male youth are currently being treated for acute care through a contract with Sierra Vista Hospital. Northern male youth are currently being treated for Intermediate Care Facility (ICF) care through

contract with the Department of Mental Health at SYRCC. Northern California females under 18 years of age are currently being treated at the Correctional Treatment Center (CTC) for acute care. Females over 18 years old are currently being treated for ICF care at the CTC.

- **Acquire Professional Journals and Publications for Each Facility** (*Mental Health Standards and Criteria Item, 6.9*)

Psychiatry On-Line has been purchased for all psychiatrists and includes: *Textbook of Psychiatry*, HALES, YUDOFISKY & GABBARD; *Treatments of Psychiatric Disorders*, GABBARD; *Textbook of Substance Abuse Treatment*, GALANTER & KLEBER; *Manual of Clinical Psychopharmacology*, SCHATZBERG, COLE & DEBATTISTA; *Essentials of Clinical Psychopharmacology*, SCHATZBERG & NEMEROFF; *What Your Patients Need to Know About Psychiatric Medications*, American Journal of Psychiatry; *Psychiatric Services*; *Academic Psychiatry*; *Neuropsychiatry & Clinical Neurosciences*; *Psychosomatics*; *Psychiatric News*; *Sleep Disorders codes effective 10/1/2005*; *DSM-IV-TR® Fourth Edition*; Previous Editions of *DSM*; *DSM-IV-TR® Handbook of Differential Diagnosis*, Michael B. First, M.D., Allen Frances, M.D., Harold Alan Pincus, M.D.; *Symptom Index: Cases from DSM-IV-TR® Casebook and Its Treatment Companion*, Robert L. Spitzer, M.D., Miriam Gibbon, M.S.W., Andrew E. Skodol, M.D., Janet B. W. Williams, D.S.W., Michael B. First, M.D; *Quick Reference to the DSM-IV-TR® Diagnostic Criteria*; *DSM-IV-TR® Handbook of Differential Diagnosis*; *Quick Reference to the APA Practice Guidelines for the Treatment of Psychiatric Disorders*.

- **Add or Appoint Senior Administrator for Plan Implementation** (*Mental Health Standards and Criteria Item, 12.1*)

Senior Administrator for the Mental Health Remedial Plan implementation has been identified as Dr. Juan Carlos Arguello, Chief (A), Mental Health. The Administrative Lead for the Mental Health Remedial Plan implementation has been identified as L. Allen on June 18, 2008. Additional clerical support has been requested.

- **Develop Mental Health Training Team** (*Mental Health Standards and Criteria Item, 12.3*)

The following training team positions have been approved: One Senior Psychologist, Supervisor; two Clinical Psychologists; one Instructional Designer; one Staff Services Analyst; one Office Technician. Thus far, a Senior Psychologist, Supervisor, Staff Services Analyst, and Office Technician have been hired. An Instructional Designer has been selected, and the paperwork is in the final stages of completion and office space has

been assigned. A Mental Health Employee Orientation program has been developed and implemented.

## 4.4 Safety & Welfare Remedial Plan Accomplishments

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### 1. Safety & Welfare Remedial Plan Significant Accomplishments

The S & W Remedial Plan, developed in conjunction with the national panel of experts, provides the framework for DJJ's overall reform. This remedial plan was filed with the Court on July 10, 2006, and the Standards and Criteria document was filed on October 31, 2006. Significant accomplishments in implementing in this reporting period the S & W Remedial Plan include:

- **Add Central Office Resources – Dedicated Staff for Policy Development and Maintenance** (*Safety & Welfare Standards and Criteria Section 2.1, Item 4a.*)

Four positions were approved for DJJ's Policy, Procedures, Programs, and Regulations Unit (PPRU). Interviews were conducted in April 2008, and the positions were filled at the end of May 2008.

- **Use of Force Policy** (*Safety & Welfare Standards and Criteria Item 3.2 a & b*)

The initial Use of Force draft policy was completed on February 21, 2008. The draft policy was developed in conjunction with Mental Health Services and incorporates requirements from the Wards with Disabilities and Mental Health Remedial Plans.

