**Appendix A**

DJJ, Memorandum: *USE OF FORCE REPORTING* (May 1, 2006)

State of California

Department of Corrections and Rehabilitation
Juvenile Justice

# Memorandum

Date : May 1, 2006

To : Superintendents
Assistant Superintendents
Chiefs of Security

Subject : **USE OF FORCE REPORTING**

Effective immediately, the Use of Force reporting process from the facilities to the Division of Juvenile Facilities per Section 2102 of Temporary Departmental Order 05-36 will be:

- The Watch Commander Review is to be completed and submitted to the Chief of Security within twenty-four (24) hours of the incident. If the package is submitted after the twenty-four (24) hours guideline, explain the delay in the comment section of the Use of Force Incident Review-Section 1 Watch Commander Review form, YA 8.440.

- The Chief of Security will review the incident package, normally within two (2) business days of receipt from the Watch Commander. This level of review is to ensure the quality of all reports, their accuracy and credibility. Upon completion of his/her review, the incident package will be submitted to the Superintendent's office.

- The Superintendent/Assistant Superintendent will review the incident report package, normally within two (2) business days of receipt from the Chief of Security. Upon completion of his/her review, the incident package will be submitted to the Institutional Force Review Committee.

- The Institutional Force Review Committee shall meet on a regular basis to ensure that all incident packages are reviewed within thirty (30) days of occurrence. The Superintendent/Assistant Superintendent of the facility will chair the committee.

- A copy of all incident report packages reviewed, the committee's minutes, findings and recommendations shall be forwarded to the Division of Juvenile Facilities Use of Force Coordinator's office within seven (7) days of the completion of each Institutional Force Review Committee (IFRC).

Please provide the dates for any currently scheduled and future IFRC's to the Division of Juvenile Facilities Use of Force Coordinator's office by the 15th of the month preceding the month the IFRC is scheduled (i.e. Dates of June 2006 IFRC due by May 15, 2006).

If you have any questions, contact Anna Rodriguez, Division of Juvenile Facilities Use of Force Coordinator at (916) 262-2702; or Assistant Director, Jay Aguas at (916) 262-1560.

Ed Wilder

ED WILDER
Director
Division of Juvenile Facilities

cc: Jay Aguas
Anna Rodriguez
Jeff Plunkett

**Appendix B**

Cambra, Memorandum: *DRAFT PLAN TO CLOSE INYO TEMPORARY DETENTION UNIT AT O.H. CLOSE YOUTH CORRECTIONAL FACILITY*

(December 30, 2005)

# Memorandum

Date : December 30, 2005

To : Donna Brorby
Special Master
Farrell vs. Hickman

Subject : **DRAFT PLAN TO CLOSE THE INYO TEMPORARY DETENTION UNIT AT O.H. CLOSE YOUTH CORRECTIONAL FACILITY**

The "Stipulation Regarding Safety and Welfare Remedial Plan and Mental Health Remedial Plan" signed December 1, 2005, requires that a plan be developed to close the Inyo Temporary Detention Unit. This plan is revenue neutral and was developed in consultation with Mr. Fred Mills, a nationally recognized expert in juvenile justice. The proposals in this plan have been discussed with Mr. Ed Wilder, Acting Director of Division of Juvenile Justice, Division of Juvenile Facilities (DJJ) and developed by Mr. John Muschetto, Special Consultant assigned to this project by Mr. Wilder. We believe submitting a draft plan will allow the parties input into the final agreements.

Mr. Wilder has agreed to discontinue the use of the Inyo Temporary Detention Unit. Wards assigned to temporary detention at the O.H. Close Youth Correctional Facility (OHCYCF) will be housed in the "wet rooms" located in the dormitory living units. We recommend wards assigned to temporary detention receive the same program afforded other wards.

We recommend DJJ be allowed to utilize the Inyo Living Unit for the purposes described in the Inyo Program Proposal section of this plan. Mr. Wilder has made it very clear, wards housed in the Inyo Living Unit will receive the same program and privileges afforded other wards at the OHCYCF.

An effort has been made to incorporate some of Dr Krisberg's recommendations into this plan (see attached letter from Dr. Berry Krisberg to Donna Brorby dated 12/13/05). He has many years of experience with the problems facing the DJJ and an understanding of policy changes necessary to create change. We recognize this plan does not address the root causes identified by Dr. Krisberg, but simply addresses a symptom, which is the utilization of "lock up units" within the DJJ. The elimination of the use of "lock up units" at this one facility is simply a first step in addressing Dr. Krisberg's concerns and recommendations. This plan will change the approach used to manage unacceptable behavior at OHCYCF.

**INYO PROGRAM PROPOSAL**

The Inyo Living Unit space will be utilized to accommodate three functions described as follows:

- Temporary Intervention Program.
- Provide housing, when necessary, for wards awaiting court proceedings or transfer to other facilities.
- Provide housing for a ward suspected of a serious assault on staff or wards involving the use of a weapon.

These three programs will be described separately.

I. Temporary Intervention Program

The Temporary Intervention Program is a short-term intervention resource service designed to assist wards and staff by aggressively providing problem solving techniques to wards. The Inyo Unit allows staff to escort wards to a neutral site, (Inyo Unit dayroom, kitchen, or rooms) in order to open dialogue, establish problem-solving strategies, and determine appropriate interventions. The Inyo Unit will only be used when other documented attempts to resolve the problem have been attempted and failed or when it is necessary to resolve an emergency and prevent substantial harm to staff or wards. When a ward is escorted to the Inyo Unit Temporary Intervention Program, staff will respond to the unit (Chief of Security, the Unit Treatment Team Supervisor (TTS) and the wards living unit staff). They will question the ward/wards, determine the problem, the appropriate intervention and resolve the problem. Wards will not be assigned to the Inyo Living Unit. The wards will:

- Return to their living unit.
- Transfer to a different living unit.
- Be referred to the appropriate medical/mental health professional, who will assume responsibility for determining the appropriate setting or housing.
- Be placed on temporary detention status in one of the living unit "wet rooms".

Staff recognizes the manner, in which wards are treated, who cannot function within the norms that have been established, is of crucial importance. It is essential to provide an action-oriented philosophy which recognizes, 1) The

aggressive acting out characteristics of many wards, 2) Realizes that certain actions must be carried out from at treatment standpoint, 3) Permits staff to use best practice strategies in dealing with wards misbehavior or behavioral issues. The goal will be to return the ward to his program unit as soon as possible.

We are not suggesting that all problems be solved at Inyo. Most problems/issues/behaviors should be solved or attempted to be solved in the ward's assigned unit utilizing living unit staff and living unit physical plant "wet rooms" if necessary. However, taking these wards to Inyo gives staff the opportunity to interview the wards and see the wards in a safe, quite atmosphere where there is no audience/peer pressure to influence the intervention.

This is a good message for staff and wards and begins the process of doing away with "being locked down at Inyo, to a place that is utilized for intervention when only absolutely necessary."

Example: the past two days while visiting OHCYCF, there were two incidents where immediate interventions at Inyo resolved problems and wards were immediately returned to their living units.

The first incident involved a smaller ward being picked on by a larger ward concerning some religious item the smaller ward had. The ward went to Inyo as being in danger from others. Immediately, staff (Chief of Security/TTS/Hall staff etc.) responded to Inyo and questioned the ward, determined the problem, determined the intervention, and resolved the problem. The ward was immediately returned to his living unit.

The second incident involved a north/south fight in the school area. Several factors that staff witnessed indicated there might be more to the incident. Six wards were taken to Inyo, not to be placed on TD, but to identify if there were any further issues concerning this problem. Immediately, the chief of security, gang coordinator, and lodge staff responded to the Inyo Unit. They interviewed the wards, determined the problems, resolved the problems and returned the wards to their living units.

II. Provide housing, when necessary, for wards awaiting court proceedings or transfer to other facilities.

There are going to be times when wards may be held at Inyo due to pending court cases, transfer to another institution, etc. We are recommending that these wards not be placed on TD status, but are actually assigned to the Inyo Living Unit Program until they are transferred or until the pending court case is resolved. Once assigned, treatment plans will be established that will include education, individual counseling, work crew, recreation, group activity, etc. within the program areas of Inyo. Each individual treatment plan will stress structured time out of rooms, instead of structured time in rooms. Wards will have appropriate bedding, clothing, writing materials, books, property etc. Wards will eat meals out of their rooms.

The assignment to Inyo shall be as short of time as possible. Wards being transferred from OHCYCF to other facilities for disciplinary reasons should be transferred immediately when possible. The ideal count at Inyo will be no count. When unit counts are reduced, and an appropriate system of classification is established there will be less, if any reason to maintain Inyo and assigned staff can be redirected to support other institutional programs.

Note: "Lockup Unit" security protocols will not be used, i.e. mechanical restraints, one on one escorts, cell feeding, spa recreational programs, etc.

III. Provide housing for a ward suspected of serious assault on staff or wards involving the use of a weapon.

The goal should be to transfer a ward who meets this criteria as soon as possible; however, until the transfer is accomplished, the ward's individual treatment plan will include a security section establishing the appropriate and reasonable security protocols to ensure staff or ward safety. This placement will only be utilized upon the review and approval of the Director, of DJJ.

**ADMINISTRATION AND SUPERVISION WHEN WARDS ARE HOUSED IN INYO**

a) Plan of Operation: The Treatment Team Supervisor in charge of the Inyo program will maintain a detailed "Operational Procedure" for the Program, which will be reviewed and approved by the Superintendent on an annual basis. The plan will be updated as necessary to reflect current procedures and practices.

b) Management and Supervision: The management of the Inyo Program will not be delegated to a staff member below the Treatment Team Supervisor level. The

supervision of the program will not be delegated to a staff member below the level of Senior Youth Correctional Counselor.

c) Daily Visitation: On regular business days, the Treatment Team Supervisor will visit wards assigned to the Inyo Program daily. On weekends and holidays, the Executive Officer and/or Duty Lieutenant will visit wards assigned to the Inyo Program daily. Ward requests to be visited by other staff will be promptly referred to the staff member. A timely response should be given to such requests whenever reasonably possible.

d) Manager/Supervisor Responsibilities: The Inyo Program Treatment Team Supervisor is responsible for the sanitary working and living conditions within the unit. When any condition within the unit or behavior, conduct or appearance of any ward confined therein, appears to warrant the attention of specific or specialized treatment staff, the matter will be promptly brought to the attention of the appropriate staff.

e) Unit Inspections: The OHCYCF Superintendent will inspect the Inyo Program at least weekly to ensure that conditions meet appropriate standards. The Treatment Team Supervisor will inspect the unit daily, during regular business hours.

f) Training: All staff who work with wards assigned to the Inyo Living Unit Program will receive training on and be familiar with the unit operational procedures.

**UNIT OPERATIONS**

Wards will be provided the same clothing, bedding, hygiene items, food and property allowed wards in dormitory living units. They will also receive the same program treatment and privileges afforded wards housed in other OHC living units.

1) Living Quarters: Wards will be housed in single rooms that are clean, well lighted and graffiti free, with a fully functioning sink and toilet. Rooms will have adequate heating, cooling and ventilation.
2) Wards will dine, recreate, visit, program, and work outside of their rooms.
3) The Inyo living unit will establish security protocols similar to those used in all the other living units located in OHCYCF. The only exception will be made on the individual treatment plan of a ward suspected of a serious assault on staff or wards involving the use of a weapon

**TIMELINES:**

Upon acceptance by the parties of the final Inyo Plan, DJJ will immediately implement the "Temporary Intervention Program" portion of this plan, utilize the "wet rooms" located within the dormitory living units for wards assigned to temporary detention and close the Inyo Unit for use as a temporary detention living unit.

Within 30 days following the acceptance of the final Inyo Plan by the parties, DJJ will revise the Plan of Operations for the Inyo living unit. The revised Plan of Operation will include the philosophy, proposals, agreements and necessary daily operational procedures to comply with the Inyo Program Proposal section of this plan. The Plan of Operations will be provided to the parties.

Within 90 days following the acceptance of the final Inyo Plan by the parties, DJJ will implement the remaining requirements of the final Inyo Plan.

Compliance with the proposals outlined in the final Inyo Plan:

Upon acceptance by the parties of the final Inyo Plan, Steve Cambra, Mr. Fred Mills and Mr. John Muschetto will provide assistance to DJJ staff for a period of 90 days in order to come into compliance with the plan.

On May 1, 2006, Steve Cambra, Fred Mills, and John Muschetto will provide the parties with a compliance report on the DJJ's compliance with the final Inyo Plan.

STEVE CAMBRA
Expert Witness/Consultant
Division of Juvenile Justice/

Attachment(s)

SC/sk/yl

DISTRIBUTION LIST:

Bernard Warner
Ed Wilder
Elizabeth Siggins
Amy Seidlitz
Barry Krisberg
Monica Anderson
Sherleen Redd
Donald Spector
Sarah Norman
Fred Mills
Mark Blaser
Eleanor Silva

**Appendix C**

Muschetto and Cambra, Memorandum: *MONTHLY PROGRESS REPORT ON THE PLAN TO CLOSE THE INYO TEMPORARY DETENTION UNIT AT O.H. CLOSE YOUTH CORRECTIONAL FACILITY* (March, 2006)

State of California

Department of Corrections and Rehabilitation
Juvenile Justice
Division of Juvenile Facilities

# Memorandum

Date :

To : Donald Spector, Esq.
Attorney for Plaintiff
Prison Law Office

Bernard Warner
Division of Juvenile Justice

Donna Brorby
Farrell vs. Hickman

Subject : **MONTHLY PROGRESS REPORT ON THE PLAN TO CLOSE THE INYO TEMPORARY DETENTION UNIT AT O.H. CLOSE YOUTH CORRECTIONAL FACILITY**

The parties agreed to the plan to close the INYO Temporary Detention Unit at O.H. Close Youth Correctional Facility (OHCYCF). The plan requires the completion of a monthly report to the parties starting February 1, 2006. The timelines established for the implementation of the plan are as follows:

**TIMELINES:**
Upon acceptance by the parties of the final INYO Plan, DJJ will immediately implement the "Temporary Intervention Program" portion of this plan, utilize the "wet rooms" located within the dormitory living units for the wards assigned to temporary detention and close the INYO Unit for the use of a temporary detention living unit.

Within 30 days following the acceptance of the final INYO Plan by the parties, DJJ will revise the Plan of Operations for the INYO living unit. The revised Plan of Operation will include the philosophy, proposals, agreements and necessary daily operational procedures to comply with the INYO Program Proposal section of this plan. The Plan of Operations will be provided to the parties.

Within 90 days following the acceptance of the final INYO Plan by the parties, DJJ will implement the remaining requirements of the final INYO Plan. This report will evaluate the DJJ's progress in the following areas of March 1, 2006:

**March Progress Report**

The INYO Plan of Operation has been implemented. The INYO "lock-up unit" security protocols were discontinued and replaced with an open program model for the wards assigned to the INYO living unit. The use of the INYO living unit for wards assigned to temporary detention status has been discontinued. The post orders for the INYO living unit staff positions have been revised. OHCYCF staff received training on the revised Plan of Operations. Mr. John Muschetto conducted weekly site visits to develop the information for this report.

## I. Temporary Intervention Program

**The Temporary Intervention**

The Temporary Intervention Program is a short-term intervention resource service designed to assist wards and staff by aggressively providing problem solving techniques to wards. The INYO Unit allows staff to escort wards to a neutral site, (INYO Unit dayroom, kitchen, or rooms) in order to open dialogue, establish problem-solving strategies, and determine appropriate interventions. The INYO Unit will only be used when other documented attempts to resolve the problem have been attempted and failed or when it is necessary to resolve an emergency and prevent substantial harm to staff and wards. When a ward is escorted to the INYO Unit Temporary Intervention Program, staff will respond to the unit (Chief of Security, the Unit Treatment Team Supervisor(TTS) and the ward's living unit staff). They will question the ward/wards, determine the problem, the appropriate intervention and resolve the problem. Wards will not be assigned to the INYO Living Unit. The wards will: return to their living unit; transfer to a different unit; be referred to the appropriate medical/mental health professional, who will assume responsibility for determining the appropriate setting or housing; or be placed on temporary detention status in designated approved "wet rooms."

**Audit Findings:**

The following is the Inyo Temporary Intervention Program March 2006 monthly report:

Intake /Releases/Time in Program

March 1, 2006
0855 – Ward [redacted] transferred to HGSYCF.
0925 – Ward [redacted] released back to Del Norte Hall.
Time at Inyo for intervention – 22 hrs. 25 min.
1735 – Ward [redacted] released back to El Dorado Hall.
Time at Inyo for intervention – 23 hrs.

2020 – Ward [redacted] YA [redacted] in fro Glenn Hall.

March 2, 2006
No entries this date in log.

March 3, 2006
1600 – Ward [redacted] l YA [redacted] released back to El Dorado Hall..
Time at Inyo for intervention -
1900 – Ward [redacted] YA [redacted] in from Glenn Hall.
2015 – Ward [redacted] released back to Glenn Hall.
Time at Inyo for intervention – 1 hr. 15 min.
2105 – Ward [redacted] YA [redacted] in from Glenn Hall.
2135 – Ward [redacted] YA in from El Dorado Hall.
2145 – Ward [redacted] YA [redacted] in
2250 – Wards [redacted] YA [redacted], and [redacted] YA [redacted] in from
El Dorado Hall for fighting.

March 4, 2006
1110 – Ward [redacted] released back to Glenn Hall.
Time at Inyo for intervention – 13 hrs 25 min
1110 – Ward [redacted] released back to Glenn Hall.
Time at Inyo for intervention 13 hrs 25 min.
1110 – Ward [redacted] and [redacted] released back to El Dorado Hall.
Time at Inyo for intervention – 12 hrs 20 min.
2050 – Ward [redacted] YA [redacted] in from Glenn Hall.
2120 – Ward [redacted] YA [redacted] in from Glenn Hall.
2140- Wards [redacted] YA [redacted] and [redacted], and
[redacted] YA [redacted] in from Glenn Hall.
2200 – Ward [redacted] YA [redacted] in from El Dorado Hall..

March 5, 2006
0935 – Ward [redacted] released to El Dorado Hall,
Time at Inyo for intervention – 10 hrs 35 min
1050 – Ward [redacted] released to Calaveras Hall.
Time at Inyo for intervention
1450 – Ward [redacted] released back to Glenn Hall.
Time at Inyo for intervention 17 hrs 30 min
1450 – Ward [redacted] and [redacted] released back to Glenn Hall.
Time at Inyo for intervention – 17 hrs 10 min.
1715 – Ward [redacted] released back to Glenn Hall.
Time at Inyo for intervention – 20 hrs 25 min.

2115 – Ward [redacted] YA [redacted] in from Calaveras Hall.
2307 – Ward [redacted] YA [redacted] in from Glen Hall.

March 6, 2006
0449 – Ward [redacted] YA [redacted] in from Glenn Hall.
1035 – Ward [redacted] released back to Glenn Hall.
Time at Inyo for intervention – 11 hrs 28 min
Major Group Disturbance.

Institution placed on lockdown to effectively respond to North/South group disturbance. Sixty-seven wards involved. All available wet rooms utilized including temporarily opening of Butte Hall to house the Southern Hispanics. Inyo initially utilized to house the Northern Hispanics. Over the next several days ongoing interventions, transfers etc. to resolve issues and restore institution to normal operating procedures.

March 6, 2006 through March 16, 2006 Inyo had numerous in and out traffic to resolve North/South disturbance.

March 16, 2006
1235 – Ward [redacted] YA [redacted] in from Calaveras Hall.
1625 – Ward [redacted] YA [redacted] in from Glenn Hall.

March 17, 2006
1110 - Ward [redacted] released back to Glenn Hall.
Time at Inyo for intervention – 18 hrs 45 min.
1428 – Ward [redacted] released back to Calaveras Hall.
Time at Inyo for intervention – 25 hrs 53 min.
1520 – Ward [redacted] YA [redacted] in from Calaveras Hall.
2000 – Ward [redacted] YA [redacted] in from Glenn Hall.

March 18, 2006
0800 – Ward [redacted] released back to Calaveras Hall.
Time at Inyo for Intervention – 16 hrs. 40 min
0950 – Ward [redacted] released back to Glenn Hall.
Time at Inyo for intervention. – 13 hrs 50 min

March 19, 2006
No wards to Inyo this date.

March 20, 2006

1325 – Wards [redacted] YA [redacted] and [redacted] YA [redacted] in from Del Norte Hall.
1645 – Ward [redacted] released back to Del Norte Hall.
Time at Inyo for intervention – 3 hrs 20 min.
1705 – Ward [redacted] released back to Del Norte Hall.
Time at Inyo for intervention. 3 hrs 40 min
1723 – Ward [redacted] YA [redacted] in from Calaveras Hall.
2028 – Ward [redacted] YA [redacted] in from Calaveras Hall.

March 21, 2006
1320 – Ward [redacted] YA [redacted] in from Glenn Hall.
1426 – Ward [redacted] released to Calaveras Hall.
Time at Inyo for intervention – 17 hrs. 58 min
1945 – Wards [redacted] YA [redacted] and [redacted] YA [redacted] in from Glenn Hall,
2115 – Ward [redacted] YA [redacted] in from El Dorado Hall.

March 22, 2006
0905 – Ward [redacted] released back to El Dorado Hall.
Time at Inyo for intervention – 11 hrs 50 min
1020 – Wards [redacted] and [redacted] released back to Glenn Hall.
Time at Inyo for intervention 14 hrs 35 min ([redacted])
Time at Inyo for intervention ([redacted]) – 21 hrs.
1037 – Ward [redacted] released back Del Norte Hall.
Time at Inyo for intervention – 40 hrs 37 min.
2035 – Ward [redacted] YA [redacted] and [redacted] YA [redacted] in from El Dorado Hall.

March 23, 2006
0930 – Wards [redacted] and [redacted] released back to El Dorado.
Time at Inyo for intervention – 13 hrs 5 min
1645 – Ward [redacted] in from Fresno Hall.

March 24, 2006
No time of release entered for Ward [redacted] back to Fresno Hall.

March 25, 2006
2045 – Ward [redacted] YA [redacted] in from Glenn Hall.
2140 – Ward [redacted] YA [redacted] in from El Dorado Hall.
2230 – Ward [redacted] YA [redacted] in from Calaveras Hall.
2240 – Ward [redacted] YA [redacted] and [redacted] YA [redacted] in from Calaveras Hall.

March 26, 2006
0955 – Ward [redacted] released back to El Dorado Hall.

Time at Inyo for intervention – 13 hrs 10 min
1428 – Ward [redacted] released to Glenn Hall.
Time at Inyo for intervention – 17 hrs 43 min.
1757 – Ward [redacted] YA [redacted] in from Calaveras Hall.
1927 – Ward [redacted] released to Calaveras Hall.
Time at Inyo for intervention – 20 hrs 27 min
1927 – Ward [redacted] back to Calaveras Hall.
Time at Inyo for intervention – 20 hrs 57 min.
1933 – Ward [redacted] released to Calaveras Hall.
Time at Inyo for intervention 20 hrs 53 min.
2105 – Ward [redacted] YA [redacted] in from Calaveras Hall.

March 27, 2006
1345 – Ward [redacted] released back to Calaveras Hall.
Time at Inyo for intervention – 19 hrs 48 min
1345 – Ward [redacted] back to Calaveras Hall.
Time at Inyo for intervention – 16 hrs.
1841 – Ward [redacted] YA [redacted] released back to Fresno Hall.
Time at Inyo for intervention – 4 days 1hr 32 min

March 28, 2006
1040 – Ward [redacted] YA [redacted] in from Calaveras Hall.
1145 – Ward [redacted] YA [redacted] in from Glenn Hall.
1210 – Ward [redacted] YA [redacted] in from Calaveras Hall.
1349 – Ward [redacted] YA [redacted] in from Glenn Hall.
1523 – Ward [redacted] released back to Calaveras Hall.
Time at Inyo for intervention – 4 hrs 43 min
1530 – Wards [redacted] YA [redacted] and [redacted] YA [redacted] in from El Dorado Hall.
1840 – Ward [redacted] released back to Glenn Hall.
Time at Inyo for intervention 4 hrs 51 min
1915 – Ward [redacted] released back to Glenn Hall.
Time at Inyo for intervention – 6 hrs 30 min.
2325 – Ward [redacted] YA [redacted] in from El Dorado hall.