To better reflect the policy intent, the name of the policy was changed to *Crisis Prevention and Management* with a subsection titled "Use of Force". Additional revisions were made and the policy was reviewed by a Mental Health Subject Matter Expert for clinical validity, completeness, authority and procedures. The new draft was sent to the Superintendents and the Chiefs of Security for review and feedback on July 18, 2008 with a deadline of July 25, 2008. The Crisis Prevention and Management committee will meet on August 7, 2008 to discuss the feedback and revise the policy as necessary. The policy will then be sent to the PLO, the Office of Special Master and the Mental Health, Safety and Welfare and Ward with Disabilities Program court experts for review.

Once the policy is approved, Labor Unions will be notified, training will occur and the policy will be implemented within 90 days of being signed.

- **Develop and Use Databases to Track Violence and Use of Force** (*Safety & Welfare Standards and Criteria Section 3, Item 5, 6a, & 10b*)

DJJ staff completed Performance-based Standards (PbS) Outcome Measures Comparisons for April 2008. PbS safety outcome measures, numbers 2, 3, 4, 11, and 12 are recorded for every day of the year. The safety outcome standards are

based upon the following factors:

- injuries to youth, per 100 days of youth confinement;
- injuries to staff per 100 days of staff employment;
- injuries to youth by other youth, per 100 days of youth confinement;
- assaults on youth, per 100 days of youth confinement; and
- assaults on staff, per 100 days youth confinement.

- **Lay the Foundation for Treatment Reform – Complete Risk/Needs Assessment Tool** (*Safety & Welfare Remedial Plan Standards and Criteria Section 5, Item 3b.*)

The contractor, Orbis Partners, Inc., finished a draft of the Risk/Needs Assessment tool and trained a group of Case Managers, Parole Agents, and Integrated Behavior Treatment Model (IBTM) staff to conduct 350 youth assessments needed to norm the risk assessment instrument. Additionally, IBTM staff has begun discussions with Parole and the Youth Parole Board to incorporate the risk assessment instrument into their daily operations.

- **Complete Staff Training In Use Of Risk/Needs Assessment Tool** (*Safety & Welfare Remedial Plan Standards and Criteria Section 4, Item 3b and Section 6, Item 7b.*)

Training was provided on Risk/Needs Assessment Tool developed by Orbis, Inc., in May as follows:

**05/12 & 05/13/2008**

Preston Youth Correctional Facility;

**05/14 & 05/15/2008**

Heman G. Stark Youth Correctional Facility;

Total of 51 staff completed training in these two sessions

- **Lay Foundation for Treatment Reform – Case Managers: Establish/Modify Job Classifications for Treatment Staff** – (*Safety & Welfare Remedial Plan Standards and Criteria Section 5, Item 5a.*)

In April 2008, 40 Case Managers were designated or hired at seven DJJ facilities. OH Close designated eight, Preston hired 12, N.A. Chaderjian designated 13, Ventura hired 14, and the Southern Reception Center Clinic (SYCRCC) designated four, Heman G. Starks hired 14 and designated seven others and Pine Grove hired three. Case Managers will be hired at all facilities until full staffing is achieved.

- **5.5 Grievances** (*Safety & Welfare Standards and Criteria Item 8.5 (Except 8.5.5c, 8.5.10, 8.5.12)*)

On June 10 and 11, 2008, Facility Youth Grievance Coordinators were trained for their duties and to deliver the *Youth Grievance and Staff Misconduct Complaint Policy Training* to others.

At the end of June and beginning of July 2008, staff received *Youth Grievance and Staff Misconduct Complaint Policy and Procedure Training* at the following facilities:

	<u># Staff</u>
➤ Heman G. Stark:	286
➤ N. A. Chaderjian:	199
➤ O.H. Close:	90
➤ SYCRCC:	238
➤ Ventura:	292
➤ Preston:	<u>265</u>
	<b>1,370</b>

Youth also received training in July 2008.

- **WIN (Ward Information Network) Exchange** (*Safety & Welfare Standards and Criteria Section 2.1, Item 4a.*)

The WIN Exchange system, which includes various data elements and tracking requirements associated with the *Farrell* Remedial Plans, was initiated at all facilities on April 1, 2008.

Enterprise Information Systems (EIS) staff continues to improve the data collection. In May, staff completed a “Data Cleansing” of the WIN Exchange. The WIN Exchange gathered 31 million records from all the remote WIN Servers. The EIS staff then wrote routines to consolidate the records to avoid redundant data and also performed testing-intake, departure, record-saving, and editing routines.