March 29, 2006
0940 - Ward [redacted] and [redacted] released back to El Dorado Hall.
Time at Inyo for intervention – 18hrs 10 min
0940 – Ward [redacted] released back to El Dorado Hall.
Time at Inyo for intervention – 10 hrs 15 min
1815 – Ward YA [redacted] in from Glenn Hall.
1830 – Ward [redacted] released back to Calaveras Hall.

Time at Inyo for intervention – 30 hrs 5 min.
1840 – Ward [redacted] YA [redacted] in from Glenn Hall,

March 30, 2006
0815 – Ward released back to Glenn Hall.
Time at Inyo for intervention - 14 hrs
0815 – Ward [redacted] released to Glenn Hall.
Time at Inyo for intervention – 13 hrs 35 min
1640 – Ward [redacted] YA [redacted] in from El Dorado Hall.
2240 – Wards [redacted] and [redacted] in from El Dorado Hall.

March 31, 2006
1930 – Wards [redacted] and [redacted] released back to El Dorado,
Time at Inyo for intervention – 20 hrs 50 min
2030 – Ward [redacted] released back to El Dorado.
Time at Inyo for intervention – 24 hrs 50 min..

**Summary of Audit Findings:**

**Substantial Compliance**
During the month of March there were a total of 62 wards taken to Inyo for interventions and returned to open program within 24 hours.
Staff at OHCYCF continue to utilize the Inyo Intervention Program as designed.

## II. Provide housing, when necessary, for wards awaiting court proceedings or transfers to other facilities.

There are going to be times when wards may be held at Inyo due to pending court cases, transfers to other institutions, etc. We are recommending these wards will not be placed on TD status, but are actually assigned to the Inyo Living Unit Program until they are transferred or until the pending court case is resolved. Once assigned, treatment plans will be established that will include education, individual counseling, work crew, recreation, group activity, etc. within the program areas of the Inyo. Each individual treatment plan will require structured time out of rooms, instead of structured time in rooms. Wards will have appropriate bedding, clothing, writing materials, books, property, etc. Wards will eat meals out of their rooms.

The assignment to Inyo shall be as short a period of time as possible. Wards being transferred from OHCYCF to other facilities for disciplinary reasons should be transferred immediately when possible. The ideal count at Inyo will be no count. When unit counts are reduced, and an appropriate system of classification is

established there will be less, if any reason to maintain Inyo and assigned staff can be redirected to support other institutional programs.

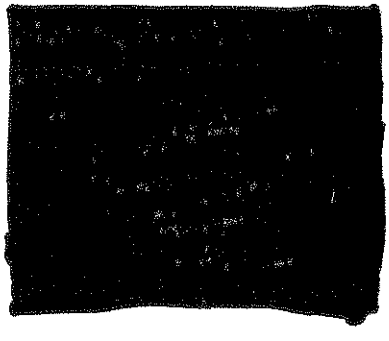
**UNIT OPERATIONS**
Wards will be provided the same clothing, bedding, hygiene items, food and property allowed wards in dormitory living units. They will also receive the same program treatment and privileges afforded wards housed in other OHCYCF living units.

1) Living Quarters: Wards will be housed in single rooms that are clean, well lighted and graffiti free, with a fully functioning sink and toilet. Rooms will have adequate heating, cooling and ventilation.
2) Wards will dine, recreate, visit, program, and work outside of their rooms.
3) The Inyo living unit will establish security protocols similar to those used in all other living units located in OHCYCF. The only exception will be made on the individual treatment plan of a ward suspected of a serious assault on staff or wards involving the use of a weapon.

**Audit Findings:**

Intake/Releases/Time in Program

For the month of March 2006, there were a total of eight wards assigned to the Inyo Intervention Program waiting for transfers to other facilities.



**Summary of Audit Findings:**

**Substantial Compliance**
Wards assigned to Inyo have been afforded open program in compliance with the Inyo Intervention Program Statement. The conditions of confinement have been met. Wards are being housed in clean rooms with appropriate lighting and functioning sinks and toilets. Except for breakfast, wards are dining, recreating,

visiting, and working out of their rooms. Wards have been allowed personal property in their rooms that is stored in plastic containers issued by Inyo staff. All Inyo assigned ward programs are documented on individual ward treatment plans. Ward program generally begins at 0900 hours and runs through 1930 hours daily. This is a total of ten and one-half hours daily that wards may be out of their rooms.

As the program has been developing staff have increased their enthusiasm and creativity to meet the programs goals as they realize the effectiveness of their actions. Inyo staff stated they are having no major disruptive behaviors such as, pounding on doors, destroying rooms, etc. since implementing the Inyo Intervention program. Inyo is clean, quiet and relaxed.

**III. Provide housing for a ward suspected of serious assault on staff or wards involving the use of a weapon.**

The goal should be to transfer a ward who meets this criteria as soon as possible; however, until the transfer is accomplished, the ward's individual treatment plan will include a security section establishing the appropriate and reasonable security protocols to ensure ward and staff safety. This placement will only be utilized upon the review and approval of the Director, of DJJF. These ward placements will be reviewed on a weekly basis by the Director's office to ensure the ward is receiving appropriate services and the ward continues to meet the criteria to be housed on Inyo Living Unit.

**Audit Findings:**

Intake/Releases/Time in Program

There were no wards assigned to Inyo for the month of March under criteria III.

**Summary of Audit Findings:**

**Substantial Compliance**
Substantial Compliance to this section is indicated as there were no wards assigned to Inyo for the month of March under criteria III of the Inyo Program Statement.

**INYO Compliance Report**
Beginning February 1, 2006, OHCYCF fully implemented the Inyo Intervention Program. This essentially closed Inyo Hall as a "lock-up" unit housing wards on TD status and converted it to an intervention unit. The conversion of INYO has been completed and is operating within the guidelines agreed upon by all parties.

Overall, the progress and operation of Inyo has been positive and well supported by OHCYCF staff. The administration and staff have endorsed the program and have worked exceedingly hard to make it work. During the months of February and March there have been no instances at INYO where chemical or physical restraint has been utilized. The building is clean, well maintained, and the conditions of confinement are being met. The atmosphere is relaxed and staff working INYO generally state that the wards have been well behaved.

Training has been provided to institutional staff explaining the INYO Temporary Intervention Program. The administration continues to nurture the program and stress the change in philosophy from using Inyo as a "lock-up" unit, to using Inyo as a problem-solving unit. The leadership displayed by [redacted] Director Division of Juvenile Facilities, [redacted] Superintendent OHCYCF, and [redacted] has greatly contributed to the unit's successful transition.

The INYO Temporary Intervention Program, as designed, appears to be serving the wards and staff as a positive asset that supports the rehabilitative efforts being provided at the OHCYCF.

John Muschetto and Steve Cambra are available to answer any questions with regards to this report. Please feel free to leave a message at (916) 262-1494 and they will return your call.

JOHN MUSCHETTO
Consultant
Juvenile Justice

STEVE CAMBRA
Expert Witness/Consultant
Juvenile Justice

CC: Ed Wilder
Monica Anderson
Sherleen Redd
Jay Aguas
Yvette Marc-Aurele
Mark Blaser
Eleanor Silva

**Appendix D**

Schwartz, *California Department of Corrections and Rehabilitation—Juvenile Division Audit #1* (October 20-26, 2005)

**Barbara K Schwartz, Ph.D**
**Clinical and Forensic Psychology**
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# California Department of Correction and Rehabilitation- Juvenile Division
# Audit #1

## October 20-26, 2005

**INTRODUCTION:**

The California Department of Correction and Rehabilitation has set as a goal the development of a state-of-the-art treatment program for wards whose sexually inappropriate behavior has resulted or contributed to their placement within the Department. Currently about 250 wards are participating in the following facilities:

- O. H. Close Youth Correctional Facility Stockton, California
- N.A. Chaderjian Youth Correctional Facility Stockton, California
- Herman G. Stark Youth Correctional Facility Chino, California
- Southern Youth Correctional Reception Center and Clinic Norwalk, California

These programs are designated as Residential Programs as the wards live together on designated housing units. The aim is to provide 20 hours a week therapy through a combination of core groups, resource groups, large groups, individual and family therapy. Wards spend various amounts of time in treatment, depending upon when they are transferred to these facilities and how long their sentences run. Program administrators said that there was a waiting list for the Sexual Behavior Treatment Program (SBP), but they were unable to produce the list before the preparation of this report.

The plan submitted to the courts also outlines a ten hour per week Outpatient Treatment Program for wards in each of the remaining facilities including Ventura Youth Correctional Facility which houses females. There is a small informal program for the girls at Ventura. However, there are no other Outpatient programs at this time.

The plan outlines a continuum of care which includes triaging all wards convicted of a sex offense or whose behavior suggests a need to treat inappropriate sexual conduct into three groups. Wards with minimal need for treatment will receive a psycho-educational course in Healthy Sexuality. The other individuals will receive either Residential or Outpatient treatment, followed by maintenance groups after they have completed the more intensive programs and then participation in aftercare programs in the community. Maintenance programs have not been implemented. The

staff has been unable to get any information about the Aftercare Programs which is operated by the Parole Department,

The program is staffed by a group of devoted psychologists and youth workers who have lacked sufficient resources and overall direction. Currently they are attempting to implement a comprehensive unified program

## EVALUATION OF COMPLIANCE

I calculated the degree of compliance with all the issues defined in the SBTP plan submitted to the courts. The plan did not include a time line for each of the issues. However, for several issues time frames were referenced. Where this was the case, I have referenced that the Task Force is making progress towards those issues. Where no reference was made to deadlines, I have assessed the current level of compliance.

An attempt was made to calculate exact percent of compliance. However, in all cases involving the evaluation based on the official records, there in so much inconsistency that percentages could not be fairly ascertained.

Audit Criteria:

- Policies and Procedures-the Sexual Behavior Task Force has set a deadline of July, 2006 to complete the P & P Manual. The Task Force is actively working on that goal.
    - General policies and procedures
        - I was informed by the staff that no written policies or procedures specific to the SBTP have been developed but those are being developed. .
    - Policies and procedures related to ethics/rights of wards-See comment above.
        - I have not received any policies or procedures which address issues of confidentiality or informed consent specifically for the SBTP.
    - Policies provide for equitable vocational training opportunities-See comment above.
        - I have not been provided with any policies at all. Thus I have not reviewed any policy which mandates in writing that wards convicted of sexual offenses are offered appropriate vocational opportunities.
- Clinical notes and observations on the following
    - Special needs groups-The Sex Behavior Task Force has set a deadline of June, 2006 to adapted the curriculum for the developmentally disabled as well as other special needs populations such as non-English speakers or the mentally ill.-Partial Compliance
        - I observed a Spanish language core group at Stark which was composed of a psychologist, a Youth Counselor who served as the translator and two participants. One participant was describing his offense, and this was effectively translated to the psychologist and myself. There was minimal group interaction but this was due to the nature of the discussion. Supportive interaction was observed between staff and participants.
        - Other institutions apparently do not currently have specialized SBTP group for special needs populations. However, Chaderjian does have a special mental health program (The Stanford Project) which has an "informal sex offender program." The SBTP staff reported that this program is a residential program for special needs wards but is run by Parole Agents rather than mental health professionals. However, this is not being

ordinated with the SBTP, and the treatment is not provided by mental health professionals.

- Core groups-Inconsistencies in documentation make evaluation of compliance impossible.
  - Group notes are kept in a variety of different files depending upon the institution. At Close the group notes are kept in notebooks maintained by the different psychologists. The notes are on the whole group, not on different participants. Of the three psychologists preparing these notes, two of the three records were essentially unreadable. Dr. Bowles used a form entitled Treatment Progress Evaluation which did address sex offender issues. Notes from other two psychologists tended to focus on here and now issues with process rather than content being commented on. The group that I did observe was run by Dr. Herkovic and Y.C. Curry. It ran for 45 minutes and focused on a new member presenting his sexual history. There was good group interaction with positive interaction between the therapists and participants.
  - A core group was not available to be observed at Chaderjian as none were scheduled on the day of our visit. The group notes had been prepared on the WIN system, printed out and filed in individual hall fields. Up until February, 2005 the staff had used a group note template which appeared to be very useful. However, after that date the form was no longer used. Dr. Kirkwood stated that the form had disappeared from the WIN system, and they were unable to access it. The notes are not identified as to whether they are referring to a core group, a resource group or individual therapy and sometimes this could not be detected even by reading them. There also needs to be notation as to time the service occurred.
  - A core group was not available to be observed at Stark as none were scheduled on the day of our visit. .
  - I observed two groups at the Southern Reception Center. The first group was run by Dr. Louyn and YC Jessie for 7-9 participants in a very crowded room. Three of the participants were paroling in the immediate future and were talking with the rest of the group about their offenses and cycles. The participants were enthusiastic and knowledgeable. Therapists were very supportive and encouraging. The group ran for three hours with active participation throughout. Some of the group members appeared to showing off for me. However, overall the group appeared to be functioning effectively as a cognitive behavioral treatment for inappropriate sexual behavior. The second core group that I observed was run by Dr. Courelli and YC Shanks for 10 participants, again in a very crowded space. Several of these participants had been in Dr. Louyn's group as well and all but two were about to be paroled. Dr. Courelli had shown the movie, *The Woodsman*, and had prepared questions which the group discussed in an insightful way. I asked Dr. Courelli if the therapists shared this type of material with each other, and she agreed that this would be a good idea but is not currently done.
- Individual therapy –Partial compliance
  - The group notes on individual therapy are maintained in the medical file which is kept in the Health Unit, not accessible to either the psychologists or to the rest of the SBTP team. Most of the individual treatment notes which I reviewed focused on general adjustment, rather than sexual, behavior.

- Resour groups-( The Sex Behavior Task Forc as set a deadline of January, 2006 to evelop a Dynamic and Experiential Gui e) Inconsistency of documentation make evaluation of the current program impossible.
    - I observed a Criminal Thinking Group at Chad run by Youth Counselor Stevens. This was the seventh of a ten week curriculum. The participants were quite involved and insightful. The leader was positive and enthusiastic although more training would assist him in understanding different types of offenders, knowledge which would have been helpful to him in this situation.
    - I observed a casework group at Stark. It is difficult to know where this group fits into the current SBTP plan, or whether it should be considered a resource group. Three wards met with Y.C. Watson who had reproduced some short articles on child abuse from a book entitled *Power Source.* However, this did not appear to be part of a larger curriculum. It would appear that were the counselor provided with one of the SBTP's curriculum that it could presented in an effective manner, saving the counselor from having to devise activities on his or her own. The group leader interacted in a very positive way with the participants
    - It was difficult to find documentation of resource groups in the files. In some institutions such as O.H. Close, these files are kept in separate folders maintained by the YC's and are limited to one note for each meeting rather than separate notes for each participant. In some institutions notes for each participant are recorded in the WIN system but not printed out and filed in the wards' files. In some institutions the notes are prepared on the WIN system, printed out and filed in individual's hall files.
- Special resource groups-Not in compliance
    - There was no evidence of special resource groups other than the substance abuse programs that are offered by the institution to all wards.
- Family therapy-Partial compliance
    - There were notes on family therapy for some wards which are being conducted at all institutions with the exception of Chad-where I was told that family therapy could not be conducted per order of the administration.
- Maintenance group-Not in compliance
    - No maintenance groups appear to be operating.
- Large group notes and observations-Not in compliance
    - I observed the large group at O.H. Close which was conducted by the Youth Counselors for the 60 participants on Humboldt unit. The program participants had prepared a skit complete with sets which depicted a young man going through the stages of treatment including understanding one's history and one's assault cycle and preparing a relapse prevention plan. The audience was very active in asking insightful questions. The Youth Counselors were very supportive. YC Cosetta Greg is a professional gospel singer and has written a song celebrating the boys' birthdays which the large group convinced her to sing.
    - I found only one note at the rest of the facilities which referred to a large group. This note recorded a discussion of housekeeping issues.
- Therapeutic Community Activities-Not in compliance
    - The above description of the large group at Humboldt reflects a Therapeutic Community activity but this appears to be an isolated incident. The staff needs to be trained in developing TC community-building techniques.
- Specialized services-Partial compliance

        - There are specialized services for the wards including a number of programs such as Substance Abuse and Victim Awareness which are offered to all wards. There are also special units for wards needing intensive mental health counseling. The Stanford Project at Chad does offer an "informal sex offender treatment program." Reportedly this program is offered by parole agents with little or no training in providing treatment for sexually inappropriate behavior.
- Outpatient Program-Not in compliance
    - Not only is there no outpatient treatment program, staff has informed me that these institutions have not been told that they will expected to develop a comprehensive SBTP which will involve providing 10 hours a week treatment to all of their sex offenders.
    - Other than Ventura which houses the female SBTP, representatives of the facilities that will house the Outpatient programs are not participating on the SBTF)
- Assessment (The SBTF has set a deadline of January, 2006 to evaluate the validity of the SORD)
    - Development of screening devise-Not in compliance
        - The SORD is still being used. However, at least 30% of the files which I reviewed did not have SORD scores although at least 90% had completed SORD questionnaire
        - A request has been made for a letter from the department stating that the SBTP wishes to participate in the norming of the J-SOAP, a widely recognized risk assessment tool for juvenile sex offenders, However, this letter has not been received.
    - Implementation of screening devise-Not in compliance
    - Development of assessment protocol-Not in compliance
        - The SBTF has been exploring instruments to be included in the assessment process. I did note that there are well-written psychological evaluations in all of the files. However, they vary in the issues that they address and do not necessarily include sex offense-specific assessments although some of the reports did use such tools.
    - Implementation of assessment protocol-Not in compliance
- Treatment Plans
    - Written treatment plans-Partial compliance
        - All of the files contained Individual Change Plans and Annual Treatment Reviews.
        - There is no form which addresses the steps in the SBTP so that it is impossible to track progress in the program.
    - Quarterly treatment reviews-Partial compliance
        - All of the files had periodic Progress Reports conducted by multi-disciplinary teams. Some of these clearly focused on SBTP issues. However, the more problems a ward has, the less space is devoted to goals related to the SBTP.
- Development of Behavioral Management System-Partial compliance
        - It appears that a new Incentive Program has been developed for the entire department and that the staff is currently being trained in this system. However, there is no documentation on how this is being implemented.
- Implementation of policies-Not in compliance
    - Signed releases-Not in compliance

        - There was no evidence that the program participants are being informed about confidentiality or about the pros and cons of the participating in the program.
    - Termination process follows policies-Not in compliance
        - Since there are no policies specific to the SBTP, there are no specific termination policies. I did review the files of several wards who had been terminated. Some of these participants had been put on contracts before being terminated and others had not.
    - Completion of program based on established standards-Not in compliance
        - I attended groups in which a number of participants who were being discharged imminently were in attendance. Some of the participants had made significant progress in treatment but other participants had only been in treatment for a matter of weeks.
- Prerelease
    - Prerelease package prepared by parole officer-Not in compliance
        - Although I observed a parole officer making prerelease plans with a program participant, I did not see any prerelease plans in the records.
    - Assistance in establishing support system-Not in compliance
        - Although I overheard contact being made with a support member, I did not see written documentation of similar contacts in any records although reference to this may have been included in narrative notes.
- Healthy Sexuality Program (The Sex Behavior Task Force has set a deadline of January, 2006 for the development of this curriculum.)
    - Curriculum developed-Partial compliance
        - It is my understanding that Dr. Cellini is working on this curriculum
    - Program implemented-See above.
- Staffing
    - Staff qualifications-Not in compliance
        - Staff appear to be qualified, However, I was told that labor issues prevented me from reviewing resumes, even if redacted.
    - Staff training-
        - Professional staff training-Currently being planned by the Task Force.
            - A good deal of time is being devoted to identifying treatment needs by the SBTF. However, no concrete plans for training staff have been presented to me. The SBTF may be in the process of planning specific trainings.
        - Adjunct staff training-Currently being planned by the Task Force.
            - At this time there do not appear plans to provide this type of training which probably will not be developed until after the professional staff is trained.
    - Staff supervision-Not in compliance
        - Staff supervision appears to vary from institution to institution and to be offered to staff according to their discipline rather than as a treatment team for the SBTP.
    - Hiring of the SBTP Program Coordinator-Partial compliance
        - The position has been submitted to the Department of Budget and Finance.
- Aftercare Program-Not in compliance
        - Inhouse parole agents coordinating with aftercare programs need to have adequate knowledge of these programs.

- Very little information could be obtained about these positions including whether a new RFP has been awarded and what the particulars of the qualification of the providers are.

**ISSUES:** These issues reflect factors which need immediate attention and have been arranged in order of priority.

***Waiting List:*** In order as ascertain how effective the resources of the SBTP are being utilized, I need information about the waiting list including how many wards are waiting to be transferred to Inpatient Programs, how many of these wards needs specialized services,

***Recommendation***

- Provide waiting list as soon as possible.

***Hiring of Program Coordinator:*** Many of the recommendations outlined below can best be tackled by a full time program coordinator. The recruitment and hiring of this individual should be fast tracked as current staff is overwhelmed by other duties.

***Recommendation:***

- A national search should be immediately undertaken for an expert in the field treatment of juveniles with sexual behavior problems to serve as the Coordinator.

***Treatment Records:*** One of the biggest concerns identified by the audit and probably one of the most easily correctible aspects of the program is the lack of standardization and accessibility of the files. A file produced by a treatment program is the blueprint for treatment. It would be unthinkable for a patient to be treated by a health professional without ready access to that patient's file. The information therein drives the treatment. This should be equally true in the SBTP.

The staff must first develop a form which documents in an easily interpretable way the progress that a participant has made in the steps in the program. I have attached several examples. These must accessible to both the psychologists and the Youth Counselors. It must also relate to the requirements for each step so that is clear not only what a participant has accomplished but what they need to accomplish and consequently exactly what they should be working at any point in time.

The record should clearly document what resource groups have been completed. This might be best done by awarding certificates at the completion of each resource group.

The maintenance of the forms must be standardized. Currently each facility maintains files in different ways. Documentation needs to be maintained for participation in group therapy including core group and resource groups as well as individual therapy in a way which will assist the treatment team to plan and administer therapy for each participant. Type of activity and the exact timing of that activity must be clearly noted.

***Recommendations:***

- A clinical file containing all material relevant to the SBTP should be developed for each program participant which would contain legal and court documents related to the crime/s, the SORD and its score, psychological assessments, group notes from all groups as well as individual therapy notes or summaries relevant to SBTP treatment.
- This file needs to be readily available to the SBTP team.
- This file needs to be consistent across institutions.
- This file should contain a document which clearly outlines the steps in the program and documents the participant's progress through these steps.

***Appropriate Housing & Programs:***

The plan states that the SBTP will be conducted in appropriate physical settings including appropriate facilities as well adequate physical space within those facilities. With the exception Chaderjian Youth Correctional Facility, the other facilities housing the Inpatient Programs appeared to be adequate as far as appropriate security level and overall safety of the program participants.. However, many of the rooms in all of the institutions that I observed were extremely crowded.

I was quite concerned about the safety of the participants in the Inpatient SBTP at Chaderjian. At the time of my first visit two participants had sustained broken bones within the SBTP housing unit in two months, At that time one of the perpetrators of the latest assault was still living on the housing unit despite repeated requests to have him moved. On both visits the staff reported that the program participants are frequently assaulted or tormented by other residents when they go to school or other programs. Living in fear for their physical safety significantly impairs the ability to participate in treatment.

Juveniles who are convicted of committing sexual offenses are rarely in need of maximum security confinement. They are rarely gang affiliated, aggressive towards their male peers or heavily involved in drugs. Those who have molested children tend to be very immature, socially isolated and passive. Furthermore the combination of individuals convicted of sex crimes with wards who have committed sexual assaults while incarcerated is inappropriate. Programs addressing juveniles with sexual behavior problems have not been developed to address the basically criminal offender whose behavior is part of the inmate culture. The SBTP plan addresses the development of specialized treatment for subpopulations such as this. I believe that every effort should be made to move the SBTP to a more suitable facility. The fact that one is from Northern California should not necessitate being placed in a facility ill-suited to house treatment programs for youths with sexual behavior problems.

The Department has been discussing whether program participants should be housed in dorms or in cell. .Having operated programs that had (1.) single cells (2.) double bunking, (3) six man rooms (4) open dorms of up sixty men, I believe that single cells and double cells are the least therapeutic for this population. Individuals with sexual behavior problems tend to withdraw and isolate when under stress. Single cells facilitate this and also allow for the privacy in which to engage in deviant fantasy and behavior. Double cells provide the opportunity for roommates to act out sexually with each other. More communal housing including open dorms discourage isolating and sexual involvement between program participants.

***Recommendations:***

- The Department should consider alternative housing for the SBTP rather than continuing to operate it within Chaderjian.

***Treatment Time:*** The plan submitted for the SBTP sets ambitious time schedules for the groups (Eg,Core groups are to run for three hours once a week and large groups are to run for two hours twice a week). However, these treatment hours are not being consistently met. Additionally groups do not have set meeting times. For example, at Chad the case workers could offer resource groups any time within a four hour time frame. Additionally groups appear to end when they "run out of steam" rather than at specified times. Groups operate much more effectively when the time frame is clearly established and faithfully followed. Additionally it would appear to be difficult to schedule other activities when therapy groups do not follow a strict schedule. It was noted that therapeutic activities are frequently cancelled because other required activities interfere such as evaluations or case conferences.. However, if groups were always scheduled for certain hours, other meetings, case conferences, etc could be scheduled around them.

***Recommendations:***

- Because there are not set times for the groups, it is difficult to evaluate whether there is compliance with the hours required by the plan.
- Group notes need to include exact times that the group was in session.

***Policies regarding ethics:*** Currently the staff of the SBTP are providing treatment without clarification on issues such as confidentiality and informed consent. The department needs to clarify how they will handle issues such as access to treatment records in connection with involuntary commitment proceedings so that appropriate release forms can be developed.

***Recommendations:***

- Current policies do not adequately address issues of confidentiality and informed consent. This places professional staff in the position of operating outside their own professional standards.
- Legal staff needs to clarify these issues.

***Curriculum***: There is a large manual which contains a standardized curriculum but without the necessary handouts. These could be developed so that the curriculum would be useable. I have no problem with the curriculums as they have been developed if they can be completed by adding the required participant materials and developing a handbook of experiential exercises that can be added to curriculum. It has been my observation that many groups are not following any kind of curriculum which necessitates the youth counselor or the psychologist having to develop group materials at the last minute. This also leads to the lack of consistency which is very evident in the activities. It also makes much extra work for the staff.

***Recommendations:***

- The Task Force has set January, 2006 as the deadline for developing the curriculum including that for the Healthy Sexuality classes. This can be facilitated by using the existing curriculum as a starting point.

***Staff:*** Without exception, the program staff including the psychologists, parole agents and Youth Counselors were professional, caring and competent. These are primarily mature individuals who serve as ideal parental models and related to the wards in a supportive and encouraging manner. I was able to observe a number of informal contacts as I was monitoring files and could conclude that the wards related easily to the above staff. In the therapy sessions the leaders were encouraging and used positive reinforcement, appearing to be instinctively following the principles of Motivational Interviewing.

The staff appeared to be knowledgeable about the specific area they were presenting. It was difficult to ascertain the breadth of expertise in sex offender treatment of any specific staff member but each one seemed familiar with the topic they were presenting which included Relapse Prevention and Criminal Thinking Errors as well as a general casework group and a large group. However, the staff also consistently expressed a desire for more training in the area.

The clinical staff also reported widely ranging knowledge and support of the Sexual Behavioral Treatment Program Plan. They all requested additional training.

Although the staff appeared to be qualified, I was not provided with staff resumes despite requesting them prior to the audit and at the exit interview, I have only received one. Therefore the Department cannot be credited with complying with this factor.

***Recommendations:***

- The Task Force is currently making plans for training the staff. I need to be informed of these plans as soon as possible.
- It is recommended that the Task Force contact Dr. Steve Bengis of NEARI Publishing in Holyoke, Massachusetts (sbengis@aol.com) who is developing a multimedia training program on treating juveniles with inappropriate sexual behavior.

***Assessment:*** The instrument that is currently being used does not have demonstrated reliability or validity. The Department has the opportunity to participate in the norming of both a risk assessment, the J-SOAP-15, and an assessment packet, the Matrix. Both of the authors are requesting that contact with the Department.

Although a standardized assessment protocol has not been developed, the Task Force is actively working on selecting the instruments and format.

I did review a number of very well done psychological evaluations done by institutional psychologists for a variety of different reasons.

***Recommendations:***

- The Department immediately needs to contact Dr. Robert Prentky (Justice Resource Institute 63 Main St Bridgewater, MA 02360) regarding participation in the norming of the J-SOAP.
- The Task Force should contact Dr. Moccia-Fonsekia of Sexual Dynamics in San Diego or Dr.Rassmussen of the University of San Diego School of Social Work. in regards to the development of the Matrix.

***Outpatient Treatment:*** Although staff of the Inpatient SBTP has been involved in the Task Force , with the exception of the female program at Ventura, the staff who will conduct the outpatient SBTP have not been involved. These institutions need to be part of the planning program so that they will be ready to implement these programs in a timely manner.

***Recommendations:***

- Representatives from the SBTP need to meet with the administration of the facilities which will house the Outpatient Treatment Programs to introduce them to what will be expected of their staff.
- As soon as possible representatives of these facilities should be involved in the Task Force.

***Aftercare Treatment:*** The staff of the SBTP needs to acquire information about the treatment programs being offered through the Parole Department.

***Recommendations:***

- Details regarding the aftercare programs for juveniles with sexual behavior problems need to be obtained including qualifications of the vendors and of the specific therapists.

Inquiries about this audit may be directed to me at the above address.

Respectfully submitted,
Barbara Schwartz PhD
Barbara K Schwartz. Ph.D.
Date: 11/30/05

**APPENDIX 1: Audit Schedule**

Thursday, October 20, 2005

8:30 am Flight from Boston to Oakland
11:30 am Arrived in Oakland
2:30 pm Arrived at O.H. Close Youth Correctional Facility where I met with staff and observed a case conference, attended at core group and met with Rosa Rivera, Deputy Superintendent and contact person for the SBTP .
5:30 Reviewed records
7:00 Left

Friday, October 21, 2005

8:30 am Met with administration of N.A.Chaderjian Youth Correctional Facility.
9:00 am Observed Criminal Thinking Errors group
11:00 am Reviewed records
12:00 pm Met with Dr. Kirkwood, SBTP Psychologist
1:00 pm Reviewed records
2:30 pm Returned to Close and reviewed records
6:00 pm Leave institution

Saturday, October 22, 2005

9:00 am Observed large group at O. H, Close
12:00 pm Drive to Bakersfield, CA.
4:30 pm Arrive in Bakersfield, CA.

Sunday, October 23, 2005

9:00 am Review documents
12:00 pm Drive to Chino, CA.
5:00 pm Met with Dr. Cellini, Ms. Rivera and Sherleen Redd, Attorney for the Department
7:00 pm Meeting over

Monday, October 24, 2005

9:00 am Met with program staff at Herman Stark Youth Correctional Facility including J, Hetherton, Youth Counselor and L. Povcio, Ph.D, Senior Psychologist
10:30 am Reviewed files
1:30 pm Attended Spanish-speaking Core group

3:00 pm Attended casework group
5:00 pm Left facility

Tuesday, October 25, 2005

9:00 am Met with staff at Southern Youth Correctional Reception Center and Clinic including Ted Bongon, Cassandra Stansberry, Asst Superintendent. Deborah Louyn, Psychologist; L, D Cowen, Program Administrator; Dr, Courelli, Psychologist
10:30 am Attended Core Group
1:30 pm Met with Dr. Leong
2:30 pm Review records
5:00 pm Left facility

Wednesday, October 26, 2005

8:30 am Attended Core group with Dr. Courelli, Psychologist at Southern
10:30 am Exit interview
12:30 pm Organized and reviewed observation files.
8:30 pm Depart from Long Beach Airport

Thursday, October 27, 2995

7:30 am Arrive in Boston

## APPENDIX 2: Materials Reviewed

- At each institution the files of ten participants were reviewed. Depending on how the files were maintained, on a single ward this could included
    - Hall files
    - Mental health files maintained in the Medical file
    - Group notes maintained by youth counselors
    - Group notes maintained by psychologists
    - The file which is maintained for the Parole Board
- Files of wards who were terminated from the SBTP at Close, Stark and Southern and who were then transferred to Chaderjian.

The following materials were requested but were not available:

- Policies and procedures related to the SBTP which are currently in effect.
- Notes and rosters from Community meetings.
- Written evidence that program participants are involved in the operation of the Therapeutic Communities.
- Documentation of step progression.
- Documentation that graduates of the program have
    - Successfully complete the program
    - Participated in a Prerelease process including evaluation of residence and support system.
- Documentation of the validation/revision of the SORD.
- Any materials related to the development of a uniform assessment protocol.
- Documentation of progress towards the development of curriculums for resource groups.
- Redacted resumes of staff
- Training logs including attendance at conferences or requests to attend conferences and whether approved or denied.
- Staff supervision logs.
- Signed consent forms regarding confidentiality and informed consent.
- Contracts with aftercare providers including:
    - Redacted resumes of staff
    - Randomly selected treatment files of SBTP graduates from aftercare providers. .
- Material related to the development of a program evaluation.
- Material related to the development of an RFP for curriculum development.
- Materials related to the recruitment/hiring of a SBTP Program Coordinator.
- Materials related to the recruitment/hiring of additional professional staff, clerical staff and research coordinator.

- Evidence that documents that youth with sexual behavior problems are afforded the opportunity to participate in vocational training programs.
- Materials related to the Healthy Sexuality Program.
- Materials related to the training of adjunct institutional staff in the needs of youths with sexual behavior problems.

**Appendix E**

Hopper, *Wards with Disabilities Program Remedial Plan Annual Auditor's Report* (May 31, 2006)

## Introduction

During the year since the Department of Juvenile Justice authored and adopted the Wards with Disabilities Program Remedial Plan, in response to the Consent Decree entered in the matter of *Farrell v. Hickman*, the Department has made significant strides in accomplishing many of the goals established by the plan. In addition, the department has started planning for other goals that were not specifically scheduled for implementation during the first year of the plan.

However, some other goals scheduled for implementation during the first year of the plan have yet to be realized. It is believed that the primary reason for not meeting some expected timelines centers largely on administrative changes from the somewhat autonomous former California Youth Authority to the current Department of Juvenile Justice, a part of the larger California Department of Corrections and Rehabilitation. While long-term efficiencies are expected as part of this reorganization, it is also to be expected that short-term policies and procedures would be more difficult to implement.

The purpose of this introduction to the auditor's report is to summarize the successful implementation actions taken by the DJJ, as well as to pinpoint some of the areas where more focus is needed, together with some recommendations intended to improve progress in these areas.

### *WDP Coordinators*

The strongest development over the past year has been the establishment of Wards with Disabilities Program Coordinators department-wide and at each correctional facility. While facility WDP Coordinators were named prior to the approval of the remedial plan, they have only recently become active, and assistants to these coordinators have been hired at six facilities. Also, Karen L. Smith has been performing the Departmental WDP Coordinator oversight functions since March, 2006. Before that, Bill Anderson worked part-time to coordinate implementation of the remedial plan and performed this task admirably, even though the reorganization effort affected compliance efforts as described above. Ms. Smith is assisted by Troy Kaestner, and they have begun training for their roles and begun the required monitoring of programs for wards with disabilities at the facilities. The WDP Coordinators' monthly reports required by the remedial plan have been prepared for the first time for April, 2006, although I would recommend that the current format be expanded to include more information on the services actually provided to wards with disabilities, as well as information on wards with disabilities grievances and disciplinary actions, and those placed in restrictive settings.

### *Staff Assistants for Wards with Disabilities*

The WDP Remedial Plan requires the establishment of staff assistants at each facility, for the purpose of assuring that reasonable accommodations are provided to wards during disciplinary and grievance procedures, Board hearings, parole planning, and other specified activities. Since about February, 2006, these groups have typically been set up at the facilities, and while there have been few instances of actual assistance, this facet of the remedial plan appears to be proceeding in a positive direction.

### *ADA Rights Notification and Ward Orientation*

The Wards' ADA Rights Notification Form has been updated and is in use at the three intake facilities. It is believed that wards are properly advised of their rights and understand the basics of these rights, although a more detailed orientation is still needed. The WDP Remedial Plan requires that an ADA orientation component be developed and presented to all wards at one of the reception centers. While a Power Point presentation has been developed, I would recommend that Ms. Smith review it and add some materials, and that it be presented to all new wards on a regular basis (bi-monthly would be preferable) by trained reception center staff.

### *Physical Accessibility Alterations*

The WDP Remedial Plan requires few architectural modifications within the first year of the plan, but the DJJ has been proactive in completing smaller projects ahead of schedule. Most larger accessibility projects have also been in the planning process, and it is expected that most of the required projects will be completed by the required dates.

**Introduction (Continued)**

***Wards with Hearing Disabilities***

During the last year, the number of wards who are deaf or hard of hearing has decreased dramatically. Nevertheless, the DJJ had done an admirable job of providing TTY's (or telephone equipment for the deaf) and closed captioned television at the facilities, as required by the remedial plan. Interpreter use logs and available contracts or purchase orders for interpreter services have also been updated. While there was one difficult situation involving a deaf ward encountered at one facility (a situation not specifically caused by the DJJ), the appropriate actions seem to have been taken and the matter resolved.

***ADA Staff Training***

The WDP Remedial Plan requires that an outside agency conduct a needs assessment for staff training by June 30, 2006. California State University Chico has prepared a basic outline for how the training should be developed; however, it is unclear who will prepare the final course curriculum. I would recommend that a disability advocacy agency be consulted, as required by the remedial plan, to assist in developing the final curriculum elements, including those related to sensitivity training, discrimination, and harassment.

***Coordination with Special Work Groups and other Remedial Plans***

The WDP Remedial Plan has a number of activities that require this type of coordination, but with no specific schedule for implementation. These required activities include: (1) a special educational working group to make recommendations regarding improvements to IEP accommodations and parent participation, (2) a special working group to study and provide recommendations for residential programs for wards with developmental disabilities, (3) coordination with those working on the health care remedial plan to document the inclusion of several specific items for wards with disabilities, (4) a special working group and coordination with the mental health experts to study the effects of certain psychotropic drugs on wards, and (5) coordination with safety and welfare issues for wards with disabilities, as they would relate to and be included in the safety and welfare remedial plan. To date, only the working group described in (1) above has occurred, and this group is proceeding expeditiously to resolve the outstanding issues. I would recommend that the other groups and coordinating activities be set up to occur as soon as possible.

***Educational Issues for Wards with Disabilities***

There is a degree of overlap between the requirements of the WDP Remedial Plan and the Educational Services Remedial Plan, particularly in the area of educational services for wards with disabilities enrolled in special education programs. The group of three experts has attempted to coordinate monitoring activities in these areas. The educational experts have raised the issue of reduced school days at several facilities, and 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 be implemented to improve the number of hours of instruction. Also, monitoring activities indicated some consistent problems in the preparation of high school graduation plans and individualized education plans (IEP's), and I would recommend attention to the requirements of the WDP Remedial Plan, such as the use of staff advocates during IEP meetings, to resolve these issues.

***WIN Information Systems***

During the year since the approval of the WDP Remedial Plan, the DJJ has worked steadily to upgrade its computerized ward record-keeping system, referred to as the WIN system. The 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 all staff. While there was no specific time line for having the system ready and available for use, it was inherent that perfecting the system would take some time. I believe that the DJJ has made reasonable progress to this end, but would also recommend that the required items of information relating to wards with disabilities that are currently available (it is understood that some items related to classification are not yet resolved in the safety and welfare remedial plan) be incorporated into the WIN system, and that staff be trained to access this information, as soon as it is practical.

**Facility Compliance Chart**

This chart represents the combined auditing report for the first round of site visits to the eight DJJ correctional facilities and headquarters by the Disabilities Auditor, Logan Hopper. Facilities are listed in the chart in the order visited, using the following abbreviations:

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

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

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

| Item | Method | Compliance Rate | | | | | | | | | Comments / Recommendations |
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| **Headquarters** | | | | | | | | | | | |
| **I. Directorate** | | | | | | | | | | | |
| Maintain a current copy of the Wards With Disabilities Program Remedial Plan in the Director's office. | Verify current copy is retained. | -- | -- | -- | -- | -- | -- | -- | -- | SC | A current copy of the Wards With Disabilities Program Remedial Plan was present in the Director's office. |
| **A. Departmental Ward Disability Coordinator & Functions** | | | | | | | | | | | |
| By October 2005, establish and maintain a full-time Departmental Wards with Disabilities Program (WDP) Coordinator and analytical staff to develop, support, lead and manage a quality program. | Verify positions are in place and filled. | -- | -- | -- | -- | -- | -- | -- | -- | SC | At the present time, Karen L. Smith is the full-time WDP Coordinator and Troy Kaestner is the full-time assistant and support, with other staff available as needed. Prior to Ms. Smith's appointment in February, 2006, Bill Anderson performed the WDP Coordinator's functions at Headquarters. |

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| Ensure duty statement encompasses all Departmental WDP Coordinator duties as defined in the WDP Remedial Plan. | Review duty statement. | -- | -- | -- | -- | -- | -- | -- | -- | SC | Both Karen Smith and Troy Kaestner have signed appropriate duty statements for their respective positions. |
| The WDP Coordinator shall perform the oversight functions as set forth in the WDP Remedial Plan. | Review documentation maintained by the Departmental WDP Coordinator. | -- | -- | -- | -- | -- | -- | -- | -- | SC | Karen Smith is believed to be performing the required oversight functions. |
| Establish and maintain full-time WDP Coordinators at each facility by February 2006. | Verify positions are in place and filled. | SC | SC | SC | SC | SC | SC | SC | SC | SC | Each facility currently has an active WDP Coordinator in place. |
| The Departmental WDP Coordinator will develop a standardized emergency announcement protocol by December 2005. | Review emergency announcement procedures to ensure procedures are in place to provide the needed assistance for wards w/ disabilities. Determine timeliness of announcement. | -- | -- | -- | -- | -- | -- | -- | -- | PC | Karen Smith has developed a draft emergency announcement protocol, which has not yet been approved by the DJJ. A preliminary review by the auditor indicates the protocol to be acceptable, with a recommendation to include more specificity on the assistance necessary for wards with physical and psychiatric disabilities. |
| The Departmental WDP Coordinator shall ensure that a WDP report is completed monthly, quarterly and annually for each site. | Review monthly, quarterly and annual reports for completeness. | NC | NC | NC | NC | NC | PC | NC | PC | PC | WDP Coordinators' monthly reports have been prepared for April, 2006, although I would recommend that the current format be expanded to include more information on the services actually provided to wards with disabilities, as well as information on wards with disabilities grievances, disciplinary actions, and those placed in restrictive settings. |

| Item | Method | Compliance Rate | | | | | | | | | Comments / Recommendations |
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| In conjunction with the Health Care Transition Team, Medical Experts and Disabilities Expert, prepare an "action plan" for wards with mobility or other physical impairments to integrate with the general population as soon as medical issues are resolved, including determining the most physically accessible locations available and making the barrier removal improvements required on a timely basis. | Audit to determine implementation and review documentation to ensure compliance. | -- | -- | -- | -- | -- | -- | -- | -- | NC | This consultation has not yet occurred. |
| In conjunction with the Health Care Transition Team, the Mental Health and Medical Experts, and Disabilities Expert, ensure systems are in place to monitor the use of psychotropic prescriptions and medications including SSRI's for wards under the age of 20. | Audit to determine implementation and review documentation to ensure compliance. | -- | -- | -- | -- | -- | -- | -- | -- | NC | This consultation has not yet occurred. |
| The CYA shall conduct annual compliance reviews of the court-approved Disabilities Program Remedial Plans in all CYA facilities to monitor compliance with the Remedial Plan, to ensure that wards with disabilities are being effectively identified, to ensure that the needs of those wards are being met and to reassess and reevaluate the level of staffing and training needed to comply with the Remedial Plan, commencing in the 2006 calendar year. | Verify completion of annual compliance reviews. | -- | -- | -- | -- | -- | -- | -- | -- | SC | The DJJ completed a quarterly report on about April 30, 2006. It is believed that this report forms a part of the annual report required by this item, although the annual report may not be required until the end of this (2006) calendar year. |

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| Within six months of the court approval and adoption of this plan the Department's Ward Disability Program Coordinator will receive a higher level of training provided by qualified trainers/consultants from outside the Department as recommended in Section 5.1 of the Expert's report. | Review the outside consultants training material to determine compliance with the requirements contained in the WDP Plan. Review and confirm training schedule to ensure all individuals complete the required training. | -- | -- | -- | -- | -- | -- | -- | -- | PC | Karen Smith has attended two training sessions, one in-house and one from a national ADA coordinator's association. While these have been helpful in meeting the training goals, we have jointly discussed some additional training resources and have agreed to continue discussions of what other trainings may be helpful. |
| Develop the Disability Health Services Referral Form. | Monitor for completion by December 2005. | -- | -- | -- | -- | -- | -- | -- | -- | NC | No specific form has yet been developed for this specific purpose. |
| **C. Headquarters Policies** | | | | | | | | | | | |
| The CYA shall procure two wheelchair accessible vans to transport wards with disabilities by July 2006. | Review purchase orders (PO) (STD 65) to confirm purchase and within established timeline. | -- | -- | -- | -- | -- | -- | -- | -- | -- | This requirement is not yet due. The Auditor would welcome any information as to the types of vans being considered. |
| By July 2006, the Department shall develop and maintain system that documents the mental & physical impairments of wards with disabilities and any reasonable accommodations. | Audit to determine implementation within the given timeframe and review documentation to ensure compliance. | -- | -- | -- | -- | -- | -- | -- | -- | -- | This requirement is not yet due. The DJJ has been working on documentation through the WIN system upgrades and is believed to be close to completing the task. |
| The Department shall ensure that wards with disabilities have access equal to non-disabled wards in all levels of care within the youth correctional system. | Review 10% of placements and all level of care for wards with disabilities. | -- | -- | -- | -- | -- | -- | -- | -- | SC | Reviews of random files did not indicate any specific lack of equal access. It is recommended that the Department prepare a documentation form to aid in assurances of equal access. |

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| All wards under the jurisdiction of the CYA shall be given equal access to all programs, services and activities offered by the Department. Programs, services, and activities shall be offered in the least restrictive environment, with or without accommodations. | Review 10% of placements and access to special programs for wards with disabilities. | -- | -- | -- | -- | -- | -- | -- | -- | SC | Reviews of random files did not indicate lack of equal access to special programs. It is recommended that the Department prepare a documentation form to evaluate the least restrictive environment requirement (see above). |
| Establish policies to assure that placement of wards with disabilities into restrictive programs is not based either directly or indirectly on a ward's physical or mental disability, or on manifestations of that disability. | On-going audit. | -- | -- | -- | -- | -- | -- | -- | -- | PC | It is recommended that specific policies and procedures be documented in writing to evaluate a ward's (with or without a disability) placement into any restrictive program. |
| By December 2005, the Education Branch shall establish a working committee consisting of the Disability Expert, one Education Expert, the SELPA Director and the Manager of Special Education to study and make recommendations to improve the adult ward's and parents' meaningful participation during IEP meetings, to encourage more active participation, and to provide informational materials for parents and/or surrogates. | Review recommendations and develop appropriate implementation plans. | -- | -- | -- | -- | -- | -- | -- | -- | SC | The working committee has been established, has met several times, and is working effectively, although no final recommendations have yet been made. |

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| The Education Branch working committee shall also study the need for and evaluate the ability of the various public or private groups or agencies to assist with the means of attending IEP meetings for parents. (This is not be interpreted as requiring the Dept. to provide such means.) | Review recommendations and provide support if applicable. | -- | -- | -- | -- | -- | -- | -- | -- | SC | The working committee has been established, has met several times, and is working effectively, although no final recommendations have yet been made. |
| The Education Branch working committee shall also study the need to include a wider variety of individualized accommodations in IEP's. | Review recommendation develop appropriate implementation plans. | -- | -- | -- | -- | -- | -- | -- | -- | SC | The working committee has been established, has met several times, and is working effectively, although no final recommendations have yet been made. |
| In consultation with the disabilities expert, the CYA will conduct a study regarding the need for a residential pro-gram for wards with certain developmental disabilities. The study will commence within 6 months from the date that the Disabilities Remedial Plan is filed with the court. | Review documented study for meeting timeline and evaluate recommendations. | -- | -- | -- | -- | -- | -- | -- | -- | NC | This consultation and the resulting study have not yet occurred. |
| The visiting facility at Ventura is currently under construction & will be fully operational by Jan. 2006. The new facility at Preston will be fully operational and safe for all wards, visitors and staff by July '06. The CYA will confer with the Disability Expert to explore and implement, as reasonably appropriate, interim solutions to address architectural barriers at the existing Preston visiting area until new facility is opened by July '06. | Visit locations to determine completion/ level of operation by established dates. | -- | -- | -- | -- | -- | -- | -- | -- | NAv | The site visit to Ventura YCF was prior to January, 2006, and while the visiting facility appeared to be ready for occupancy, it is not known if it was indeed staffed and fully operational by January, 2006. Preston's visiting facility is not schedules for operation until July, 2006. |