Work on coding and testing has been completed. EIS staff has transferred records from all sites over to the WIN Exchange server while continuing to monitor server communications, WAN issues, and record issues. Additional work is still needed on reporting at the local and Executive levels. The WIN Exchange has been scheduled to be available to DJJ staff in July 2008.

EIS staff anticipate other issues that will need to be resolved. Therefore, the staff have requested sites to report as necessary any problems that can be addressed. EIS continues to update the servers as needed.

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

On April 2, April 4, and May 20, 2008, 24 staff attended a two-day Instructor

Re-certification course conducted by Dr. Steve Laidacker at DeWitt Nelson.

A JKL-certified instructor conducted seven three-day training sessions entitled, "Safe Crisis Management," on April 10, April 17, May 1, May 8, May 15, May 29, and June 19, 2008. A total of 108 staff received training.

On May 10, 2008 fifteen staff received a training called "Safe Crisis Management-Staff Delivering Training." This training was conducted by JKM.

On May 9 and June 20, 2008, 81 staff received a five-day training entitled, "Aggression Replacement Training." This training was conducted by Barry Glick, Ph.D., at Heman G. Stark.

## 2. Items In Progress

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

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

The draft Master Table of Contents for policies was completed by DJJ during the week of April 28, 2008. The Table of Contents was sent to the S & W Expert on May 31, 2008, for review and comments. On June 18, 2008, the S & W Expert provided substantive feedback. A meeting was then held on July 14, 2008, to discuss and clarify the S & W Expert's comments. The S & W Expert indicated the document was not sufficient as he was not able to discern which policies were *Farrell*-related, specifically related to the Safety & Welfare Remedial Plan.<sup>1</sup>

To address the concerns raised by the S & W Expert, PPPRU made the following revisions:

- It developed a color coded legend to identify each plan by color; and
- It created an additional binder for all the S & W policies, both proposed and existing.

The Table of Contents changes will be forwarded to the S & W Expert for review. A conference call with the S & W Expert to discuss any additional concerns he may have will be set up.

- **Program Service Day (PSD)** (*Safety & Welfare Standards and Criteria Items 6.2a, 6.2b, 6.2c, 6.6*)

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<sup>1</sup> For more details regarding the Expert's comments, contact the Office of Legal Affairs.

The Preston Workgroup continues to prepare a Pilot Program Service Day for implementation in August 2008, on the first day of the Fall school session. Two meetings have occurred with the Pilot Program Service Day Workgroup at Preston on April 25, 2008 and May 16, 2008, thus far. The Preston Workgroup continues to meet its August timelines for the scheduled implementation.

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

The Disciplinary Decision Making System draft policy has been developed. The draft policy was sent for Executive and Legal Review. A policy case conference was held on July 17, 2008 to discuss and incorporate feedback as necessary. The policy was sent out again for Executive Review on August 1, 2008 for review of the revisions. The policy will then be sent to the PLO, the Office of Special Master and the Mental Health, Safety and Welfare and Ward with Disabilities Program court experts for review.

Once the policy has been approved, Labor Unions will be notified, training will occur and the policy will be implemented within 90 days of being signed.

- **Grievances** (*Safety & Welfare Standards and Criteria Items 6.2a, 6.2b, 6.2c, 6.6*)

The grievance automation in WIN is in the final stages of development and is scheduled for deployment on August 4, 2008. With the training of Youth Grievance Coordinators and direct care staff completed, training of youth in the new policy will be completed by the end of July 2008. *Youth Grievance and Staff Misconduct Complaint* policies will be fully implemented by August 5, 2008.

A meeting with the S & W Expert is scheduled for July 31, 2008 to develop the weekly and monthly reports to identify trends. The reports will be finalized by the end of August 2008.

- **Time Adds – Time Add Tracking** (*Safety & Welfare Standards and Criteria Items 8.4.8b, 8.6.4d, 8.6.4e, 8.6.4f*)

The Juvenile Justice Administrative Committee form was updated in March 2008. Information Systems has updated the Offender Based Information Tracking System to collect data. The information will be available in October 2008 to begin to analyze the specific reasons for time adds. The data will be analyzed, and a corrective action plan will be completed by December 2008.