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| The CYA shall conduct a needs assessment and prepare Department wide disability training materials, with the assistance of an outside disability advocacy organization or consultant, in consultation with the Disability Expert, by June, 2006. | Review needs assessment and training materials. | -- | -- | -- | -- | -- | -- | -- | -- | PC | CSU Chico has prepared a basic outline for how the training should be developed; however, it is unclear who will prepare the final course curriculum. I would recommend that a disability advocacy agency be consulted, as required by the remedial plan, to assist in developing the final curriculum elements, including those related to sensitivity training and harassment. |
| 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 Dec., 2006. | Review screening tool to ensure validation. Ensure that the assessment is completed within the given timeframe. | -- | -- | -- | -- | -- | -- | -- | -- | -- | This screening tool is not required until the end of this (2006) calendar year. |
| Within 12 months of the court approval of the plan, all staff will receive training, prepared with the assistance of an outside disability advocacy organization or consultant, and in consultation with the Disability Expert in sensitivity, awareness & harassment. This training will be provided to all staff on an annual basis. Until such time as this training is incorporated in the basic training academy curriculum, this training will be provided to all new hires within 90 days of placement in the facility. | Review the outside consultant training material to determine compliance with the requirements contained in the WDP Plan. Review and confirm training schedules and document attendance to ensure all staff and new hires are provided training. | NC | NC | NC | NC | NC | NC | NC | NC | NC | California State Univ. Chico has begun the needs assessment and prepared a basic outline for how the training should be developed; however, it is unclear who will prepare the final course curriculum. I would recommend that a disability advocacy agency be consulted, as required by the remedial plan, to assist in developing the final curriculum elements, including those related to sensitivity training, awareness, and harassment. |

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| The Department shall ensure that a ward is not precluded from assignments to a work or a camp program based solely upon the nature of a disability. | Review departmental list of wards with disabilities; conduct interviews. Audit work / camp program rosters to determine placement of wards with disabilities. | -- | -- | -- | -- | -- | -- | -- | -- | SC | Reviews of random files and interviews did not indicate any exclusion from camp or work programs. It is recommended that the Department prepare a documentation form to aid in assurances of equal access. This does not include fire camps, for which no auditing has yet been undertaken. |
| The CYA shall develop a provisional form that contains a written advisement of ADA Rights Notification in simple English and Spanish by August 2005. | Review form for completion. | -- | SC | -- | -- | -- | SC | -- | SC | SC | The provisional form was completed and sent to the Auditor prior to the site visits. The form was included in the WDP Coordinator's Disabilities Remedial Plan Manual and was used during intake at all three facilities. |
| **D. Headquarters Programs/Screening** | | | | | | | | | | | |
| Maintain a contract for sign language interpreter services, as well as a record of use of this service. | Review contracts (STD 213/210) for sign language interpreter's services. | SC | SC | SC | SC | SC | SC | SC | SC | SC | Headquarters has a standard purchase order available, although some facilities might use their own form. |
| The Intake and Court Services Unit staff shall review incoming documentation from the committing courts and counties of all wards for indicators of impairments that may limit a major life activity and require accommodations or program modifications. | Sample 10% or 10 ward master files, whichever is greater, reflecting intake for the last quarter. Interview Intake and Court Services Unit staff. | -- | -- | -- | -- | -- | -- | -- | -- | SC | Review of files and interviews indicated that arriving documentation is adequately reviewed, although I would recommend additional documentation verifying such within the Intake and Court Services Unit. |
| The CYA will revise the Referral Document, YA 1.411 by replacing the term "handicap" with "disability" within 30 days of the filing date of this plan. | Review form for completion. | SC | SC | SC | SC | SC | SC | SC | SC | SC | The form has been revised, and the revised form was present at all facilities. |

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| When indicators of impairment exist, the Intake and Court Services Unit staff shall complete the disability section on the Referral Document and forward to the designated Reception Center and Clinic. | Sample 10% or 10 ward master files, whichever is greater, reflecting intake for the last quarter. Interview Intake and Court Services Unit staff. | -- | -- | -- | -- | -- | -- | -- | -- | SC | Review of files indicated that staff generally complete the section, although sometimes cursory. I would recommend additional documentation be provided by the Intake and Court Services Unit, a procedure that should be aided in the future with the completion of the WIN system upgrades. |
| **Facility Administration** | | | | | | | | | | | |
| **A. Superintendent** | | | | | | | | | | | |
| Maintain a current copy of the Wards With Disabilities Program Remedial Plan retained in Supt.'s office. | Verify current copy is retained. | SC | SC | SC | SC | SC | SC | SC | SC | -- | The Superintendent's Disabilities Remedial Plan Manual was present in the Superintendent's office at all facilities. |
| Superintendents shall ensure wards with disabilities are informed, during orientation, of the existence of electronic equipment in libraries, what equipment is available, how and when equipment can be accessed, and where the equipment is located. | Review orientation program for inclusion of information. | PC | PC | PC | PC | PC | PC | PC | PC | -- | No formal ADA orientation program was provided at any intake facility, but this item is believed to be an additional orientation requirement and facility-related. New wards were shown to have signed the ADA Rights Notification Form, although it was usually unclear that wards were provided with information regarding these particular accessible features. |
| The Superintendent shall report to the Deputy Director, within twenty-four hours, when a ward with a disability that requires accommodation is placed in a restrictive setting, i.e., TD or lockdown. | Interview wards and SAs. Audit TD forms for compliance. Review Special Incident Reports (YA 8.401) related to Administrative Lockdowns. | PC | PC | PC | PC | PC | PC | PC | PC | -- | At most facilities, YA 8.401 "Serious Incident Reports" and a list of wards on TD were provided to the Auditor. There was no indication that wards with disabilities required an accommodation or were not provided with one. However, there was also no indication that a formal system of reporting, within the 24 hour time line required by the remedial plan, has been fully implemented. |

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| The Superintendent shall be responsible for ensuring that due process and equal access occurs for wards with disabilities who require accommodations during institutional Youth Authority Board (YAB) hearings. | Audit Case Report Transmittal Form. | PC | PC | PC | PC | PC | PC | PC | PC | -- | At the present time, the YAB has instituted its own procedures based on the *Armstrong* case that would assist in accommodating wards with disabilities, although the review of YAB procedures is beyond the scope of this audit. "Case Report Transmittal" forms printed from the WIN system, as required by the auditing instrument, are not specifically provided to the YAB. I would recommend that this transmittal form be revised to document due process, equal access, and accommodations, as required by the remedial plan |
| **B. Facility's Ward Disabilities Coordinator** | | | | | | | | | | | |
| Maintain WDP Coordinators at each facility. | Verify positions are in place and filled. | SC | SC | SC | SC | SC | SC | SC | SC | SC | Each facility had an active WDP Coordinator in place at the time of each site visit. |
| Ensure duty statement encompasses all facility WDP Coordinator duties as defined in the WDP Remedial Plan. | Review duty statement. | SC | SC | SC | SC | SC | SC | SC | SC | SC | Each WDP Coordinator and assistant have signed an appropriate duty statement. |
| The facility WDP Coordinator shall perform the oversight functions as set forth in the WDP Remedial Plan. | Review documentation maintained by the facility WDP Coordinator. | SC | SC | SC | SC | SC | SC | SC | SC | SC | Each WDP Coordinator and assistant are believed to be performing the required oversight functions. |

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| Within six months of the court approval and adoption of this plan the facility Ward Disability Program Coordinators will receive a higher level of training provided by qualified trainers/consultants from outside the Department as recommended in Section 5.1 of the Expert's report. | Review outside consultants training material to determine compliance with the requirements in the WDP Remedial Plan. Review and confirm training schedule to ensure all individuals complete the required training. | PC | PC | PC | PC | PC | PC | PC | PC | -- | Facility WDP Coordinators have attended meetings to discuss requirements and procedures, but the Auditor has not reviewed ADA training materials, nor is it clear that the extent of training required by the remedial plan or the expert's report have been accomplished. |
| The facility WDP Coordinators shall submit monthly reports to the Department WDP Coordinator. | Review monthly reports. | NC | NC | NC | NC | NC | PC | NC | PC | PC | WDP Coordinators' monthly reports have been prepared for April, 2006, although I would recommend that the current format be expanded to include more information on the services actually provided to wards with disabilities, as well as information on wards with disabilities grievances, disciplinary actions, and those placed in restrictive settings |
| **C. Facility's Policies** | | | | | | | | | | | |
| Efforts to identify wards with disabilities within youth correctional facilities shall be continuous, and shall include self-referrals, staff-referrals, facility ADA screening and assessment, and special case conferences. | On-going audit. | PC | PC | PC | PC | PC | SC | PC | PC | -- | Lists of wards with disabilities were typically identified by DJJ and provided to the Auditor at the facilities. Facility screenings and assessments vary between facilities. No special case conferences were held during the site visits. |

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| Assistive devices may be taken away from a ward only to ensure the safety of persons, the security of the facility, to assist in an investigation, or when a Department physician or dentist determines that the assistive device is no longer medically necessary or appropriate. | Interview wards and review supporting documentation. | PC | PC | PC | PC | PC | PC | PC | PC | -- | While there were no documentation or specific instances encountered where ward's assistive device was "taken away", there were a few instances where an assistive device needed by a ward was not provided, or was otherwise unusable by a ward. There was no indication that either safety or security was jeopardized in these instances. Also, there was no indication that medical staff were directly involved. |
| Wards with hearing disabilities shall be provided use of a Telecommunications Device for the Deaf (TDD). | Interview wards and WDP coordinators to verify presence of operational TDD. | SC | SC | SC | PC | SC | PC | SC | SC | -- | TDD's were present at all but two of the facilities, but were not necessarily operational if no deaf wards were present. No ward reported the inability to have an operable TDD available. |
| Wards with hearing impairments shall have access to at least one facility television located in their assigned living unit that utilizes the closed captioning function at all times while the television is in use. | Interview wards and WDP coordinators to verify presence of operation closed captioning function TV. | SC | SC | SC | SC | SC | PC | SC | SC | -- | Closed captioned TV's were present and operational at all but one facility. No ward reported the inability to have an operable closed captioning TV available. |
| Distribute and post reports, brochures, treatment, and education materials in a manner that is accessible to wards with disabilities. | Conduct site visits to verify presence of accessible posted materials. | SC | SC | SC | SC | SC | SC | SC | SC | -- | Informational materials were generally noted to be at accessible heights and locations. For future reference, these should be centered 48" above the floor, and any materials that require reaching should be no higher than 54" above the floor. |

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| A ward may make a self-referral requesting an accommodation for a documented or perceived impairment through his or her assigned PA, Casework Specialist or by completing the Referral for Sick Call (RSC) form. A ward may make a self-referral for an accommodation for a documented or perceived impairment through an Education Advisor by completing the Self-Referral to the School Consultation Team (SRSCT) form. | Review submitted RSC (YA 7.464) and SRSCT (YA 8.229) forms and determine appropriateness of disposition. Observe random interviews at intake. | PC | NC | NC | NC | NC | NC | PC | PC | -- | Although the DJJ would allow a ward to make such a self-referral, it was not evident that forms YA 7.464 and YA 8.229 were being used by either wards or staff for self-referrals or staff referrals. Form YA 7.464 is a general referral form, presumably also used for self-referral, although not specifically stating such. Also, the form does not specifically list the ADA or the presence of a disability as a reason for referral, which is recommended. The YA 8.229 form may be in the process of revision. It is recommended that the YA 8.229 form or any revision of it also list the ADA and/or presence of a disability as a reason for the request |
| The Principal shall ensure students with disabilities are trained in the proper use of electronic equipment. | Interview wards and Principal for proof of practice. | SC | SC | SC | SC | SC | SC | SC | SC | -- | No wards with physical disabilities that would be affected by this item were specifically identified by DJJ. Facilities appeared prepared to provide the necessary and appropriate training. |
| Students who take the CAHSEE with a modification and receive the equivalent of a passing score are eligible for the waiver request process. Students who are eligible will be granted waivers based on the SBE process and policy. | Verify by records review of students taking state-mandated exams that waivers were requested for students with modifications who receive equivalent passing scores (in accord with CDE guidelines.) | -- | -- | -- | -- | -- | -- | -- | -- | SC | The CAHSEE was administered to wards in special education programs at several times throughout the year. Since the CASHEE requirement for special education students was deferred for the '05-'06 school year by SB517, this particular requirement is not applicable during this monitoring cycle. Recently, the DJJ Superintendent of Education has recently notified all principals that students in special education should graduate if otherwise eligible, regardless of CAHSEE results, and she has requested lists of all such students. |

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| Each ward with a disability shall have a High School Graduation Plan. | Review randomly 10 or 10%; whichever is greater, of students with IEP's graduation plans. | PC | PC | PC | PC | PC | PC | NC | NC | -- | Of the student files reviewed, some did not have had properly prepared graduation plan forms completed within the last year. The degree of problems varied for each facility, as shown in the previous columns. Some files that did have plans did not have all of the necessary information, nor specificity how goals were to be accomplished. Other issues needing further review included: (1) graduation plans not being followed once updated and (2) graduation plans that did not lead toward the graduation goal. |
| Provide for and implement the four exceptions to the graduation standards for students with disabilities, as listed in the remedial plan. | Review randomly 10 or 10%; whichever is greater, of students with IEP's graduation rates and uses of the exception to the grad-uation requirements. | SC | SC | SC | SC | SC | SC | SC | SC | -- | Some facilities provided lists of students with disabilities graduating in the last year, while others did not. There were no specific indications that any of the four graduation exceptions listed in the remedial plan was denied. |
| The principal shall ensure that wards with disabilities enrolled in educational programs have equal access to educational programs, services, and activities. | Review randomly 10 or 10%; whichever is greater, of access for students with IEP's. | PC | NC | PC | PC | PC | NC | NC | NC | -- | Based upon student files reviewed and interviews, there were indications that some wards with disabilities, particu-larly those at restricted units, had limited access to full-day programs at some facilities. In addition, some special education students had outdated or incomplete IEP's, which would limit proper access to this program. The degree of problems varied for each facility, as shown in the previous columns. A number of wards had some specific complaints about lack of access to academic programs. |

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| Non-emergency verbal announcements, in living units where wards with hearing and other impairments reside, shall be done on the public address system and by flicking the lights on and off several times to notify wards with disabilities of impending information. Verbal announcements may be effectively communicated in writing, on a chalkboard, or by personal notification. | Review operational procedures. Interview wards with disabilities to determine effectiveness of non-emergency communications. | SC | SC | SC | SC | SC | SC | SC | SC | -- | Interviews and observations indicated no significant but some minor problems in this area. It should be noted that the Department WDP Coordinator has completed a draft document for emergency announcement protocols, subject to further DJJ review, which could be also applied to these issues.. |
| CYA staff shall be aware of accommodations afforded to wards with disabilities in developing and implementing security procedures including use of force, count, searches, transportation, visiting and property. | Interview 10 security personnel and wards yearly for specific inquiry regarding security issues. | SC | NC | SC | PC | PC | SC | PC | SC | -- | Interviews and observations indicated some sporadic problems in this area, although further guidelines from the Safety and Welfare Plan are needed. |
| Prior to placing a ward with a disability into a restricted setting, the Superintendent shall review the referral form and ensure that any accommodation required by a ward has been documented. | Review records of 10 or 10%, whichever is greater, of wards placed in restrictive settings. | PC | PC | PC | PC | PC | PC | PC | PC | -- | Lists of wards placed in restricted settings were usually provided to the Auditor. While there were no specific indications of the lack of accommodations and there were some indications that placements were starting to be reviewed as required by the remedial plan, these procedures are not fully implemented. |

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| Each Education Specialist that is assigned as a case carrier, or alternate, will discuss the tenets of advocacy with the ward and surrogates prior to the IEP meeting to encourage active participation. During the IEP meeting, the specialist or alternate, will serve as the advocate of the student. | Attend pre-meetings and IEP meetings to determine degree of participation and advocacy roles. | NC | NC | NC | NC | NC | NC | NC | NC | -- | There were no indications from IEP records and discussions with the teaching staff that this policy has yet been implemented. Only a few IEP meetings were scheduled during the Auditor's visits, and the advocate position was not utilized during these meetings. |
| All individuals who serve as surrogate parents will receive annual training in the role and responsibilities of a surrogate as identified by the State Department of Education. Student advocacy will be addressed as part of the training and the training will also encourage active participation. | Review training curriculum to ensure compli-ance with the State Department of Education criteria. Attend training sessions provided to surrogate parents. | PC | PC | PC | PC | PC | PC | PC | SC | -- | A copy of the surrogate training materials, as prepared by the California Department of Education, was provided to the Auditor. It appears that surrogate parents from Preston are the only ones who attended a recent training. The Auditor was not aware of and thus did not attend this training. |
| Reasonable accommodation shall be afforded wards with disabilities to ensure equally effective communication with staff, other wards, and the public. Assistive devices that are reasonable, effective, and appropriate to the needs of a ward shall be provided when simple written or oral communi-cation is not effective or as necessary to ensure equal access to the programs and services. (A list of potential devices omitted for brevity) | Interview wards and WDP coordinators to determine level of availability and accessibility of assistive devices. | PC | PC | PC | PC | PC | PC | PC | PC | -- | Some assistive devices for equally effective communication were usually available, but procedures for providing the required variety of devices have not been fully developed at the facilities, or department-wide. |

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| The Department shall provide reasonable accommodations or modifications for known physical and mental disabilities of qualified wards. Accommodations shall be made to afford equal access to the court, to legal representation, and to health care services for wards with disabilities. | Interview wards with disabilities and WDP coordinators to confirm accommo-dations. | PC | PC | PC | PC | PC | PC | PC | PC | -- | Reasonable accommodations or modifications were usually provided, though no written documentation was provided. Ward interviews indicated some problems. I would recommend that procedures for providing the required variety of reasonable accommodations or modifications be more fully developed at the facilities and department-wide. |
| Qualified sign language interpreters shall be provided as necessary to ensure effective communication and at a minimum for all due process functions, medical consultations, video-conferencing and special programs. | Review record of use logs for qualified interpreters. | SC | PC | SC | SC | SC | SC | SC | SC | -- | Qualified sign language interpreters were available at all facilities, if needed. A departmental use log has been prepared and presumably distributed to the facilities for use when interpreters are active. |
| Reasonable accommodations may only be denied if the accommodation 1) poses a direct threat to the Health and Safety of others, 2) constitutes an undue burden, or 3) if there is equally effective means of providing access to a program, service, or activity through an alternative method that is less costly or intrusive. Alternative methods may be used to provide reasonable access in lieu of modifications requested by the ward as long as those methods are equally effective. All denials of specific requests shall be in writing. | Review (written) denied requests for accommodation to determine if alternative method provided reasonable access. | SC | SC | SC | SC | SC | SC | SC | SC | -- | Refer to two items above for the basic provision of reasonable accommodations. For this specific item, there were no instances encountered where written requests for accommodation were denied in writing. |

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| The Department shall ensure that wards with disabilities have access to all Youth Authority Board (YAB) proceedings. To this end the Department shall provide reasonable accommodations to wards with disabilities preparing for parole and YAB proceedings. | Interview wards with disabilities and IPA's / Casework Specialists to ensure compliance. | SC | PC | SC | SC | SC | SC | SC | SC | -- | At the present time, the YAB has instituted its own procedures based on the Armstrong case that would assist in accommodating wards with disabilities, although the review of YAB procedures is beyond the scope of this audit. The DJJ typically also provides reasonable accommodations it deems to be necessary, with only one isolated instance of a problem in this area. |
| Dept. staff shall ensure wards with disabilities are provided staff assistance in understanding regulations and procedures related to parole plans & the completion of required forms. | Interview wards with disabilities and Staff Assistants to ensure compliance. | SC | SC | SC | SC | SC | SC | SC | SC | -- | Assistance is adequately provided in parole planning, although the identified Staff Assistants are not yet actively involved in this process. |
| Institutional parole staff will provide detailed information regarding the ward's needs and make recommendations to field parole staff regarding referrals to key community agencies and service providers. | Review sample of Parole Consideration reports for identified wards with disabilities. Interview institutional parole agents / Casework Specialists to ensure compliance. | PC | PC | PC | PC | PC | PC | PC | PC | -- | I would recommend that parole reports provide more detailed information on ward's with disabilities specific needs for the continuation of accommodations and special services. |
| Institutional parole staff shall work collaboratively with field parole staff and Regional Center personnel to coordinate services, as forth in the remedial plan, for individuals with developmental disabilities and their families upon release. | Review sample of parole plans for identified wards with developmental disabilities. Interview institutional Parole Agents/Casework Specialist to ensure compliance. | -- | -- | -- | -- | -- | -- | -- | -- | -- | No wards with developmental disabilities were identified as recently paroled. |

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| The IIPA/Casework Specialist shall complete and forward the Case Report Transmittal Form, along with all supporting documents on the issue of a disability, to the PA III or Supervising Casework Specialist II, when scheduling a YAB hearing. PA I/Casework Specialist shall be responsible for requesting accommodations for wards with disabilities during YAB hearing when a ward requests an accommodation, or when the PA I/Casework Specialist is aware of a disability or should have been aware of a disability. | Review copies of Case Report Transmittal Forms. Interview wards with disabilities and IPA's / Casework Specialists to ensure compliance. | PC | PC | PC | PC | PC | PC | PC | PC | -- | At the present time, the YAB has instituted its own procedures based on the Armstrong case that would assist in accommodating wards with disabilities, although the review of YAB procedures is beyond the scope of this audit. "Case Report Transmittal" forms printed from the WIN system, as required by the remedial plan, are not specifically provided to the YAB. I would recommend that this transmittal form be revised to document the necessary accommodations, as required by the remedial plan |
| The Department shall ensure that aid is provided to all wards with disabilities who request assistance in requesting accommodations during YAB hearings. | Interview wards with disabilities and SA's to ensure compliance. | PC | PC | PC | PC | PC | PC | PC | PC | -- | See item directly above. |
| ***1. Disciplinary Decision Making System*** | | | | | | | | | | | |
| To assure a fair and just proceeding, if the rule violation is recorded as a Level 3 (Serious Misconduct), all wards with disabilities who require an accommodation shall be assigned a Staff Assistant (SA) from the facility SA team. | Review DDMS documents concerning wards with disabilities to ensure SA assistance. | PC | PC | PC | PC | PC | PC | PC | PC | -- | A number of YA 8.401 "Serious Incident Reports" were usually provided at each of the facilities. There were few specific indications that affected wards required such accommodations, but this policy has not yet been fully implemented, as the identified SA's were not usually ready for assignment. |

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| Each facility shall have a SA team with at least one representative from each of the following disciplines: mental health, health care, and education. | Review composition of SA teams. | NC | NC | PC | PC | SC | SC | SC | SC | -- | The SA teams were set up at of the facilities at the time of the visits as shown in the previous columns, although it is believed that all now have a SA team in place, though not necessarily fully trained and active. |
| Disposition chairperson shall be trained to communicate with wards that have disabilities. | Audit training module and review training record of disposition chairperson for compliance. | NC | NC | NC | NC | NC | NC | NC | NC | -- | The disposition chairperson training has not yet been completed, nor has the specific training module been reviewed by the Auditor. |
| The SA shall complete a course to become a staff assistant that contains modules that define SA roles and responsibilities, describe cognitive/emotional disabilities & present an overview of the DDMS process. | Audit training module and review training record of SA for compliance. | NC | NC | NC | NC | NC | NC | NC | NC | -- | SA training has not yet been completed, nor has the specific training module been reviewed by the Auditor. |
| The facility WDP Coordinators shall review all DDMS/grievance forms at least monthly to identify any patterns of misbehavior that may be related to cognitive and emotional disabilities. | Review monthly audit documents to confirm compliance. | PC | PC | PC | PC | PC | PC | PC | SC | -- | This policy has not yet been fully implemented at all facilities. A departmental report form has not yet been prepared. Most newly appointed Assistant WDP Coordinators are aware of the requirement and are beginning to review DDMS and grievance forms. |
| ***2. Grievance Procedures*** | | | | | | | | | | | |
| The SA shall be assigned to each grievance (from filing to resolution) involving a ward with a mental or physical disability who currently requires an accommodation. | Review completed grievance documents (Grievance Form-YA 8.450, Appeal Form-YA 8.451) concerning wards with disabilities to ensure SA assistance through confirmed signature. | PC | PC | PC | PC | PC | PC | PC | PC | -- | A number of YA 8.450 grievance forms were reviewed at each facility. There were a few indications that a SA assignment might have been warranted. However, SA assistance policy has yet been implemented. |