- **Behavior Treatment Programs** (*Safety & Welfare Standards and Criteria Items 8.4.8b, 8.6.4d, 8.6.4e, 8.6.4f*) and **Open Sufficient Behavior Treatment Programs** (*Safety & Welfare Standards and Criteria Section 3, item 9a*)

In order to open sufficient BTPs for projected 2008-2009 demand, a draft plan to implement the BTPs has been completed with finalization projected to occur in July 2008.

The Program Workgroup is completing the design of the BTPs and related protocols. A meeting will be held with the S & W Expert during the next reporting period to obtain input on the design. It is anticipated that the draft will be completed during the next reporting period. Once approved, an implementation schedule will be developed.

## 4.5 Sex Behavior Treatment Program Remedial Plan Accomplishments

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### 1. Sex Behavior Treatment Program Remedial Plan Significant Accomplishments

Significant accomplishments in implementing the Sex Behavior Treatment Remedial Plan this quarter include the following:

#### **Sex Behavior Treatment Program Remedial Plan (SBTP) Screening and Assessment Tools** (*Sex Behavior Treatment Standards and Criteria, Standard 3, pp. 1-2*)

Thirty DJJ sex behavior treatment staff was trained in the Juvenile Sex Offender Risk Recidivism Assessment Tool (JSORRAT II) on May 13, 2008, at DJJ Headquarters. The staff who participated in this training included each of the following three groups:

1. Clinic Casework Specialists and Supervising Casework Specialists, who will be conducting the majority of the JSORRAT II screenings of incoming youth. This group consisted of eight staff.
2. Residential SBTP staff (Psychologists, Casework Specialists, Supervising Casework Specialists, Program Administrators), who will occasionally administer JSORRAT but will primarily be expected to be proficient in applying JSORRAT II results during treatment-planning and provision. This group consisted of 15 staff.
3. Staff from Field Parole Offices and the Regional Parole Offices, who will be expected to train parole staff in understanding the JSORRAT II measures and how to apply this knowledge to parole supervision levels. This group consisted of five staff.

The other remaining two participants to the training were the SBTP Remedial Plan Coordinator, Dr. Frederick Martin, Senior Psychologist (Supervisor), and Paul Woodward, Program Administrator and member of the SBTP Task Force.

The staff who attended this JSORRAT II Training can be broken down by job classification into the following categories:

- Chief Psychologist (1)
- Senior Psychologist, Supervisory (2)
- Psychologists (9)
- Program Administrators (3)

- Casework Specialists (6)
- Supervising Casework Specialists (4)
- Field Parole Agents (3)
- Regional Parole Office Parole Agents (2)

**Sex Behavior Treatment Program Remedial Plan (SBTP) Staff Training** (*Sex Behavior Treatment Standards and Criteria, Standard 11, p. 9*)

Recently, the SBTP Coordinator completed a two-week management leadership skills training at California State University, Sacramento, in April 2008.

In addition, fifteen direct sex behavior treatment providers and SBTP Task Force members, primarily DJJ Psychologists, Psychology Interns, and Supervising Casework Specialists, attended the California Coalition on Sexual Offending (CCOSO) Training Conference that was held in San Francisco May 14 through 16, 2008. The conference provided staff with an opportunity to attend training seminars on such topics as assessment measures, laws and regulations, treatment models, strategies, and practices. DJJ Treatment staff exchanged information on these and other aspects of treating juvenile sex offenders with a variety of outside professionals who also attended the training.

- **Healthy Living Curriculum** (*Sex Behavior Treatment Standards and Criteria, Standard 26, p. 10*)

DJJ and the SBTP Task Force completed the testing of the Healthy Living Curriculum in five facilities with 6 to 10 pre-selected youth during May 2008. The facilities included N.A. Chaderjian, O.H. Close; SYCCC; Preston; and Heman G. Stark.

**2. Items in Progress**

Items in progress in furtherance of the Sex Behavior Treatment Remedial Plan include:

- **Sex Behavior Treatment Curricula**

There are three separate sex behavior curricula being developed: the Healthy Living Curriculum, the Residential Sex Behavior Treatment Curriculum (“Residential Curriculum”), and The Outpatient Sex Behavior Treatment Curriculum (“Outpatient Curriculum”). These curricula are referenced within the Sex Behavior Treatment Standards and Criteria as follows:

- **Healthy Living Curriculum** (*Sex Behavior Treatment Standards and Criteria, Standard 26, p. 10*)
- **SBTP Residential and Outpatient Treatment Curriculum** (*Sex Behavior Treatment Standards and Criteria, Standards 4, 5, & 6, p. 2-5*)

DJJ's contractual relationship with the contractor charged with writing its three sexual behavior treatment program curricula ended with the expiration of the contract on June 30, 2008, without DJJ receiving final versions of the curricula. The Sexual Behavior Treatment Program Coordinator is actively soliciting curricula and treatment programs from other states for possible use in DJJ.

- **SBTP Policy and Procedures** (*Sex Behavior Treatment Standards and Criteria, Standard, p. 1*)

The 12 SBTP policies identified in the SBTP Remedial Plan were originally combined into a single comprehensive SBTP policy. Dr. Barbara Schwartz, the SBTP Court-appointed Expert, reviewed the policy and identified the need for significant revisions. With Dr. Schwartz's recommendation in mind, DJJ sub-divided the policies into three sets designated as follows:

- Policy I: Principles
- Policy II: Program
- Policy III: Staffing and Training.

The SBTP Coordinator is currently in the midst of finalizing the first draft of Policy II: Program. This is the first of the three SBTP set of policies to be developed. The first draft will be completed within the next reporting period, then provided to the Sex Behavior Expert for review and comment. Progress on the policy has been significantly impacted by the discontinued relationship with the contractual SBTP curriculum writer. Because the policies must support the Sex Behavior Treatment curricula, revisions to Policy II will be dependent upon the final curricula development.

## 4.6 Wards with Disabilities Program Accomplishments

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### 1. Wards with Disabilities Program Remedial Plan Significant Accomplishments

Significant accomplishments in implementing the WDP Remedial Plan include:

- **Preston and Ventura Youth Correctional Facility Projects** (*Wards with Disabilities Standards and Criteria, Headquarters, p. 6, Section C*)

The Ventura Youth Correctional Facility (VYCF) successfully opened its accessible family visiting center on May 17, 2008, with regular security staffing for both days of visiting. The visitor center meets the federal American with Disabilities Act (ADA) standards for accessibility.

- **Action Plan** (*Wards with Disabilities Standards and Criteria, Headquarters, p. 2, Section C*)

DJJ has developed a draft of the Action Plan for youth with mobility or other physical impairments. The Action Plan was forwarded to the WDP Expert with a request for feedback by July 7, 2008. The Action Plan was then updated based on the WDP Expert's feedback. After final review and approval, a finalized version of the Action Plan was disseminated to all the medical sites and was forwarded to all the WDP Coordinators on July 18, 2008.

- **El Paso De Robles Youth Correctional Facility 4 Removal of Architectural Barriers** (*Wards with Disabilities Standards and Criteria, Proof of Practice, Section 1, 2, 3, 4, 5, 6*)

El Paso De Robles removed the architectural barriers as outlined in the WDP Remedial Plan.

On March 20, 2008, CDCR Architect, Richard L. Traverse, Jr., submitted an inspection report which documented ADA compliance at El Paso De Robles. In it, the Architect stated that he:

. . . inspected the structural items listed in the status column of the Institution's Barrier Report, and they were found to be compliant with the appropriate accessibility guidelines within construction tolerances.

- **Heman G. Stark Youth Correctional Facility 4 Removal of Architectural Barriers** (*Wards with Disabilities Standards and Criteria, Proof of Practice, Section 1, 2, 3, 4, 5, 6*)

Heman G. Stark removed the architectural barriers as outlined in the Disabilities Remedial Plan.

On June 27, 2008 and July 9, 2008, the Architect who inspected the facility submitted an inspection report documenting ADA compliance at Heman G. Stark. In his report, he stated that he:

. . . inspected the structural items listed in the status column of the Institution's Barrier Report, and they were found to be compliant with the appropriate accessibility guidelines within construction tolerances.

- **Dewitt Nelson Youth Correctional Facility 4 Removal of Architectural Barriers** (*Wards with Disabilities Standards and Criteria, Proof of Practice, Section 1,2,)*

Dewitt Nelson removed the architectural barriers as outlined in the Disabilities Remedial Plan.

On April 03, 2008, the Architect who inspected the facility submitted an inspection report documenting ADA compliance at Dewitt Nelson. In his report, he stated that he:

. . . inspected the structural items listed in the status column of the Institution's Barrier Report, and they were found to be compliant with the appropriate accessibility guidelines within construction tolerances.