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| All grievance respondents shall be trained to communicate with wards that have disabilities. | Audit training module and review training record of grievance respondent for compliance. | NC | NC | NC | NC | NC | NC | NC | NC | -- | The grievance respondents training has not yet been completed, nor has the specific training module been reviewed by the Auditor. |
| The SA shall complete a course to become a staff assistant that contains modules that define SA roles and responsibilities, describe mental / physical disabilities and present an overview of the grievance process. | Audit training module and review training record of SA for compliance. | NC | NC | NC | NC | NC | NC | NC | NC | -- | SA training has not yet been completed, nor has the specific training module been reviewed by the Auditor. |
| The WDP Coordinator shall review all grievance forms at least monthly to identify any patterns of repetitive involvement that may be related to mental / physical disabilities and refer such cases to the appropriate supervisory staff. | Review monthly audit documents to confirm compliance. | -- | -- | -- | -- | -- | -- | -- | -- | NAv | It is believed that the Departmental WDP Coordinator or Assistant is beginning to review grievance forms, although this has not been verified. |
| Completed grievance forms should be randomly monitored by the facility WDP Coordinator to determine if indeed disability is an issue, even though the ward filing the grievance may not have specifically cited it. | Included in meetings with WDP Coordinators. | PC | PC | PC | PC | PC | PC | PC | SC | -- | This policy has not yet been fully implemented at all facilities. A departmental report form has not yet been prepared. Most newly appointed facility Assistant WDP Coordinators are aware of the requirement and are beginning to review grievance forms. |

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| The grievance screening process for accommodations, including the medical verification process for accommodations, should be completed in a timely manner and interim accommodations shall be provided to the extent necessary. | Review randomly 10 or 10%, whichever is greater, of accommodation related grievances. | PC | PC | PC | PC | PC | PC | PC | PC | -- | Grievances regarding accommodations have been rare. It is recommended that procedures to facilitate the screening process be prepared and implemented. |
| The Wards Rights Coordinator, within 24 hours of receipt, shall review grievances, with attached documentation, that request accommodations or allege discrimination to determine whether the grievance meets one or more of the following criteria for review and response: allegation of non-compliance with department WDP policy; allegation of discrimination based on a disability under WDP; denial of access to a program, service, or activity based on disability. | Sample of 10 or 10%, whichever is greater, of grievances filed during the last quarter. | PC | PC | PC | PC | PC | PC | PC | PC | -- | Grievances regarding accommodations or discrimination based on disability have been rare. It is recommended that procedures to facilitate the Wards Rights Coordinator review be prepared and implemented. |
| The Wards Rights Coordinator shall forward to the facility WDP Coordinator or designee all grievances that meet the criteria for review and response within 48 hours of receipt. | Audit grievances from ward with disabilities (Grievance Form - YA 8.450) that request accommodations or allege discrimination to confirm meeting timelines. | PC | PC | PC | PC | PC | PC | PC | PC | -- | Grievances regarding accommodations have been rare. It is recommended that procedures to facilitate the screening process be prepared and implemented. |

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| Grievances referred to the CMO when medical verification of a disability or identification of an associated limitation is required and returned to the Wards Rights Coordinator are handled within timeframes as defined within the remedial plan. | Audit grievances from wards with disabilities (Grievance Form - YA 8.450) that request accommo-dations or allege discrimination to determine compliance of protocol within time constraints. | PC | PC | PC | PC | PC | PC | PC | PC | -- | Grievances requiring verification of disability or limitations have been rare. It is recommended that procedures to facilitate the required verification process be prepared and implemented. |
| If medical verification is not available in the UHR, and medical staff determines that a referral to an expert consultant, external to the department, is required, an appointment shall be scheduled within ten working days to determine whether a disability or any limitations exist. The medical staff, upon receipt of report from an expert consultant, shall note verification of a disability and any limitations that exist on YA grievance form, and in the UHR of a ward. | Review grievances from wards with disabilities (Grievance Form –YA 8.450) that request accommodations or allege discrimination and their UHR to determine compliance of protocol within given time constraints. | PC | PC | PC | PC | PC | PC | PC | PC | -- | Grievances regarding medical verification have been rare. There were some instances where outside assistance from an expert consultant was necessary, but not necessarily the result of a grievance. It is recommended that procedures to facilitate the outside verification process be prepared and implemented. |

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| After consultant verification of a disability, medical staff shall return the grievance, with all required documentation, to the Wards Rights Coordinator. The Wards Rights Coordinator shall forward to the Office of the Superintendent all grievances that meet the criteria for review and response within 48 hours of receipt from Health Care Services staff. | Audit grievances from wards with disabilities (Grievance Form - YA 8.450) that request accommodations or allege discrim-ination to determine compliance of protocol within given time constraints. | PC | PC | PC | PC | PC | PC | PC | PC | -- | Grievances regarding medical verification have been rare. There were some instances where outside assistance from an expert consultant was necessary, but not necessarily the result of a grievance. It is recommended that procedures to facilitate the outside verification process be prepared and implemented. |
| The Wards Rights Coordinator shall refer a grievance to the facility WDP Coordinator when verification of a non-medical disability is required and ensure it is handled as defined within the remedial plan and within timeframes. | Audit grievances from wards with disabilities (Grievance Form - YA 8.450) that request accommodations or allege discrimination. | PC | PC | PC | PC | PC | PC | PC | SC | -- | Grievances regarding non-medical verification have been rare. However, this policy has not yet been fully implemented. A departmental report form has not yet been prepared. Most newly appointed Assistant WDP Coordinators are aware of the requirement and are beginning to review such grievance forms. |
| Wards may use the WDP Grievance process to file a grievance based on the denial of a request for a reasonable accommodation during YAB proceedings. | Interview wards with disabilities. Review grievances to determine compliance. | -- | -- | -- | -- | -- | -- | -- | -- | -- | There was no indication that a ward had a grievance relating to this item during the auditing period. |
| Wards with disabilities shall be granted reasonable accommodations with respect to timeframes, consistent with the Ward Safety and Welfare Plan, for processing of grievances. | Interview wards with disabilities. Review grievances to determine compliance. | -- | -- | -- | -- | -- | -- | -- | -- | -- | There was no indication that a ward had a problem with time lines associated with grievances during the auditing period. To my knowledge, the Ward Safety and Welfare Plan has not been finalized, although the draft does not appear to address this issue. |

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| **D. Programs** | | | | | | | | | | | |
| *1. Reception Center and Clinic Functions* | | | | | | | | | | | |
| As part of the clinic screening and assessment process, all wards shall be screened at the reception centers, and as indicated, throughout their stay in the Department, to determine whether they have a developmental disability, which may make them eligible under criteria set forth in the Americans with Disabilities Act (ADA) and/or may make them eligible to receive services from a Regional Center. | Review screening documents (YA 1.411) in ward field files. | -- | NC | -- | -- | -- | NC | -- | NC | -- | Wards are not formally screened at the reception center for the presence of a developmental disability, although past screenings (e.g., IQ testing scores) are reviewed, as they are during initial ward acceptance at Headquarters. The DJJ has expressed concern whether this item is appropriate and expedient, and further clarification and direction may be necessary. |
| During the initial wards interviews, advise wards of their rights under the ADA and section 504, and receive formal documentation that they have received and understood this advisement. | Observe random interviews at intake facilities. | -- | SC | -- | -- | -- | SC | -- | SC | -- | Although only a few initial ward interviews were attended, it is believed that the ADA Rights Notification form is presented to and signed by all wards during initial intake. The extent to which they understand all aspects of the form is unclear. |
| Assigned Casework Specialists shall refer a ward to a mental health professional on a Mental Health Referral Form when indicators of a mental impairment exist that may limit a major life activity. | Review copies of Mental Health Referral Form for completeness. | -- | SC | -- | -- | -- | SC | -- | SC | -- | Casework Specialists use a "Mental Health Services Referral" form and a "Critical Factors Assessment for Determining Need for Mental Health Evaluation" form to refer wards to a mental health professional during intake and at other times. |

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| Assigned Casework Specialists shall refer a ward to a medical professional on a Disability Health Services Referral form when indicators of a physical impairment exist that may limit a major life activity. | Review copies of Disability Health Services Referral Form for completeness. | -- | PC | -- | -- | -- | PC | -- | PC | -- | Casework Specialists use various methods to refer wards with disabilities to the appropriate persons during intake and at other times. However, no specific, coordinated disability health services form is used for this purpose. |
| Assigned Casework Specialists shall use a Referral to School Consultation Team (SCT) form to refer a ward to an educational professional to verify the existence of a learning impairment that may limit a major life activity. | Review copies of Referral to School Consultation Team (YA 7.464) for completeness. | -- | SC | -- | -- | -- | SC | -- | SC | -- | Casework Specialists use various methods to refer wards with learning disabilities to the SCT during intake and at other times, although the YA 7.464 form is not used for this purpose. |
| Licensed mental health professionals and medical personnel shall complete the screening process on a ward within 10 working days of a referral from an assigned Casework Specialist. | Review screening forms for completeness and timeliness: MH – SPAN/ YA 8.216; Med – Medical HX/YA 8.260. | -- | SC | -- | -- | -- | SC | -- | SC | -- | Special Program Assessment Needs (SPAN) Assessments are routinely performed, and usually, but not always, within 10 working days. |
| Within 15 calendar days of completing the Educational Disability Screening process, the education staff shall develop an assessment plan. | Review screening forms for completeness and timeliness: Ed – CASAS, CELDT, High Point Testing, HX in file | -- | PC | -- | -- | -- | PC | -- | SC | -- | The initial intake interview includes a checklist for educational needs. Based upon interviews and records review, It was evident that assessment plans were usually developed if indicated by the checklist, but not always within the 15 calendar day time line (refer to columns at left). |

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| Within 10 working days of completing the disability screening process, department staff members who are licensed mental health professionals and medical personnel shall use standardized psychological test instruments, medical, dental practices to assess wards. | Review appropriate documentation for completeness and timeliness. | -- | PC | -- | -- | -- | PC | -- | PC | -- | It is unclear to what extent psychological testing of all wards is required by this section of the remedial plan. The initial intake interview highlights further needs for psychological assessment, including possible testing, that may be necessary, but this is individualized and not a standard procedure. Further clarification is needed. |
| Credentialed Education Staff shall complete educational assessment within 50 calendar days. | Review appropriate documentation for completeness and timeliness. | -- | PC | -- | -- | -- | PC | -- | PC | -- | Interviews and records indicated that educational assessments, as well as initial IEP's, are usually developed, but often not within 50 calendar days. |
| If it is determined prior to or during the ICR that a ward is in need of an accommodation in order to allow for effective participation, the Supervising Casework Specialist II shall ensure that such accommodations are provided. | Review random ICR reports for wards with disabilities. | -- | SC | -- | -- | -- | SC | -- | SC | -- | The Initial Case Review (ICR) provides the opportunity for such accommodations, and these appear to be provided in general at the present time, but it is unclear that appropriate procedures or documentation have been instituted. Since much of this procedure relies on the diligence of the Supervising Casework Specialist II, I would recommend that these procedures be written for future documentation. |

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| All wards shall complete the orientation process at a reception center that contains a standardized Disability module which shall include: 1) a summary of the main points of the Disability law under Title II of the ADA and IDEA and their relevance to wards, 2) a summary of the main points of the Department Disability Policy as it relates to wards, 3) an explanation of the Disability self-referral process, and 4) the Ward's Rights Handbook section on Disability. | Review orientation program for required components and audit ward-signed orientation forms to confirm participation. | -- | NC | -- | -- | -- | NC | -- | NC | -- | While various orientation presentations for wards have been drafted, including a PowerPoint module on disabilities and the ADA, there were no indications that this ADA orientation module was currently being provided to all new wards. I would recommend that the Departmental WDP Coordinator assist in coordinating and supplementing these past efforts, and possibly even present the first few orientations, to effect implementation of this provision. |
| Presenters of ward orientation program shall make the reasonable accommodations or modifications necessary for wards with disabilities who require accommodations during the orientation. | Review ward-signed orientation forms for documented information regarding provided accommodations. | -- | -- | -- | -- | -- | -- | -- | -- | -- | The ADA orientation module was not currently being provided to all new wards. |
| ***2. Residential Programs*** | | | | | | | | | | | |
| For each special program or activity, evaluate eligibility criteria to assure that wards with disabilities are not excluded when they can perform the essential functions of the activity. | On-going audit, based on detailed factors listed in the plan. Visit special program locations yearly. | -- | PC | -- | SC | SC | -- | -- | -- | -- | There were unique, non-educational work program encountered at only three facilities. There were no specific indications that wards with disabilities would not be included on an equal basis in special programs. The Fire Camp programs have not yet been visited and are not included. |

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| Staff shall refer wards to Health Care Services and the Education Department for screening when information is observed or received that indicates the presence of a physical or mental impairment that has not been documented and verified. | Review submitted SRSC (YA 7.464) and SCT Referral (YA 8.229) forms and determines appropriateness of disposition. | -- | -- | -- | -- | -- | -- | -- | -- | -- | Forms YA 7.464 and YA 8.229 are not currently being used by either wards or staff for self-referrals or staff referrals. There were no indications that a ward with a disability was precluded from filing these forms or making a referral, although no documentation was provided to demonstrate compliance. There were a few instances where wards were referred to various service components (education, mental health, etc.), but referrals were informal and did not follow the time lines or procedures described in the WDP remedial Plan. Since the procedures are not fully implemented, several items dealing with time lines are omitted as part of this report. I would recommend that a system of documentation be developed to track ward and staff referrals. |
| The Treatment Team Supervisor/ Supervising Casework Specialist shall ensure that within five days of receipt of WDP Assessment reports, from licensed mental health professionals, medical personnel, or credentialed education staff, that the assigned PA /Casework Specialist conducts a special case conference. | Audit case conference forms (ICP) for wards with disabilities to ensure implementation and timeliness. | -- | PC | PC | -- | -- | -- | -- | -- | -- | No assessment reports or case conference forms were provided to show compliance, and to the Auditor's knowledge, no assessment reports requiring special case conferences were submitted during the audit period. There was one situation regarding a ward needing follow-up with a special case conference, although no resolution or referral forms setting up the necessary assessments and special case conference were provided to the Auditor during the site visit. |

| Item | Method | Compliance Rate | | | | | | | | | Comments / Recommendations |
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| | | DN | Ven | Pas | HS | Cha | SY | Clo | Pre | HQ | |
| The Superintendent shall ensure that the following data is documented for all wards with a disability: (1) Name, age, YA number; (2) Location by facility, living unit, or parole office; (3) Specific impairment; (4) Impairments that substantially limit a major life activity: (5) Impairments that substantially limit a major life activity and require accommodations; (6) Specific accommodations required; (7) Need for a Staff Assistant; (8) Level of care designation; (9) Classification code. | Review documentation for completeness of information. | NC | NC | NC | NC | NC | NC | NC | NC | NC | The DJJ has worked steadily to upgrade its computerized ward record-keeping system, referred to as the WIN system. While there was no specific time line for having the system ready and available for use, it was inherent that perfecting the system would take some time. I believe that the DJJ has made reasonable progress to this end, but would also recommend that the first 8 required items of information relating to wards with disabilities that are available be incorporated into the WIN system, and that staff be trained to access this information, as soon as it is practical. |
| The Program Manager shall ensure that the presentation, the curriculum, and any supplemental materials used for individual and small group counseling, large group meetings, and resource groups are modified to ensure equal access to the information by wards with disabilities. | Review modified materials. | SC | SC | SC | SC | SC | SC | SC | SC | -- | While no specific documentation of modified materials were generally made available, there were no indications that wards with disabilities did not have equal access to informational materials. |

| Item | Method | Compliance Rate | | | | | | | | | Comments / Recommendations |
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| | | DN | Ven | Pas | HS | Cha | SY | Clo | Pre | HQ | |
| The Program Manager shall ensure that a Staff Assistant (SA) is assigned to a ward with a disability when individualized assistance in the completion of mandated or necessary functions. | Review list of SA and assignments. Conduct interviews with SA & wards with disabilities to determine effectiveness. | PC | PC | PC | PC | PC | PC | PC | PC | -- | There were few specific indications that affected wards required individualized assistance, but this policy has not yet been fully implemented, as the identified SA's were not usually ready for assignment. |
| The facilities shall ensure equal access to services, such as medical and religious, and activities, such as visiting and recreation, to wards with disabilities as to those provided to wards without disabilities. | Interview wards with disabilities to determine access and participation. | SC | SC | SC | SC | SC | SC | SC | SC | -- | There were no indications that a ward with a disability did not have equal access to non-educational services, such as those listed . |
| ***3. Developmental Disabilities*** | | | | | | | | | | | |
| No outward signs of identification or labeling will be posted for wards involved in the developmental disabilities program. | Tour facilities to ensure compliance. | SC | SC | SC | SC | SC | SC | SC | SC | -- | No such signs of identification were encountered. |
| Services will be provided to all wards identified as being developmentally disabled or who have been determined to need supportive services similar to wards with developmental disabilities, irrespective of age of onset. | Review departmental list of DD wards, program placement (YA 1.503 PDF) and ICP. | SC | SC | SC | SC | SC | SC | SC | SC | -- | No wards were specifically identified by the DJJ or listed on YA 1.503 forms as being developmentally disabled. |

| Item | Method | Compliance Rate | | | | | | | | | Comments / Recommendations |
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| | | DN | Ven | Pas | HS | Cha | SY | Clo | Pre | HQ | |
| *4. Removal of Architectural Barriers* | | | | | | | | | | | |
| The Department committed to the renovation of one room at each facility, as a minimum, to ensure the provision of accessible housing for wards with disabilities. The total completion of this project is scheduled for June 30, 2006. | Monitor the project completion timeline and visit each institution upon completion to ensure compliance with accessibility criteria. | -- | SC | -- | SC | SC | SC | -- | SC | -- | Since the required room renovation completion date of June 30, 2006, has not yet arrived, site visits only reviewed the appropriateness of certain areas for renovation. Nevertheless, those areas completed ahead of schedule are noted as "SC". |
| The Department committed, at a minimum, to have one fully accessible shower and/or lavatory area at each facility. Each of these fully accessible shower and/or lavatory areas must be **in close** proximity to the renovated accessible cells due to be completed by June 30, 2006. Presently, the schedule includes nine areas to be completed in FY 2005/06 and eight areas in FY 2006/07. | Monitor the project timeline and visit each facility area upon completion to ensure compliance with accessibility criteria. | -- | -- | -- | PC | -- | -- | PC | SC | -- | Since the required shower / lavatory renovation completion date of June 30, 2006, has not yet arrived, site visits only reviewed the appropriateness of certain areas for renovation. Nevertheless, those areas completed ahead of schedule are noted as "SC" or "PC". |
| 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. | Monitor the project timeline and visit each institution upon completion to ensure compliance with accessibility criteria. | -- | -- | -- | -- | -- | -- | -- | -- | -- | Since the required critical barrier removal completion date has not yet arrived, site visits only provided a general review of certain areas of future barrier removal. |

| Item | Method | Compliance Rate | | | | | | | | | Comments / Recommendations |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | DN | Ven | Pas | HS | Cha | SY | Clo | Pre | HQ | |
| The Department committed to analyze the 3000 additional barriers identified in the report prepared by Access Unlimited and provides a report that would categorize the barriers into three distinct areas. This report is due July 15, 2005 and will be filed at Appendix C to the Disability Remedial Plan. | Review, approve and submit required report. | SC | SC | SC | SC | SC | SC | SC | SC | -- | Appendix C of the WDP Remedial Plan has been completed and filed. |
| Construction of the first category of projects, which involves projects that can be fixed in a short period of time with minimum costs, shall be completed by September 30, 2006. | Audit first category projects for compliance of completion within defined timeline. | -- | -- | -- | -- | -- | -- | -- | -- | -- | Since the lesser priority barrier removal completion date of July 15, 2006, has not yet arrived, site visits only reviewed the appropriateness of certain areas for barrier removal. Nevertheless, some amount of barrier removal work has been completed ahead of schedule, though it was impossible to depict these areas in the chart. |
| The second category of projects, which involve projects that will require substantial funding, will be completed by September 30, 2008 | Audit second category projects for compliance of completion within defined timeline. | -- | -- | -- | -- | -- | -- | -- | -- | -- | Since the required critical barrier removal completion date of September 30, 2006, has not yet arrived, site visits only provided a general review of certain areas of future barrier removal. |

**Appendix F**

DJJ, *WARDS WITH DISABILITIES PROGRAM REMEDIAL PLAN INITIAL QUARTERLY REPORT*

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Bibliography

# PART II: STATUS OF REMEDIAL PLANS

## II. A. Wards with Disabilities Remedial Plan

WARDS WITH DISABILITIES PROGRAM

REMEDIAL PLAN

# INITIAL QUARTERLY REPORT

## I. INTRODUCTION AND BACKGROUND

In the original **Complaint for Injunctive and Declaratory Relief** filed in the **Farrell v Harper** (Superior Court of California, County of Alameda, RG-030793344), it was alleged that wards with disabilities in the California Department of Corrections and Rehabilitation (CDCR), Division of Juvenile Justice (DJJ) Facilities, then known as the Youth and Adult Correctional Agency and the California Youth Authority, faced discrimination on physical, sensory, developmental, cognitive, mental, and learning levels in violation of Government Code sections 4450 and 11135 and Education Code sections 56000 et seq.

In response to these allegations, parties agreed to utilize subject-matter experts to review certain conditions of the operations of the DJJ. These subject-matter experts, jointly selected by the parties, where charged with the responsibility to: review appropriate operational policies and practices; tour facilities; interview wards and staff; and, prepare written reports verifying allegation findings and, where appropriate, propose recommendations to ameliorate the described deficiencies.

To address the issues related to wards with disabilities, the subject-matter expert agreed upon was Mr. Peter Robinson of Access Unlimited, an expert in structural and program access for individuals with disabilities. Subsequently, Mr. Logan Hopper, an expert in the programmatic access for wards with disabilities, was retained to supplement the disability report with evaluations directed at specific program access issues. The consensus of both disability experts was:

- On a system-wide level, wards with disabilities were not provided required reasonable accommodations
- The Division does not provide appropriate testing to identify cognitive disabilities
- Wards with disabilities do not have appropriate access to services, programs, and activities as required by state and federal regulations
- Division facilities do not generally comply with federal access regulations
- The Division does not provide equally effective communications for wards who have hearing and vision impairments
- The Division does not have adequate written policies to ensure equal access to facilities, programs, services, and activities for wards with disabilities
- The Division does not have adequate training for staff to assure wards with disabilities access to services, programs, and activities and to eliminate discrimination and harassment

As a condition of negotiating a course of action in addressing this litigation complaint, the parties agreed that facts and opinions, generalized above, were substantially correct concerning wards with disabilities. Also, that the facts and opinions detailed in the submitted reports were sufficient to propose remedies to address the system-wide and facility-level disability deficiencies. The result of these negotiating strategies between the parties culminated in the filing of a Consent Decree (Superior Court of California, County of Alameda) in November 2004.

The filed Consent Decree required the Department to develop and implement detailed remedial plans to provide all wards in DJJ with adequate and effective care, treatment and rehabilitative services. Each of the remedial plans was to be developed in consultation with the relevant expert to address the deficiencies identified in their assigned subject area. Related specifically to the disabilities category, the Consent Decree required the Division of Juvenile Justice to prepare a remedial plan to address the deficiencies in the following areas:

- Reasonable Accommodations
- Testing for Cognitive and Learning Impairments
- Access to Programs, Services, and Activities
- Effective Communication
- Removal of Architectural barriers
- Related Grievances Procedures
- Access Coordinators
- Written Policies and Procedures on Access
- Protection from Harassment and Abuse
- Adequacy of Education Services
- Adequacy of Integration
- Awareness Training

## II. DEVELOPMENT OF WARDS WITH DISABILITIES PROGRAM – REMEDIAL PLAN

Utilizing the Report of Findings of Disability Access at CYA prepared by Mr. Peter Robertson and the report of Access to Programs and Services for Wards with Disabilities in CYA prepared by Mr. Logan Hopper as foundation documents in developing a remedial plan, the Department established a working committee made up of key professional and management staff. The committee's efforts included, but were not limited to:

- A review of state and federal statutes regarding individuals with disabilities such as, the Americans with Disabilities Act (ADA), the Individuals with Disabilities Education Act (IDEA), and the California's legislative statues concerning individuals with disabilities
- A search of current disability literature and issues

- Review of current correctional practices related to individuals with disabilities, specifically reviewing the California Department of Corrections' Armstrong (Inmates with Disabilities), Clark (Developmentally Disabled Inmates) Remedial Plans, and Coleman (Mentally Ill Inmates Court Order) programs
- A review of current DJJ Policies and Procedures
- Development of various proposals to evaluate and analyze impact on wards with disabilities within current DJJ policies, procedures, and practices
- Scheduling and conducting meetings with management staff, clinical professionals, designated disability expert, attorneys (State and Plaintiff) to discuss, review and establish disability policy
- Prepared and submitted numerous remedial plan drafts for review and comment
- Prepared, finalized and obtained parties approval for Wards with Disabilities Program (WDP) Remedial Plan

The essential, consensus-reached disability policy and goals embedded in the (WDP) Remedial Plan are as follows:

- It is the accepted policy of the Division that no qualified individuals with a disability shall, by reason of such disability, be excluded from participation in, or be denied the benefits of, the services, programs, or activities of the Division, or be subjected to discrimination by any Division representative.
- The goals for this policy are:
  1. Assure equality of opportunity and full participation in all services, programs, and activities
  2. Assure the elimination of discrimination against individuals with disabilities, and,
  3. Provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities
- The Department shall ensure that wards with disabilities have access equal to non-disabled wards in all level of care within the youth correctional system
- All wards under the jurisdiction of the DJJ 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
- Finally, the DJJ shall ensure that the constitutional rights of all wards are met.

## III. SIGNIFICANT ACCOMPLISHMENTS

1. On May 31, 2005, the **Wards With Disabilities Program Remedial Plan** was submitted and accepted by the Superior Court of California, County of Alameda.

2. Prepared and submitted FY 2005/2006 Budget Change Proposals (BCP) that obtained funding authorization in the amount of $1,955,000 for facility physical plant renovations to modify physical plant items that were identified as potential access barriers to wards with disabilities. The funding obtained in this BCP has allowed the Department to develop and establish a renovation schedule that runs yearly through FY 2008/2009 to completely address the physical issues identified by the subject-matter experts.

    - As of March 31, 2006, the Southern Youth Reception Center and Clinic, Preston Youth Correctional Facility, El Paso de Robles Youth Correctional Facility, Ventura Youth Correctional Facility, N.A. Chaderjian Youth Correctional Facility, and the Herman G. Stark Youth Correctional Facility have completed renovations that ensure one room in each facility is fully accessible for wards with disabilities. O.H. Close Youth Correctional Facility has an established construction completion date of 9/29/06 and Dewitt Nelson Youth Correctional Facility has an established construction completion date of 8/7/06.

3. Also in the FY 2005/2006 Budget Change Proposals (BCP) funding authorization was granted in the amount of $883,000 for staffing resources to establish the statewide oversight functions required by the remedial plan. Funding authorization was obtained to establish one (1) Staff Services Manager I and eleven (11) Associate Governmental Program Analysts to form the basis for this required oversight responsibility.

    - In October 2005, prepared and submitted job descriptions and duty statements for Division and Facility WDP Coordinators to Department Personnel Office.

    - In November 2005, received approval and position number authorization for all WDP positions from Personnel Office.

    - In November 2005, all facility's, Regional Parole Offices, and Departmental Headquarters were authorized to initiate recruitment and hiring processes.

    - As of March 31, 2006, the Division Headquarters and six of the facility's WDP Coordinator positions are filled: SYCRCC (Southern Youth Correctional Reception Center-Clinic and Heman G. Stark Youth Correctional facility have completed interviews and are awaiting hiring approval. Both the northern and southern regional parole offices are in the interviewing process of potential candidates.

4. Since May 31, 2005, DJJ has appointed and maintained a full-time Division WDP Coordinator to provide a focal point for the development and implementation of the disabilities program.

    - Ms. Holly Bowers: May – June 2005
    - Mr. Greg Brewer: July – August 2005
    - Mr. William B. Anderson: September 2005 – February 2006
    - Ms. Karen Lynn Smith: March 2006 - Present

5. Since August 30, 2005, all wards that are received in DJF are being advised of their rights under the ADA and Section 504 of the Rehabilitation Act. As part of the Clinic process, disability rights information contained in the Provisional Form titled: Disabilities Rights Notice, is reviewed with each ward. The provisional form then is signed individually by staff and ward, a copy given to the ward, and a copy is placed in the field file.

6. As of March 31, 2006, all of the facilities have established and appointed Staff Assistance Teams in accordance with the requirements specified in the Remedial Plan.

7. As of March 31, 2006, all facilities have acquired and are capable of utilizing the Telecommunication Devices for the Deaf (TDD). Although there was an original agreement that DeWitt Nelson Youth Correctional Facility, O.H. Close Youth Correctional Facility, and N.A. Chaderjian Youth Correctional Facility – "the complex" - could share a common TDD, a January 20, 2006 directive from Mr. Ed Wilder, Director of Juvenile Facilities instructed all facilities to purchase their own equipment. That has been accomplished.

8. The Division has modified and updated the Ward Information Network (WIN) computer database to allow for accurate tracking and collection of individual/aggregate data of wards with disabilities. Each of the facility's WIN computer program has been updated and initial training has been completed.

9. The WDP Remedial Plan requirement of the Education Services Branch establishing a working committee to study and make recommendations to improve and encourage more active parent and/or surrogate participation in Individualized Education Plan (IEP) has been met. The working committee has met on the following dates:

    - November 17, 2005 at Ventura Youth Correctional Facility
    - March 16, 2006 at O.H. Close Youth Correctional Facility

10. As of March 31, 2006, the Division WDP Office has participated in and assisted the Disabilities Expert Mr. Logan Hopper in conducting and completing auditing tours of seven facilities.

## IV. ITEMS IN PROGRESS

1. The Division is in its final stages of converting the policies and directives of the WDP Remedial Plan into the operational policies and procedures format that, once approved, will be incorporated in the Institutions and Camp Manual. The following steps provide an outline of actions taken thus far to convert Remedial Plan into departmental operational mandates.

    - Drafting of Remedial Plan into departmental policy and procedures format. This essential first step was completed in June 2005.

- The draft of the Disability Program policies and procedures was submitted to the Department's Executive Committee and Legal Staff for review, comment, and approval in July 2005.

- The Executive Committee and Legal Staff provided direction and recommendations to clarify certain policy aspects for dealing with wards with disability. This feedback was provided in August 2005.

- The input from the Executive Committee and Legal Staff was used to modify the draft and subsequently, the final revised draft was submitted to the Department's Office of Legal Affairs for review and approval on January 21, 2006.

- The Office of Legal Affairs completed its review and provided direction on February 21, 2006.

- Presently, the input from the Office of Legal Affairs is being incorporated into the document, and upon completion, the final draft of WDP Policy and Procedures will be submitted for Labor Opinion at the end of April 2006.

- The final Disabilities Policy and Procedures document and Labor Impact document will be submitted to the Chief Deputy Secretary for approval and signature at the end of May 2006. Upon approval, the disabilities policy and procedures will be incorporated into the Institutions and Camp Manual.

2. The WDP Remedial Plan agreed upon steps for the removal of architectural barriers commenced in the spring of 2005 and continues to be aggressively pursued by the Department.

   The responsibility for the juvenile facilities physical plants shifted to the CDCR Office of Facilities Management (OFM) with the Departmental reorganization. As the newly established OFM began operations, the new management reviewed both the scope and schedule of work presented in the WDP Remedial Plan. The management review revealed a number of significant planning and construction issues that needed to be resolved prior to the OFM authorizing the disabilities modifications to proceed. To this end in October 2005, the OFM provided direction to the facilities to complete disability renovations that were in progress, provided authorization to begin construction on specific projects, assumed responsibility to complete redesign efforts for certain projects, and, propose a new construction completion date schedule that must be approved by the Special Master and possibly, by the court. Also, OFM has appointed Mr. John Petropolous, a dedicated WDP Construction Manager, to monitor and track all of the construction issues related to the disabilities program.

   - In February 2006, the OFM has instituted a process that provides a monthly status report, by facility, of the disability construction activities.

3. The Division is required to develop a WDP training program for all staff. The Division's effort to draft the training program has been delayed pending completion of a comprehensive training program assessment.

   The Department has contracted with the California State University at Chico to conduct and complete a comprehensive training assessment to include the requirements of the remedial plan. Pending completion of study, the Department has taken a number of interim steps to develop and provide disabilities program training. These interim steps include:

   - The WDP Headquarters staff has been designated to work with the California State University at Chico consultant team in developing and preparing the DJJ training program assessment as it pertains to WDP Remedial Plan. Staff has attended a number of meetings and continues to provide input on disability program issues as it relates to Basic Academy, DJJ Academy, and Facilities specific training proposals. The consultant's training assessment report is due to the Department at the end of May 2006.

   - On December 9, 2005, WDP Headquarters staff conducted a briefing for all Facilities WDP Coordinators that included information on the ADA, IDEA, the Farrell v Hickman Consent Decree & Stipulation, and, the roles and responsibilities of the WDP Coordinator.

   - The WDP Headquarters staff has provided audit visit preparation assistance and disabilities program training to specific individuals at the seven facilities that have been visited by the Disabilities Expert.

   - The newly appointed Headquarters WDP Coordinator has prepared and submitted a request to use current year surplus funding to conduct WDP Remedial Plan training at each facility prior to June 30, 2006.

4. On March 20, 2006, WDP Headquarters Staff and a number of Facilities WDP Coordinators staff attended a DJJ Education Services Transfer of Knowledge Workshop entitled: "Strengthening Special Education, Mental Health, and Transition Partnerships Workshop". The information and documentation provided in this workshop was extremely beneficial in defining and highlighting various approaches (tools) that can be used in working and assisting individuals with disabilities. This type of training addresses the WDP Remedial Plan requirement to provide a higher level of disabilities training to key DJJ positions. Also, this information will be extremely useful in the development of the disability-training program that is currently being developed for the facilities' established staff assistance teams. WDP Headquarters Staff are joining the National ADA Coordinator's Association and will be attending the National ADA Conference in Phoenix, AZ. 4/23-4/27/06.

5. The WDP Headquarters Office has initiated procedures to address the Remedial Plan requirement for facilities to provide specific disabilities information on a monthly, quarterly, or annual basis.

- On March 23, 2006, all facilities were instructed to provide a monthly report of wards with specific disabilities currently housed at their respective sites. This initial documentation is essential in defining the total number of wards with disabilities within the DJJ.

- On March 30, 2006, the facilities were instructed to provide a report to the Director of Juvenile Facilities within 24 hours of any ward with a disability being placed in a restrictive setting, temporary detention, or administrative lockdown. This directive requires the facility Superintendent to report this situation.

6. The WDP Headquarters Office has prepared a corrective action program that will direct the Facilities to address the deficiencies that have been identified by the audit reviews conducted by the Disabilities Expert. The Office has prepared a report document that identifies the Remedial Plan's specific requirement, the rating provided by the Disabilities Experts, and Expert's comments related to the issue. Each Remedial Plan requirement that received a rating of Partial Compliance, Non Compliance, or Information Not Available will require the facility to prepare a Planned Correction response. This Planned Correction response must specify: Plan of Action, proposed date of completion, and identify individual(s) responsible for completion.

    - The WDP Headquarters Office has drafted correction action documents for the following facilities:

        1. DeWitt Nelson Youth Correctional Facility
        2. El Paso de Robles Youth Correctional Facility
        3. Ventura Youth Correctional Facility
        4. Herman G. Stark Youth Correctional Facility
        5. N.A. Chaderjian Youth Correctional Facility

7. The WDP Headquarters Office has prepared a comprehensive Remedial Plan Tracking Document (Attached) that will be used to monitor and track ALL of the required items of the plan including those items described above. The document is divided into two sections: 1) Chronological for those items in the plan with a designated date attached, and 2) Items in the plan without a specific date.

CDCR-DIVISION OF JUVENILE JUSTICE
WARDS WITH DISABILITIES REMEDIAL PLAN

Update Date: 3/31/06

| Action/Task | Plan Required Completion Date | Action Steps | Status | ACTUAL Completion Date |
|---|---|---|---|---|
| **ADA Rights Notification- As part of the Clinic process, all wards will be advised of their rights under the ADA and Section 504.** The CYA shall develop a provisional form that contains a written advisement of these rights in simple English and Spanish by August 2005. The information contained in the form shall be reviewed with each ward. | Aug 2005 | Forms were created in English and Spanish. A Directive was sent out to the Reception Centers to begin use of the form. | COMPLETED | 8/30/05 |
| **Wards with Disabilities Program Policy**<br><br>CDCR will complete the Department's Disabilities Policy for wards and submit to the Directorate for approval. When approved, the CYA shall complete all action steps related to the implementation of the Departmental Disabilities Policy for wards, including hiring staff, all levels of reviews, forms, electronic documentation development, labor negotiations, and training curriculum | Aug 1, 2005 | Initial draft policy was completed on 8/1/05. Revisions needed to be made based upon feedback from Legal Counsel. Once revisions are completed, Labor Relations will review. Meeting held on April 11, 2006. More meetings to be scheduled | IN PROGRESS<br><br>it is anticipated that draft will be completed and forwarded to labor relations and possible union negotiations in May 2006. | |
| **Final List of Projects (Appendix C)**<br><br>CDCR will file the final list of projects (Appendix C) upon approval by all parties. | Aug 15, 2005 | | COMPLETED<br><br>Filing date extended to 9/15/05. Notice to court dated August 22, 2005. | 9/15/05 |
| **WIN 2000 Modifications/Tracking-** The Department shall ensure wards with disabilities who require accommodations are tracked through the WIN system and that an accurate record is maintained for wards with disabilities that allows for the collection of individual and aggregate data.<br><br>Complete modifications to the WIN 2000 | Sept 2005 | There is an ADA/Accommodation section implemented in the WIN system. Awaiting legal opinion as to what fields are reviewable by program staff as some education, mental health, and medical related materials may be confidential. | IN PROGRESS | |

| Action/Task | Plan Required Completion Date | Action Steps | Status | ACTUAL Completion Date |
|---|---|---|---|---|
| **Wards with Disabilities Program (WDP) Coordinator**<br>CDCR will hire a full time WDP Coordinator | Oct 2005 | Permanent Full Time WDP Manager was hired and in place 2/21/06 | COMPLETED | 2/21/06 |
| **Developmental Disabilities Study**<br>CDCR will conduct a study regarding the need for a residential program for wards with certain developmental disabilities within six months of the filing of this plan. CDCR will develop and plan a plan based on the results of the study if applicable | Oct 2006 | Pending establishment of a work group committee to address wards with developmental disabilities | INCOMPLETE | |
| **Comprehensive Classification System**<br><br>A comprehensive classification system implemented as part of the Ward Safety and Welfare Remedial Plan is scheduled to be filed This will include revised time frames for processing grievances. | Nov 30, 2005 | Blueprint for Safety and Welfare Plan filed 12/1/05. Final plan, including a plan for a classification system, will be included in final Safety and Welfare Plan due to be filed June 30, 2006. | IN PROGRESS | |
| **IEP Working Committee**<br><br>Education Services Branch will establish a working committee consisting of the Disability Expert, one Education Expert, the SELPA Director and the Manager of special education programs. The charge of the committee is to:<br>1) study and make recommendations to improve the adult wards' and parents' meaningful participation during IEPs,<br>2) encourage more active participation.<br>3) provide informational material for parents/surrogates,<br>4) study the need for and evaluate the ability of various public/private groups or agencies to assist with means for parents to attend IEP meetings<br>5) study the need to include a wider variety of individualized accommodations in IEPs | Dec 2005 | First committee meeting held on 11/17/05. Second meeting was conducted on 3/16/06. Final committee recommendations not yet received. | INCOMPLETE | |

| Action/Task | Plan Required Completion Date | Action Steps | Status | ACTUAL Completion Date |
|---|---|---|---|---|
| Tenets of advocacy<br><br>The Department will implement a policy that each specialist that is assigned as a case carrier, or alternate, will discuss the tenets of advocacy with the ward and surrogates prior to the IEP meeting | Dec 2005 | Practice is in place. However, policy has not yet been completed | IN PROGRESS | |
| Surrogate parent training<br><br>All individuals who serve as surrogate parents will receive annual training in the role and responsibilities of a surrogate. | Dec 2005 | Awaiting specific dates and evidence of training for all individuals. Will be completed annually each September | IN PROGRESS- Anticipated completion date: 9/29/06 and every Sept. thereafter | |
| Standardized emergency announcement protocol- The Department shall ensure that wards with hearing and other impairments who require accommodations, benefit from effective communication regarding public address announcements and reporting procedures, including those regarding visiting, school, recreation period, movements, count, or emergency situations. The Department WDP Coordinator will develop a standardized emergency announcement protocol. | Dec 2005 | Review of standard Departmental Emergency Plans and defining sections of basic plan which need to specify dealing with disabled wards. A draft has been written but not yet reviewed by DJJ administrators. | IN PROGRESS | |
| Statewide Disability Coordinators Meeting<br><br>Statewide meeting to discuss remedial plan, role of coordinators and compliance tours. | Dec. 9, 2005 | All DJJ facilities were represented during the meeting | COMPLETED | 12/9/05 |
| Internal Compliance Review<br><br>Compliance reviews will commence to ensure implementation of the Remedial Plan | Jan 2006 | Plan of Action: DJJ needs to establish a plan, develop instrument, test, train staff then implement compliance reviews | IN PROGRESS- DJJ WDP Headquarters Manager and support staff currently participating in compliance audits with Disability Expert | |
| WDP Facility Coordinators<br><br>Facility WDP Coordinator positions will be filled. | Feb 2006 | Final two hires are awaiting medical/live scan clearance. Six of eight facilities have hired coordinators | IN PROGRESS<br>Anticipated completion date: 5/1/06 | |

| Action/Task | Plan Required Completion Date | Action Steps | Status | ACTUAL Completion Date |
|---|---|---|---|---|
| **Needs assessment and training material**<br><br>CDCR will conduct a needs assessment and prepare department-wide ADA/disability training materials. | June 2006 | Development of training materials in progress and current training practices being reviewed. Input provided to CSU Chico on 1/16, 1/17, 1/18- 2005 for department TNA final report. Mr. Anderson attended training needs workshop with CSU Chico in 4/06. | IN PROGRESS<br>Needs Assessment anticipated completion date is 6/30/06 | |
| **Wheel chair vans**<br><br>CDCR will obtain 2 wheelchair accessible vans to transport wards with disabilities. | July 2006 | To inquire with adult side of CDCR for service agreement for use of vans. Preparing a request for re-consideration of requirement. | INCOMPLETE | |
| **Develop system to document the mental and physical impairments of wards**<br><br>Department will develop and maintain a system that documents the mental and physical impairments of wards with disabilities and any reasonable accommodations. | July 2006 | WDP coordinator working with Education, Mental Health, and Health Care sections to develop comprehensive list of wards requiring accommodations. Awaiting legal opinion on confidentiality issues of various impairments for reporting purposes. Also, awaiting finalization of Mental Health and Safety & Welfare Remedial Plans | IN PROGRESS<br>Anticipated completion date: 7/28/06 | |
| **Assessment of current ward population for wards with developmental disabilities.**<br><br>CDCR will complete an assessment of the current ward population for wards with developmental disabilities in order to identify any wards who may not have been previously identified. | Dec 2006 | Coordinate with Mental Health Team assessment process and V-Disc. Awaiting finalization of Mental Health Remedial Plan. | IN PROGRESS<br>Anticipated completion date: 12/29/06 | |
| [redacted] | | | | |
| **Develop Comprehensive plant modification list.**<br><br>CYA will provide the Disability Expert and plaintiff's counsel with a comprehensive list identifying each plant modification project as either category one, two, or three and prioritizing the two project categories to be completed. | July 15, 2005 | | COMPLETED | 7/15/05 |

| Action/Task | Plan Required Completion Date | Action Steps | Status | ACTUAL Completion Date |
|---|---|---|---|---|
| **El Paso de Robles YCF room.**<br><br>Complete room modifications to the El Paso de Robles YCF. | Aug 2005 | | **COMPLETED** | 1/27/06 |
| **Dewitt Nelson YCF room**<br><br>Complete room modifications to the Dewitt Nelson YCF | Dec 2005 | Room modification in procurement stage. | **IN PROGRESS**<br>Planned construction completion date: 8/7/06 | |
| **O.H. Close YCF room**<br><br>Complete room modifications to the O.H. Close YCF | Dec 2005 | Room modification in procurement stage | **IN PROGRESS**<br>Planned construction completion date: 9/29/06 | |
| **Preston YCF room**<br><br>Complete room modifications to the Preston YCF | Dec 2005 | OHU room #6 complete | **COMPLETED** | 12/30/05 |
| **SYCRCC room modification**<br><br>Complete 2nd room modifications to Southern Clinic | June 2006 | In construction phase | **IN PROGRESS**<br>Planned construction completion date: 6/30/06 | |
| **Appendix C- Category 1 Projects**<br>Complete first category of projects | Sept 30, 2006 | | **IN PROGRESS**<br>As of March 31, 2006, all Category 1 projects have been fully completed with the exception of the following projects: 1) N.A. Chaderjian- Renovate restroom in Administration Lobby Area, Renovate staircase to second tier at the Smith/American living units. Renovate staircase to second tier at the Tuolumne/SJ living units. (Planned completion date: 8/31/06) 2) Dewitt Nelson YCF- Renovate ward restroom in new Visiting building (Planned completion date: 8/7/06) 3) O.H. Close YCF- Adjust main entry/exit door pressure and install threshold ramp at the education office, replace main entry door threshold at Humboldt & El Dorado living units (Construction completion date to be determined after working drawings are fully completed) | |

| Action/Task | Plan Required Completion Date | Action Steps | Status | ACTUAL Completion Date |
|---|---|---|---|---|
| Appendix B- "Critical Disability Related Barriers"<br><br>Complete list of critical disability related structural barriers per schedule | FY 05/06 thru 08/09 | | IN PROGRESS- Anticipated completion date: 08/09 | |
| Appendix C- Category 2 Projects<br><br>Complete second category of projects. | Sept 30, 2008 | | IN PROGRESS-Anticipated completion date: 9/29/08 | |
| | | | | |
| **DWNYCF Compliance Audit**<br><br>Compliance Monitoring by expert | Sept. 15-16, 2005 | | **COMPLETED**<br><br>Final report rec'd from special master. | 9/15-16/05 |
| **El Paso de Robles Compliance Audit**<br><br>Compliance Monitoring by expert | Oct. 13-14, 2005 | | **COMPLETED**<br><br>Final report rec'd from special master. | 10/13-14/05 |
| **VYCF Compliance Audit**<br><br>Compliance Monitoring by expert | Nov. 17-18/05 | | **COMPLETED** Final report rec'd from special master. | 11/17-18/05 |
| **HGSYCF Compliance Audit**<br><br>Compliance Monitoring by expert | Dec. 13-16, 2005 | | **COMPLETED**<br><br>Final report rec'd from special master. | 12/15-16/05 |
| **SYCRCC Compliance Audit**<br><br>Compliance Monitoring/HGS on 12/15 and 12/16 | Dec. 13-16, 2005 | Rescheduled for February 16 & 17, 2006 | **COMPLETED** | 2/16-17/06 |
| **NACYCF Compliance Audit**<br><br>Compliance Monitoring by expert | Jan. 19-20, 2006 | Rescheduled for February 2 & 3, 2006 | **COMPLETED** | 2/2-3/06 |
| **NACYCF Compliance Audit**<br><br>Compliance Monitoring by expert at N. A.Chaderjian | Feb. 2-3, 2006 | | **COMPLETED** Final report rec'd from special master. | 2/2-2/3/06 |
| **OH Close Compliance Audit**<br><br>Compliance Monitoring by expert | Feb 9-10, 2006 | Rescheduled for March 16 & 17, 2006 | **COMPLETED** | 3/16/17/06 |