- **Tracking System (WIN)** (*Wards with Disabilities Standards and Criteria, Headquarters Policies, p. 4, Section C*)

The Tracking system has been incorporated into the WIN and is operating at all facilities. A WDP meeting and training is scheduled for August 20 through 22, 2008. Staff will receive training on the newly implemented WIN system and will receive training on the audit tool for the upcoming audits from the WDP Expert.

- **Screening Assessment Tool** (*Wards with Disabilities Standards and Criteria, Headquarters p. 7, Section C*)

The interdisciplinary group consisting of WDP, Education Services, Mental Health, and Medical met again on May 22, 2008, to work toward developing a screening tool that will assess the current ward population in order to identify developmentally disabled youth who may not have been previously identified.

The assessment tool is an element of a screening process which will assess the current youth populations and identify any developmentally disabled wards within the facilities.

Representatives of each professional discipline, WDP, Education Services, Mental Health, and Medical will meet individually to identify their respective professions' screening processes. Once the individual assessment processes are identified, the interdisciplinary group will create a flow chart that combines the individual assessments into a comprehensive screening assessment process.

- **Wards with Disabilities Remedial Plan**  
**Selected Physical Plant Accommodations (ADA Compliance)**  
(A portion have been selected and listed; *Wards with Disabilities Standards & Criteria – p. 29, p. 30, p. 6*)

See attachment on ADA Remedial Plan Physical Plant Monthly Status Report May 31, 2008 through July 1, 2008.

## 2. Items in Progress

Items in process toward full implementation of the WDP Remedial Plan include:

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

DJJ is collaborating with the Department of Developmental Services (DDS) in an effort to improve the process for DJJ's assessment of youth for disabilities. On July 10, 2008, a meeting with DDS was held to discuss the following:

- 1.) Cross matching of DJJ population with DDS data base to determine if any wards in our population has previously utilized DDS services;
- 2.) Validating DJJ's own existing screening process; and
- 3.) Discussing the testing being conducted by the Regional Centers to assess areas that may need improvement in DJJ's own screening process.

DDS shared a copy of their Inter-departmental Agreement (IA) for exchange of information. DJJ legal staff is in the process of reviewing the IA. Once the review is complete, the agreement will be signed and returned to DDS.

- **Disability Awareness (DA) Training and Staff Assistant Training** (*Wards with Disabilities Program Standards and Criteria, Headquarters, p. 4, Section C; Facility Administration, p. 10, Section B*)

Disability Awareness Training was placed into block training. There will be various dates for block training, and all staff will receive these trainings in the order of their date of birth. To date, approximately 77% of all staff have received Disability Awareness Training through block training.

Based on the WDP Remedial Plan requirements as well as the recommendations of the WDP Expert, the training is being revised to incorporate input from an outside disability advocacy organization. The contract process may add an additional seven months to the implementation of the curriculum. DJJ is in the process of researching the availability of these services and whether a sole source, or no bid, process may be used in lieu of three bids from outside consultants.

## 5 REPORT IMPROVEMENTS

### 5.1 Quarterly Report Improvements

This section of the Quarterly Report establishes this new final section as what DJJ intends to be part of its on-going efforts to continually improve upon the structure and format of this report. The intent is to provide information of even greater value to all interested parties, including DJJ Management, Staff, the Court, Experts, the Special Master, Plaintiff's Counsel, and other stakeholders. Improvements this cycle include:

- Inclusion of Expert comments; and
- A listing of Proof of Practice documents provided during the last quarter.

Some other potential future improvements are discussed in the content below.

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 (as defined by Joshua Isaac Walters "activities that add cost but do not add value"). It is often the case that this means "to take it apart and put back together in a better way."

This report is the second iteration of "taking it apart and putting it back together in a 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 appropriate. Appropriate stakeholders will be encouraged to provide feedback going forward to facilitate continuous quality improvement of the Quarterly Report.

When both progress and challenges about the efforts to complete the required work are shared, there is an opportunity to bring "fresh eyes" 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** 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 provide a visual story of DJJ's progress and the challenges it encounters during the course of its reformation.

**The second section** 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** 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 section in past Quarterly Reports.

**The fourth section** addresses current and possible future improvements. For this Quarterly Report, improvements included:

- Inclusion of Expert comments garnered from their audit reports; and
- A listing of Proof of Practice documents provided to the experts and Special Master during the last quarter.