| Action/Task | Plan Required Completion Date | Action Steps | Status | ACTUAL Completion Date |
|---|---|---|---|---|
| **SYCRCC Compliance Audit**<br>Compliance Monitoring by expert at Southern Reception Center | Feb 16-17, 2006 | | COMPLETED | 2/16-17/06 |
| **OH Close Compliance Audit**<br>Compliance Monitoring by expert at O.H. Close | March 16-17,2006 | | COMPLETED | 3/16-17/06 |
| **Headquarters Compliance Audit**<br>Meeting with Headquarter personnel at 10:00am | March 30, 2006 | Rescheduled for April 17, 2006 | COMPLETED | 4/17/06 |
| **Preston Compliance Audit**<br>Compliance Monitoring by expert at Preston | April 12-13, 2006 | Scheduled for April 13 & 14, 2006 | COMPLETED | 4/13-14/06 |
| [redacted] | | | | |
| **Referral Document YA 1.411**- CDCR will revise the Referral Document, YA 1.411 to replace "handicap" with "disability" within 30 days of the filing of this plan. | WSD | | COMPLETED | 6/9/05 |
| **Interim Solutions to PYCF Visiting Area**- CDCR will confer with the Disabilities expert to explore and implement, as reasonably appropriate, interim solutions to address architecture at the existing PYCF visiting area until the new facility is opened in July 2006. Note: Work with DJJ facility director to ensure compliance | WSD | | IN PROGRESS | |
| **Evacuation Procedures**- Shall be implemented at each facility to protect the safety of staff, wards, and the general public, protect property, preserve the organizational structure and facilitate the continuity and resumption of essential services. | WSD | Will need to incorporate procedures for disabled populations into existing facility emergency evacuation plans. | IN PROGRESS | |
| **Restricted Setting**-There shall be accessible restricted setting housing in at least one designated facility for each gender. | WSD | Included in construction schedule | IN PROGRESS | |

| Action/Task | Plan Required Completion Date | Action Steps | Status | ACTUAL Completion Date |
|---|---|---|---|---|
| **Implementation of Security Procedures**- CDCR staff shall be aware of accommodation to wards with disabilities in developing and implementing security procedures including use of force, count, searches, transportation, visiting, and property | WSD | WDP Headquarters' office preparing a draft document to identify specific disability needs to be addressed | IN PROGRESS | |
| **Staff Assistants**- All wards with disabilities who require accommodations shall be assigned a staff assistant from the facility team. Each facility shall have a team with at least one representative from each of the following disciplines: mental health, health care, and education. | WSD | | **COMPLETED**<br>All facilities have established working staff assistant teams with representative from each of the required remedial plan disciplines. WDP Coordinator currently developing training for teams. | 3/21/06 |
| **WDP Coordinator Training**- The WDP Coordinator and Facility WDP Coordinators will receive a higher level of training provided by qualified trainers/consultants from outside the Department within six months of the court approval of the plan. | WSD | TOK Seminar on Education Services and Disabilities attended by Headquarters and Facility WDP Coordinators 3/06 &4/06. Joining the National ADA Coordinator's Association. Will be attending the National ADA Conference in Phoenix, AZ. 4/23-4/27 | IN PROGRESS | |
| **Shower/Lavatories**- There will be at least one fully accessible shower and/or lavatory at each facility. | WSD | | IN PROGRESS | |
| **Ward Parole Hearings**- 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. | WSD | Inform facilities of requirements to provide reasonable accommodations. | IN PROGRESS | |
| **Annual Evaluations**- Department management staff shall evaluate all Youth Authority programs, services, and activities on an annual basis to ensure equal access by wards with disabilities. | WSD | Need to develop procedures to conduct evaluations | INCOMPLETE | |

| Action/Task | Plan Required Completion Date | Action Steps | Status | ACTUAL Completion Date |
|---|---|---|---|---|
| **WDP Reporting**- The Departmental WDP Coordinator shall ensure that a WDP report is completed monthly, quarterly, and annually for each site | WSD | Develop and transmit direction to DJJ facilities | IN PROGRESS | |
| **WDP Meetings and Training**- Effective immediately, the WDP Coordinator shall conduct regular meetings and trainings, as required, with all facility WDP Coordinators. | WSD | Initial WDP Coordinator meeting was held on Dec. 9, 2005 with all facilities present. | IN PROGRESS- Training criteria and materials are being developed by WDP Manager. Meeting times and dates have not yet been established. | |
| **TDD Equipment/Interpreter Services**- Wards with disabilities shall be provided use of a TDD and telephones for people with disabilities. Qualified sign language interpreters shall be provided for all due process functions and medical consultations. | WSD | | **COMPLETED ACQUISITIONS** All facilities have acquired and are capable of utilizing (TDD) Telecommunication Devices for the Deaf. All facilities have current contracts for qualified sign language interpreters. | 3/31/06 |

**Appendix G**

O'Rourke and Gordon, *California Division of Juvenile Justice Summary Education Program Report* (May, 2006)

# California Division of Juvenile Justice Summary Education Program Report

## Section I. Introduction

### Background

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

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

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

### Review Process:

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

The reviewers conducted site visits during the period of September 2005 through March 2006 to the following DJJ schools:

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

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

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

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

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

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

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

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

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

The written materials reviewed provided data collected since the beginning of the 2005/2006 school year. Interviews with educational personnel provided staff perceptions of the strengths and needs of the education program. Analysis of this information, together with direct observations, resulted in a series of findings regarding compliance with the requirements of the consent decree in the areas of general and special education.

**Findings**

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

A written Site Compliance Report was provided by the reviewers to Special Master, Donna Brorby within 30 days of the site visit. Special Master Brorby then submitted copies of the report to representatives of plaintiffs and defendants.

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

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

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

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

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

**Content of the Summary Education Program Report:**

The content of this report is in three parts:

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

II. Summary Reports – reports indicating the compliance ratings on specific items in the Remedial Plan for the system as a whole and for each school program reviewed.

III. Major Recommendations – statements regarding areas needing improvement in order to achieve compliance with the requirements of the Consent Decree.

## Section II. Summary Reports

The summaries of the reviewers' findings are found in two (2) attached tables:

Attachment A — **California Education Services Remedial Plan Summary Report** (I.Overview, Philosophy, and Program Policy, II. Staffing, III. Student Access and Attendance, IV. Curriculum, V. Special Education, VI.California High School Exit Exam.)

Attachment A The first column on the table lists specific items selected from the Remedial Plan in each of the six areas. The middle column specifies the auditing method, describing which approaches (e.g., file review, interview, or observation) will be used to determine compliance with each part of the item. In the last column, the findings from the eight (8) site reviews are summarized to provide a system wide picture of compliance levels.

Attachment B — **California Remedial Plan Site Compliance Report** (I.Overview, Philosophy, and Program Policy, II. Staffing, III. Student Access and Attendance, IV. Curriculum, V. Special Education, VI. California High School Exit Exam.)

Attachment B On this table, the name of each site and the date of its review is shown at the top of the column. The items reviewed are listed by each of the six (6) areas and the compliance rating for each item (substantial, partial or non compliance) is shown.

## Section III. Major Recommendations

These recommendations are made by the reviewers to assist the Division of Juvenile Justice in attaining full compliance with the Consent Decree requirements. They are organized according to the six areas in the Education Services Remedial Plan.

### I. Overview, Philosophy & Program Policy

Remedial Plan: The CYA/CEA is required to develop a high school graduation plan and enroll each non-graduate student in an appropriate education program (W&I Code 1120.1)

- There continues to be a failure to provide enough courses on a consistent basis to comply with this requirement. While more High School Graduation Plans are being developed, students are not making substantial progress in meeting high school graduation requirements.

Remedial Plan: Students are prepared for successful re-integration into the community.

- Students are not being provided adequate transition planning at all sites. Schools must provide specific guidance and direction to prepare students for successful release into the community.

### II. Staffing

Remedial Plan: Each high school has adequate credentialed staff to provide instruction in content area courses needed for graduation.

- Current staffing allocations need revision due to the changes in population at many sites. Staffing allocations need to ensure that there are enough credentialed core area faculty to meet the students' high school graduation plan requirements.

- An increased number of available substitute teachers (meeting the 15% relief factor) is needed to prevent class cancellations due to teacher absences. Options need to be explored to provide qualified substitute teachers in both general and special education.

- Continued attention should be given to the teacher recruitment and hiring process. While staff recruiters have been identified, a comprehensive plan to recruit and retain qualified education staff is still needed. DJJ Central Office should take steps to reduce the lengthy delay between an education vacancy occurring and the position being filled.

### III. Student Access and Attendance

Remedial plan: All eligible students will have access to any educational programs and supplemental services necessary to ensure successful completion of all high school, vocational, and life skills courses.

- Students who are not making progress towards the high school diploma should be provided better access to GED programs. This access should include pre-GED instruction, test preparation and other strategies to promote successful acquisition of a GED certificate. Increased GED

opportunities would provide motivation for students 18 and older, not likely to meet high school diploma requirements, to attend school.

- Despite what appears to be adequate vocational facilities, too few students are participating in vocational classes. All students must be offered vocational training to provide them with employment skills to prepare them to re-enter the community.

Remedial Plan: An effective and fully functional School Consultation Team will provide instructional services for students experiencing problems of an academic, social and behavioral nature.

- Schools lack uniformity in the implementation of the SCT. The SCT process should be monitored at the Central Office and site levels to ensure uniform implementation.

Remedial Plan: A collaborative memorandum of understanding will be developed by the Directors at each site and signed by each affected Branch Deputy Director delineating a collaborative effort between custody, education and treatment to ensure equal student access to all programs.

- The written agreement described in the consent decree does not exist and must be developed immediately. While many reasons were offered at the sites, the fact remains that students are simply not being sent to school on a regular basis. All parties (education, custody and treatment) must come together to ensure all students are receiving education services.

- All options should be explored to ensure student access to instruction. One option is to expand the school day from 4 to 5 or 6 periods, with time set aside for prescribed counseling conducted at the school site. Education staff should study the feasibility of incorporating mental health services into curriculum that would allow students to earn elective course credit. The mental health counselor and teacher could work as a team to teach these classes. If teaming is not possible, the time could be used by the counselor to meet with the students at the school during one or more of the six available school hours.

- If counseling services were provided at the school facility, student movement time would be reduced, increasing the amount of available instructional and clinical time.

Remedial Plan: In order to make satisfactory progress toward high school graduation students must be provided and attend school a minimum of 240 minutes daily.

- Student absentee rates continue to be unacceptable. Strategies outlined in the remedial plan to improve school attendance must be implemented at both the Central Office and site levels (e.g., policy and procedure to eliminate class cancellations, cooperative agreements, plans to remediate deficient attendance, and attendance incentives).

Remedial Plan: Students in restricted settings will have the same school day as students in the regular school program.

- Instructional programs for both regular and special education students in the restricted settings are inadequate. Additional staff and instructional space must be identified and provided in order to provide equal educational access to these students.

## IV. Curriculum

Remedial Plan: Career technical education programs should be implemented and employability studies conducted to determine how well students are transitioning back to the community.

- A feedback loop should be developed by Central Office staff so that each site can determine whether students are being successfully employed once they return to the community. Vocational program effectiveness and necessary changes should be based on this information.

Remedial Plan: Educational technology and distance education should be added at all sites to add a wide range of learning modalities and enhance the curriculum.

- Central Office staff should emphasize the expanded use of technology to enhance the school curriculum.

- Distance learning technology should be made available in the restricted units. Central office and site staff should pursue this avenue for increasing educational service hours without compromising security for students segregated from the general population.

Remedial Plan: Teacher observations are an integral part in evaluation of the delivery and quality of the educational program.

- School administrators must consistently conduct quarterly classroom observations to document evidence of instructional planning, use of course syllabi and delivery of the state approved curriculum. Observations should be based on the rubric for classroom observation aligned with the California Standards for the Teacher Profession (CSTP)

## V. Special Education

Remedial Plan: The Special Education Manual will meet all state and federal regulations.

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

Remedial Plan: Complete special education files are required to be transferred to the receiving DJJ facility and fully implemented within 4 school days of student's arrival.

- The system for requiring receipt of complete educational records should be revised to ensure that all students entering the DJJ system from the community or who transfer from one facility to another are accompanied by complete records.

Remedial Plan: Each DJJ facility must provide a continuum of placement options, including the full range of time, frequency and duration within each option.

- All sites must improve the provision of general education classes in the frequency and duration indicated in IEPs. Teacher vacancies at many sites resulted in reductions and limitations on class offerings. The practice of holding students on their units for reasons not allowed under the consent decree must be discontinued so that special education students have access to IEP mandated segments.

Remedial Plan: The DJJ school sites are responsible for ensuring that a continuum of available special education services is provided to all eligible students including those assigned to restricted settings.

- Most special education students whether served in the main school program or on the residential units do not receive 240 minutes of instruction daily. The practice of providing minimal special education services and little or no access to the general education program must be corrected immediately.

Remedial Plan: Eligible students receive the required number of IEP segments and a full instructional day.

- IEPs written by DJJ staff must address how the student's disability affects involvement in the general curriculum. When the IEP requires access to the general curriculum, such access and a full school day must be provided. Supplemental aids and program modifications that support the student's involvement in the general curriculum must be provided.

Remedial Plan: Written policies, procedures and practice require that assessment procedures and products provided by the DJJ be updated and standardized by August 2005.

- Program administrators at the Central Office and sites must monitor not only the completion of reports but also take responsibility for accuracy and timeline expectations to ensure quality control.

Remedial Plan: Written policy, procedures, and practice require that the CYA and clinic administrators will work collaboratively with Intake and Court Service units to ensure compliance with regulations regarding the provision of IEPs prior to the acceptance of the physical custody of the student.

- Collaborative agreements between clinic administrators and intake and court service units regarding IEPs of incoming students must be developed and implemented immediately.

Remedial Plan: Special education students were provided services according to requirements of pre-existing valid IEPs.

- If specified in the student's pre-existing IEP, DJJ schools must provide students with access to a full instructional day. Any IEP change must be made with adequate documentation or rationale and by the IEP committee.

Remedial Plan: When there is no IEP, special education eligibility will be determined and team meetings will be held in a timely manner. Required participants will be in attendance. IEP notices are sent as required and required participants are present. If regular education teachers are not there, ensure that they are made aware of IEP provisions.

- Special education eligibility documents must be kept current according to guidelines. Expired or off timeline IEPs cannot support continued eligibility and must be reviewed by the IEP team.

compliance efforts should be conducted independently by each Assistant Principal responsible for special education programming.

## VI. California High School Exit Exam

Remedial Plan: Each eligible student in the DJJ shall have access to each mandated educational assessment.

- It is recommended that sites make better use of data from the statewide testing program to focus on specific goals in each individual school improvement plan.

- There is a need to explore and provide all options possible to youth who are unable to pass the equivalency exams.

- IEP meetings must be held within the prescribed time frame and documentation must be maintained indicating that regular education teachers not present at the IEP meetings were made aware of the IEP provisions for students in their classes.

Remedial Plan: Special education files must include consideration of need for related services and/or transition planning.

- In the development of special education transition plans, there is a need to emphasize and/or document the acquisition of functional skills and hands-on- knowledge that would enable the student to re-enter the community and continue education or training as required. In the IEPs reviewed at all sites, transition goal outcomes were vague and not measurable. Teachers at all sites are aware of transition plan limitations and expressed optimism that form revisions expected as a result of the new IDEA requirements would enable them to address this deficiency. Continued training and more intensive monitoring by the school administration and central office staff is recommended.

Remedial Plan: The CYA shall develop and implement a system to provide for the documentation of student progress related to his/her IEP goals and objectives based on the dates identified on the IEP. The system will ensure that progress reviews are routinely practiced by each special education provider.

- Teachers must document progress review of IEP benchmarks and where necessary, make IEP changes based on progress or lack of progress. Consistent monitoring of this process by the site Assistant Principal and Regional Program Specialist is recommended.

Remedial Plan: Written policy, procedures, and practice require that compensatory special education services are provided to students if significant gaps of missed service occur or are projected to occur, and if such services cannot be made up during the course of the week or designated period of time.

- A need for compensatory services is created by extended teacher absences and/or unfilled teaching positions not covered by substitute teachers. Lengthy school hold backs by the residence halls create compensatory obligations that have not been addressed. Personnel at the Central Office and sites must address these issues.

Remedial Plan: Training on special education will be provided by the CYA to all education staff and administrators, treatment and custody staff and administrators and other stakeholders starting July 2005. Training will use the approved Special Education Manual, approved forms and data collection systems. The frequency of the training scheduled will be dependent on each individual's role in the process and may vary from quarterly to annually.

- While the sites have been able to document their staff training, there is concern about the effectiveness of the training due to the many deficiencies in meeting consent decree requirements. Training staff should carefully examine their efforts and develop formal methods of measuring implementation of special education training objectives.

Remedial Plan: The Regional Program Specialist shall conduct at least quarterly site reviews of each school's special education compliance efforts and status.

- The Regional Program Specialists did not begin conducting quarterly site reviews at each school until midyear. The Specialists must ensure that they are monitoring the program's compliance in each special education area covered by the consent decree. Direct observation and monitoring of

ATTACHMENT A

# California Education Services Remedial Plan Summary Report

**Reviewers:** Dr. Tom O'Rourke, Dr. Robert Gordon **From September 2005 through April 2006**

| Item | # | Auditing Method | Findings |
|---|---|---|---|
| **I. Overview, Philosophy & Program Policy** | | | |
| All school sites meet WASC Accreditation Standards. | 1.1 | Verify WASC accreditation status at all school sites. Review WASC records at each site. | All schools except N. A. Chaderjian have been accredited by the Western Association of Colleges and Schools. At that site, staff reported that they were working to meet accreditation requirements. |
| The written policy, procedure and practice document that the CYA core curriculum meets the Content Standards for California Public Schools adopted by the State Board of Education (W&I Code 1120.2) | 1.2 | The CYA will provide written verification that their courses are California Education Standards driven and that they meet state curriculum standards. | It was documented and confirmed by Glenda Pressley, Acting Deputy Director of the Education Branch, that the courses were California Education Standards driven and met state curriculum standards. All sites were in substantial compliance in this area. |
| The written policy, procedure and practice document that all non-high school graduates have a High School Graduation Plan. The plan is reviewed semi-annually by education staff for student progress in completing required courses. | 1.3 | Review 10 or 10%, whichever is greater, of the student records at each site to determine the presence of a High Graduation Plan. | Six sites were in substantial compliance with the requirement to develop High School Graduation Plans for all non-high school graduates. |
| | 1.4 | Verify whether semi-annual reviews have been conducted. | Only two sites were in substantial compliance with the requirement for semi-annual reviews of the High School Graduation Plans. Documentation provided indicated that that the required reviews were not being consistently conducted. |
| Students must earn 200 credits in a range of subject matter consistent with the California Education Code and pass the state required academic assessment in order to qualify for a high school diploma. | 1.5/6 | Review 10 or 10%, whichever is greater, student records at each site to determine whether progress is being made in meeting high school diploma requirements. | File reviews indicated that students at the majority of sites were not making satisfactory progress toward meeting graduation requirements. |
| Written policy, procedure and practice document that screening and identification are provided to all English learner eligible students and services are provided to enable them to access the core education program. | 1.7 | Review 10 or 10%, whichever is greater, student files of students with a primary language other than English to verify the provision of English Learner services. | Document and file reviews indicated that 5 sites were in substantial compliance with requirements to screen, identify and provide services to English Learner eligible students. |
| Students are prepared for successful transition to the community upon release. | 1.8 | Review all files of students within 90 days prior to release to verify that transition planning is being provided to students. | None of the sites demonstrated that they were consistently providing transition planning to all students within 90 days of release to prepare them for return to the community. |

| **II. Staffing** | | | |
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| Written policy, procedure, and practice require that all teaching personnel hold valid California credentials and work in the field of credential. Each high school has adequate credentialed staff to provide instruction in content areas needed for graduation. | 2.1 | Review all teaching certificates and teaching schedules of personnel. | Document review indicated that at 5 sites all of the teachers held valid in-field credentials. |
| | 2.2 | Review courses offered at each high school to determine if there are enough courses offered to prepare students for graduation, including the following: English, math, life science, physical science, history, economics, government, art or foreign language, physical education and career-technical | Observations, interviews and records indicated that 5 of the sites failed to provide enough courses to prepare students for graduation in a reasonable amount of time. |
| A recruitment plan is in place to obtain a sufficient number of appropriately credentialed education staff to implement proposed staffing patterns. | 2.3 | Review and evaluate the written recruitment plan and the qualifications and use of the 2 recruiters. | File review indicated that work was being done to recruit qualified teachers; however, DJJ has not yet developed a comprehensive recruitment plan that includes short and long range goals with timelines and evaluation criteria. |
| | 2.4 | Determine the length of time that positions are vacant and the length of time required to recruit and hire replacement teachers during the monitoring period. | At the majority of the sites, the DJJ hiring process was too lengthy, delaying the implementation of proposed staffing patterns. |
| Written policy, procedures and practice document that qualified substitute teachers are provided for teachers who are absent. | 2.5 | Determine whether there is a pool of trained substitute teachers and specialists at each site which represents 15% of the permanent teaching staff. | At all sites the DJJ did not employ an adequate number of substitute teachers for both general and special education. |
| | 2.6 | Document class cancellations due to teacher absences that are not covered by substitute teachers. | Class cancellations due to teacher absences (not covered by substitute teachers) continue to be a major problem in the DJJ. Seven of the sites were non compliant in this area. |
| | 2.7 | Verify the use of an in-field teacher for any teacher vacancy which exceeds 45 consecutive days. | The DJJ did not consistently provide in-field substitutes for teacher vacancies of more than 45 consecutive days. |
| Written policy, procedure, and practice require programs and services to meet the guidance, counseling, testing, social services, psychological and career development needs of students. | 2.8 | Verify that each facility has a psychologist and related service providers available to ensure psychologist participation in the development of IEPs, administration of psycho-social assessments, and consultation with teachers and staff. | Significant progress has been made in providing school psychologists and related services providers, with 6 sites in substantial compliance and 2 in partial compliance. Psychological services were supplemented by the use of interns at some sites. |
| | 2.9 | Use a sample of 10 or 10%, whichever is greater, of special education students referred for testing during the monitoring period; determine how long it was from referral to testing and report. | Three of the programs demonstrated the ability to complete special education assessments within the fifty day allowable timeline. |
| | 2.10 | Use a sample of 10 or 10%, whichever is greater, of special education students referred for related services during the monitoring period; determine how long it was from referral to provision of services. | Four programs documented that students referred for speech/ language or court-mandated counseling received those related services within the allowable 50 days from the initial referral date. One school reported that no students had been referred for related services within 30 days prior to the review and it could not be rated. |
| Each high school having a restricted program shall have a minimum of 2 school psychologists. | 2.11 | Verify employment of 2 school psychologists at schools with restricted programs. | Of the 4 sites with formal restricted programs (Special Management Units), 3 provided documentation that a minimum of two school psychologists were employed at the time of the review. |

| III. Student Access and Attendance | | | |
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| Written policy, procedure, and practice document that the length of the school year, school day and instructional time are in accordance with the California law and the requirements of the California State Board of Education. | 3.1 | Verify the existence and implementation of a Standardized 220 day Academic Calendar which provides for at least 240 minutes of instruction each day for each eligible student. | At the conclusion of the site reviews, the annual 220 day Standardized DJJ Academic Calendar had been approved by the Director, but it had not yet been implemented. |
| Written policy, procedure, and practice document that educational services are provided to the eligible students based on the system wide Standardized Annual Academic Calendar. | 3.2 | Verify the existence and implementation of a Standardized 220 day Academic Calendar which provides for at least 240 minutes of instruction each day for each eligible student. | At the conclusion of the site reviews, the annual 220 day Standardized DJJ Academic Calendar had been approved by the Director, but it had not yet been implemented. |
| Written policy, practice and procedure require that all students will be enrolled into appropriate educational programs within 4 school days of arrival. | 3.3 | Review 10 or 10% of student files, whichever is greater, to document enrollment in appropriate education programs within 4 school days of arrival for students entering during the monitoring period. | Efforts were being made to enroll students in the educational program within 4 days of arrival, with 4 sites in substantial compliance and 4 sites in partial compliance with this requirement. |
| | 3.4 | Verify that high school registrars request transcripts from any prior school within 4 school days of the student's arrival at the facility for students entering during the monitoring period. | Observation and file reviews indicated that progress has been made in requesting transcripts within 4 days of the student's arrival, with 6 sites in substantial compliance. |
| Written policy, procedure, and practice, require that in all sites serving older students, the CYA will have in place a system designed to determine the most appropriate educational placement of students based on individual need. | 3.5 | Review 10 or 10% of student files, whichever is greater, to verify that students meeting criteria for GED preparation are provided the opportunity for classes to prepare for GED testing. | Many students who are not making progress towards the High School diploma are not being provided opportunities to work towards attaining a GED. This is an area that is inconsistent at the DJJ sites, with only 1 site rated substantially compliant. |
| Written policy, procedures and practice require the use of Student Consultant Teams to develop instructional services for students experiencing problems of an academic, social, or behavioral nature. | 3.6 | Verify SCT committee make up and function. Interview SCT committee members. Interview 10 or 10% of students, whichever is greater, who have been the subject of SCT team meetings to verify the provision of SCT developed instructional services. | DJJ sites lack uniformity in the implementation of the Student Consultation Teams. Only 1 of the sites was substantially compliant in this area. |
| | 3.7 | Review SCT minutes and records for planned interventions and referral to supplemental service providers. | Documentation at 3 sites indicated substantial compliance in providing interventions and referrals for students reviewed by SCT teams. |
| Written policy, procedure, and practice require that students failing to earn an average of 5 high school credits each month are referred to SCT, Special Education and/or Case Conference Teams. | 3.8 | Review 10 or 10%, whichever is greater, files of students not making minimal progress to determine if referrals have been made to SCT (general education students), the Special Education Team (special education students) and/or the Case Conference Team (all students) for evaluation and possible intervention plans. | At the majority of sites, the Student Consultation Team (SCT) was not fully functioning according to DJJ policy and procedures for SCT teams. Students meeting criteria for referral were not consistently being served by SCT or teams. |

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| Written policy, procedures, and practice require that the CYA shall establish a functional SCT tracking system that documents the effectiveness of recommended interventions and provides verification of on-going progress reviews. | 3.9 | Verify development of the tracking system by April 2005. | At the majority of the sites there was documentation that the SCT tracking system had been developed. |
| | 3.10 | Review 10 or 10%, whichever is greater, of files of students having SCT Intervention Plans for documentation of on-going progress reviews. | At the majority of the sites, there was a lack of documentation of progress reviews of SCT plans. |
| The CYA shall insure that the SCT provides appropriate identification, referral and assessment of students not previously identified as eligible for special education services, including those students in restricted settings for extended periods of time. | 3.11 | Review the SCT log at each site for proper documentation and follow-through with students that should be referred for eligibility testing. | Only 2 sites demonstrated substantial compliance in follow-through on students referred for eligibility testing. |
| | 3.12 | Review each individual student's file that has been referred from SCT for special education evaluation in last 30 days to verify that special education evaluation has been conducted. | Four sites did not have any recent referrals for special education evaluation; of the remaining sites only 1 was in substantial compliance. |
| The CYA shall provide in-service training on SCT policy and procedures, including the use of standardized SCT forms and staff roles and responsibilities. | 3.13 | Review in-service training including the outline of topics, the schedule and the dates.<br><br>Verify attendance at staff training. | Records review indicated that SCT training had taken place at 7 sites. |
| Written policy, procedure and practice document that all students who do not possess a high school diploma or GED will attend school each scheduled school day except for verified medical conditions or when the student is an immediate threat to the safety of self or others. | 3.14 | Note the procedure for security and/or dorm personnel to inform teachers of missing student's whereabouts. | Review and observation indicated that teachers were posting absences from their classes on the door for each class period. At most sites, there was no daily feedback to teachers as to why students were absent from class. |
| | 3.15 | Review 10 or 10%, whichever is greater, student files to document school attendance for the last 30 school days. | Student absenteeism was at an unacceptable level; all sites received a non compliant or partially compliant rating in this area. |
| Cooperative agreements exist between education, custody and treatment to ensure students' access to programs. Management teams will implement a program service schedule to allow service needs to be met during the work day/week without loss of mandatory instructional time. | 3.16 | Review the cooperative agreements to Ensure students' access and attendance in the school program.<br><br>Interview staff and students to verify implementation of the agreements. | The remediation plan stated that a cooperative agreement would be developed by representatives from education, custody and treatment in order to ensure student access to instructional programs. File review and interviews indicated that no written agreement existed. All sites were rated non compliant. |
| Written policy, procedure and practice document that the Director and Executive Team monitor attendance data quarterly to ensure compliance with laws, regulations and policies. Facility superintendents and principals will present their collaborative plans to remediate deficient attendance or access by April 2005. On a quarterly basis, schools with absence rates of 10% or more will continue to make corrective action plans until absence rate is below 10%. | 3.17 | Verify quarterly reviews of school attendance reports by Executive Team. | The majority of sites were rated non compliant or partially compliant based on lack of documentation of Executive Team reviews of school attendance reports. |
| | 3.18 | Review and evaluate April 2005 plans to remediate deficient attendance/access. | File reviews indicated that no sites had developed collaborative agreements to remediate deficient attendance. |
| | 3.19 | Review and evaluate quarterly corrective action plans for sites that have an absence rate of more than 5%. | File reviews did not indicate the existence of quarterly corrective action plans. All sites were rated non compliant in this area. |

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| Written policy, procedure and practice document that class cancellations will be eliminated except for verified safety or security reasons. | 3.20 | Review school schedules for the last 30 days. Review WIN Data and verify individual class cancellations at each site. Interview teachers, other staff and students. | Data review indicated that 7 of the sites were non compliant and 1 site was partially compliant in eliminating class cancellations except for verified safety and security reasons. |
| The CYA shall devise appropriate criteria for the exclusion of students from school and maintain a daily document that lists the number and names of all students who were excluded from school. The record includes the name of the youth excluded, the name of the person who authorized his or her exclusion, the reason for his or her exclusion, and the duration of the exclusion. | 3.21 | Review attendance records of a minimum of 5 teachers to verify that the location of missing students is identified. | At the majority of sites, teachers were unable to verify the location of missing students. |
| | 3.22 | Review exclusion from school forms at each site for 10 days out of the previous month for completeness of data recorded. | Five sites were substantially compliant in this area and were using Exclusion from School forms appropriately. |
| | 3.23 | Observe any students being pulled from class, held back on housing unit, or held over after meals to perform work details. | It was observed that many regular and special education students were being held back on the housing units for "programming" and for other reasons throughout the day. Six sites were non compliant and 2 sites were partially compliant in this area; no sites were substantially compliant. |
| The attendance system will be integrated into the current WIN Data Base and will reflect accurate student attendance data. | 3.24 | Verify existence and accuracy of WIN Data Base attendance information for the last 10 consecutive school days. | There were inconsistencies in the implementation of the WIN Data Base. Seven sites received partial or non compliance in this area. |
| A management team will review monthly data to remove barriers to the 240 minute minimum instructional day. | 3.25 | Review logs and minutes documenting the management team's monthly review of instructional time requirements. | None of the sites documented substantial compliance with the requirement for management team review of the instructional time requirements. |
| Superintendent of Education and the Deputy Director, Institutions & Camps will review policies, data and practices related to education attendance and develop performance expectations by July 2005. Department wide staff training (including staff in restricted settings) will be provided by December 2005. Final implementation will take place in December 2005. Policy and procedures will be updated by July 2006. | 3.26 | Review and evaluate performance expectations on attendance developed in July 2005. | File reviews indicated that performance expectations on attendance had not been developed system wide, resulting in a finding of non compliance at all sites. |
| | 3.27 | Review and evaluate training plan, outline of topics and schedule. Verify staff attendance at the training. | File review indicated that no training on attendance expectations had been provided, resulting in a finding of non compliance at all sites. |
| | 3.28 | Review and evaluate final implementation of attendance policies and procedures in December 2005. Review and evaluate revised policy and procedure in July 2006. | There was no documentation that attendance policies and procedures had been developed and implemented system wide. Final policy and procedures are due to be implemented in July 2006. |
| Instructional teams will be required to develop incentives for increased school attendance. | 3.29 | Verify the development of incentives for increased school attendance. | Only 2 of the sites had implemented incentives for increased student attendance, receiving ratings of substantial compliance. |
| The Superintendent of Education will develop an Annual Academic Calendar each year by May 15. The Annual Academic Calendar will include 44 Student Advising/Case Conference days from the days that teachers and education specialists are scheduled to work. | 3.30 | 3.30 Review and evaluate annual school calendar. | At the conclusion of the site reviews, the annual 220 day Standardized DJJ Academic Calendar had been approved by the Director, but it had not yet been implemented. |
| | 3.31 | Review scheduling and utilization of the 44 student advising/case conference days per year. | The majority of the local school calendars indicated the inclusion of 44 student advising/case conference days per year. Due to the lack of a system wide school calendar, those sites were found to be in partial compliance. |

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| Adequate instructional space is provided at all facilities.<br>A study on the adequacy of instructional space will be completed by May 2005. | 3.32 | Review number and size of classrooms and CYA study of instructional space in May 2005.<br>Monitor progress in meeting proposed classroom construction and renovation schedule. | Only 2 sites were determined to have adequate instructional space.<br><br>The Instructional space report has been completed and it identified where additional classroom space was needed. |
| Written policy, procedure and practice provide a structured positive behavior management system in each CYA classroom statewide. | 3.33 | Verify the implementation of the behavior management system in the classrooms at each site. | The consent decree indicated that a structured behavior management system would be developed and used in each classroom. Seven sites failed to document that a structured positive behavior management system was in use in classrooms. |
| An alternative behavior management classroom will be provided at each school. | 3.34 | Verify the use of the alternative behavior management classroom at each site. | None of the sites provided an alternative behavior management classroom. |
| Staff will be trained in the operation of the behavior management system. | 3.35 | Review and evaluate staff training outline, schedule and attendance. | Seven of the sites failed to document the provision of training in the operation of a classroom behavior management system. |
| Staff are required to develop behavioral goals for special education students placed in restricted programs or review/revise existing goals. | 3.36 | Review behavioral goals in IEPs of all special education students placed in restricted programs.<br>Interview IEP team members, psychologists and related service providers. | Three of the 4 sites with special management units (SMUs) failed to adequately develop/revise behavioral goals of special education students placed in the restricted units. |
| All services in restricted placements will be delivered in small classroom settings whenever possible. | 3.37 | Verify existence of classrooms in restricted settings.<br>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. | Only 1 of the 4 sites with special management units had adequate classroom space. |
| The CYA shall maintain a staffing ratio of 5:1 in all restricted programs.<br><br>All staff assignments shall be aligned with specific course offerings as well as credential authorizations. | 3.38 | Review current and previous 30 school days' class rolls for all restricted school programs to determine staffing pattern.<br>Verify teachers' credentials.<br>Review high school graduation plans, IEPs and other documents to document assignment/instructional match. | None of the 4 sites with special management units provided an adequate number of fully credentialed teachers to meet these requirements. |

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| Written policy, procedures, and practice require high school administrators, together with their living unit counterparts, to be responsible for the following in supervising staff assigned to restricted placements:<br><br>1) Use of a standardized format for reporting educational progress and data on students in restricted placements.<br>2) Use of a standardized checklist by school administrators to ensure students in restricted programs are receiving their full complement of mandated educational services.<br>3) In-service training for all education and living unit staff assigned to restricted programs regarding policy, guidelines, staff roles and responsibilities.<br>4) Technical assistance from the SB505 team process to assist in the development of guidelines and effective strategies for students frequently placed in restricted settings.<br>5) In-service training and assistance provided by special education teachers and specialists for living unit staff on effective strategies and interventions in working with students with disabilities. | 3.39 | Verify instructional program on restricted units by reviewing school schedule, education progress reports and school transcripts.<br><br>Conduct direct observation of instructional program.<br><br>Interview site administrators.<br><br>Interview teachers, custodial staff and students. | None of the 4 sites with special management units met all of the criteria listed. |
| | 3.40 | Verify that staff training and technical assistance are being provided. | Two of the 4 sites with special management units were providing staff training and technical assistance. |

| IV. Curriculum | | | |
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| Written policy, procedure and practice document that Curriculum Guides and instructional policies are aligned with the California Education Code for Public Schools related to curriculum, instruction and assessment. | 4.1 | Verify with written documentation that the CYA curriculum meets the Content Standards and Curriculum Frameworks for the California Public Schools. | It was documented and confirmed by Glenda Pressley, Acting Deputy Director of the Education Branch, that the courses were California Education Standards driven and met state curriculum standards. All sites were in substantial compliance in this area. |
| | 4.2 | Verify with written documentation that there is a process in place to coordinate curriculum revisions and develop curriculum guides on a cyclical basis. | The process to coordinate curriculum revisions was verified by document review and met the requirement, resulting in ratings of substantial compliance at all sites. |
| | 4.3 | Verify that Curriculum Guides with content, performance standards and process for instruction exist for all core area courses (English/Language Arts, Science, Mathematics, Social Studies) and vocational education courses taught in the CYA Schools. | Curriculum guides in all core courses and vocational areas were verified by document review, resulting in ratings of substantial compliance at all sites. |
| Core Curriculum Guides are made available to staff in electronic form by December 2005. | 4.4 | Verify that the core academic guides are available to all staff electronically in December 2005. | Core academic curriculum guides were available in electronic form as of 1/06. All sites reviewed after that date were found in substantial compliance on this item. |
| Written policy, procedure, and practice require all school sites to meet California DOE and WASC standards for textbooks, library books, and educational supplies and materials. | 4.5 | Compare the number of textbooks and library books at each site with applicable standards. | All sites met the California standards for textbooks and library books and received ratings of substantial compliance. |
| Each site will conduct an annual inventory beginning in August 2005 and needs assessment to determine if additional materials and equipment are needed. | 4.6 | Verify in August 2005 that the annual inventory and needs assessment has been conducted. | Annual inventory and needs assessment were conducted at each site, resulting in ratings of substantial compliance. |
| Textbooks and library books are available to all students both in classrooms and on living units.<br><br>The Education Services Branch will identify the core books that comprise the mini-libraries and the school librarian will maintain the inventory of the mini-library. | 4.7 | Observe whether adequate supplies and materials are available at each site to support the curriculum offerings. Verify the availability of textbooks and library materials to students in classrooms. | It was documented that 7 of 8 sites had an adequate supply of textbooks and library books to support the educational program. |
| | 4.8 | Verify availability of core books in the mini-libraries on the living units according to the inventory prepared by the school librarian. | Six of the sites failed to provide mini-libraries on the living units; the mini-libraries were in various states of completion. |
| Written policy, procedure, and practice require that opportunities are provided for school leadership personnel to continue professional development throughout their careers. | 4.9 | Verify the implementation of the Staff Development Plan for leadership personnel. | Five sites provided complete documentation to indicate that staff development was being provided to leadership personnel. |

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| Annual training including compliance requirements, updated policies and procedures, examples of best practice, implementation issues and other related topics will be provided to site administrators, teaching and custody staff and other stakeholders. The frequency of the training scheduled will be dependent on each individual's role in the process and may vary from quarterly to annually. | 4.10 | Verify in-service schedule including dates and outline of topics. | All sites documented compliance with the training requirements. |
| | 4.11 | Verify staff attendance at training through inspection of in-service roll information and review of Principal's Monthly Report. | Seven sites provided complete documentation verifying staff attendance at training. |
| Written policy, procedure, and practice require that Trade Advisory Committees are implemented to provide appropriate programming and liaison between the CYA, community and potential employers. | 4.12 | Verify the formation of advisory committees at each site by May 2005 and their quarterly meetings. | Advisory committees are functioning at the majority of the sites. Two sites failed to document the functioning of Trade Advisory committees. |
| | 4.13 | Verify the use of annual surveys to provide vocational course planning by July 2005. | As verified by file review, the Division of Juvenile Justice had conducted surveys to provide vocational course planning, resulting in a finding of substantial compliance at all sites. |
| | 4.14 | Verify the use of annual Career Technical job studies to determine the effectiveness of CTE programs. | As verified by file review, the Division of Juvenile Justice had conducted job studies to determine the effectiveness of the CTE program, resulting in a finding of substantial compliance at all sites. |
| Written policy, procedure and practice require a distance delivery system to provide opportunities for instruction and interaction in different locations. Distance education courses for high school graduation meet Content Standards for California Public Schools.<br><br>Global Classrooms will be available at each site by June 2006. | 4.15 | Verify the existence of the use of technology at each site by June 2005. | Teacher interviews and observation indicated the existence of technology hardware and software at all of the sites. Five sites demonstrated consistent use of the available technology resources. |
| | 4.16 | Verify that distance learning course content meets Content Standards. | In sites where distance learning was in use, the courses met content standards. |
| | 4.17 | Verify implementation and use of Global Classrooms distance learning. | Availability of Global Classrooms distance learning is scheduled for June 2006. |
| In restricted settings, distance learning will be utilized as one of the methods used to accommodate student instructional needs. Distance learning will not exempt the restricted settings from the use of instructional staff to provide direct support service to students and will not result in a reduction of the required 240 instructional minute per school day requirement. | 4.18 | Verify use of distance learning in restricted settings by direct observation, lesson plan and transcript review. | The special management units were not using distance learning at the time of the reviews. |
| An automated library system will be installed at each high school by June 2006. | 4.19 | Verify implementation and use of the automated library system. | Although library automation has been implemented at some sites, full implementation is not scheduled until June 2006. |

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| Written policy, procedures, and practice require the use of course syllabi, units of instruction and lesson plans by teachers. | 4.20 | Verify through teacher observation evidence of the use of course syllabi, units of instruction and lesson plans.<br><br>Interview teachers, students and administrators for evidence of the use of lesson plans, course syllabi and units of instruction. | All sites monitored were either substantially compliant or partially compliant in the use of course syllabi and lesson plans by teachers. |
| Quarterly classroom observations will be conducted by school administrators based on a rubric aligned with the California Standards for the Teacher Profession (CSTP). | 4.21 | Verify the practice of quarterly teacher observations by administrators using the revised rubric for Classroom Observation. | Quarterly teacher observations were not being consistently conducted at 7 sites. |
| Implement the 5 Year Strategic Plan and Comprehensive Reading Initiative to improve the quality of instruction in reading/language arts and mathematics. | 4.22 | Verify that the strategic plan and reading initiative are being implemented at each site. | The comprehensive reading initiative, the Holt and Highpoint Reading program, was fully implemented at all sites. The enrollment was extremely limited at 2 sites. |
| Education policies will be revised and made available to staff electronically by June 2006. | 4.23 | Verify that policies have been revised to reflect changes in operations. | Policy revisions are due in June 2006. |
| | 4.24 | Verify that policies are made available to staff electronically by June 2006. | Policy revisions in electronic format are due in June 2006. |

| V. Special Education | | | |
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| The Special Education Policy Manual will be approved and available to staff by September 2005.<br>The Special Education Manual will meet all state and federal regulations. | 5.1 | Verify that the manual is complete and made available to staff by September 2005.<br><br>Verify that Special Education Manual meets all relevant state and federal rules and guidelines. | All sites were able to document that approved Special Education Policy manuals were available.<br><br>The manual meets current CDOE requirements. |
| The CYA will provide special education and related services to all special education eligible students. | 5.2 | Review 10 or 10%, whichever is greater, of newly transferred student files at each site to verify that completed special education files are transferred to the receiving CYA facility and fully implemented within 4 school days of student's arrival. | Three sites were implementing IEPs within 4 days of the student's arrival. Complete special education files were not being consistently transferred to the receiving facilities in a timely manner. |
| | 5.3 | Review 10 or 10%, whichever is greater, of newly transferred student files at each site to verify that CYA special education screening procedures are being followed and that students are being referred for psychological testing as needed for new identification. | Five programs documented that DJJ special education screening procedures were being followed and that students were being referred for psychological testing as needed for new identification. |
| | 5.4 | Interview teachers to review informal procedures used to identify special education students in classrooms. | At 6 facilities, interviews with regular and special education teachers indicated that they were aware of informal procedures used to identify special education students in the classroom. |
| | 5.5 | Review 10 or 10%, whichever is greater, of special education student files at each site to verify that students are being referred for psychological testing as needed to update expired eligibility reports. In the same sample, determine whether psychological testing and reports are done in a reasonable time period and if reports are complete and useful. | Five sites were able to verify that students were being referred for psychological testing as needed to update expired eligibility reports. They also demonstrated that useful psychological testing and reports were consistently completed in a reasonable time period. |
| | 5.6 | During site visits and staff interviews, determine whether each CYA facility provides a continuum of placement options, including the full range of time, frequency and duration within each option. | No site provided the required continuum of placement options, including the provision of a full school day to all eligible special education students. All sites failed to provide educational services in the frequency or duration indicated in IEPs. |
| | 5.7 | During site visits and through staff interviews, determine whether the continuum of available special education services is provided to all eligible students including those assigned to restricted settings. | No site provided a full continuum of special education services to all eligible students, including the students in their more restricted units such as the special management units (SMUs). |
| | 5.8 | Review 10, or 10% whichever is greater, of special education student files at each site to verify that eligible students are receiving the required number of segments and full instructional day. Interview special education students to verify that services listed in IEPs are being provided. | No site documented that special education eligible students were consistently receiving the required number of segments and full instructional day. |
| | 5.9 | Determine completeness and accuracy of special education data collection system (includes type of disability, number and type of segments, etc.) | The accuracy of the special education data collection system was verified at 3 sites. |

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| Written policies, procedures and practice require that assessment procedures and products be updated and standardized by August 2005.<br><br>In-service training will be provided. Reports of assessment completion rates will be provided monthly as of October 2004.<br><br>The process will be fully implemented, including the county intake process by December 2005. | 5.10 | Verify that the revised standards are established and that the timelines are being met. | At the five sites, timelines were not being consistently met, resulting in findings of partial compliance. |
| | 5.11 | Verify that in-service training on assessments is provided. Review monthly reports of assessment completions. | At all sites staff training on assessments had been provided. All programs were able to document that reports of assessment completions were compiled monthly. |
| | 5.12 | Verify whether the revised assessment procedures, including county intake processes, have been implemented. | Revision of assessment procedures, including county intake processes, was scheduled to be fully implemented in December, 2005. Five programs reviewed prior to the implementation date received scores of NA. Three programs reviewed after the implementation due date failed to document implementation of revised assessment procedures, resulting in findings of non compliance. |
| Written policy, procedures, and practice require that the CYA and clinic administrators will work collaboratively with Intake and Court Service units to ensure compliance with regulations regarding the provision of IEPs prior to the acceptance of the physical custody of the student. | 5.13 | Verify existence of collaborative agreements. | No site documented that collaborative agreements had been completed between clinic administrators and intake and court service units regarding IEPs of incoming students. |
| | 5.14 | Verify established procedures that enforce requirements. | No site documented the existence of procedures regarding responsibilities of intake and court service units for IEPs of incoming students. |
| The CYA shall substantially implement pre-existing valid Individual Education Plans (IEPs). | 5.15 | Review 10 or 10%, whichever is greater, of special education files at each site to verify that students were provided services according to requirements of pre-existing valid IEPs. | Three of the sites demonstrated full compliance in providing services according to requirements of pre-existing valid IEPs. |
| If the previous school's IEP includes services that cannot be provided by CYA (e.g., community-based activities) or in the event that service hours or program offerings are reduced due to restricted placement, the cessation and rationale for the changes in these services must be noted on the interim/continued services information in the student's IEP. | 5.16 | Review 10 or 10%, whichever is greater, of special education files to verify that any changes in an IEP are documented with the rationale stated. | When service hours or program offerings were reduced, 5 sites failed to provide justification in the form of minutes stating rationale or IEP team consensus. |
| When there is no IEP, special education eligibility will be determined and team meetings will be held in a timely manner. Required participants will be in attendance. | 5.17 | Review 10 or 10%, whichever is greater, of special education files to verify that eligibility determination is made prior to holding IEP meeting. | Four sites were found to be substantially compliant with the requirement to determine eligibility prior to holding IEP meetings. |
| | 5.18 | In same files, verify that IEP meetings are held within prescribed time frame and if not, that proper documentation exists as to the reason.<br>In same files, verify that IEP notices are sent as required and that required participants are present. If regular education teachers are not there, ensure that they are made aware of IEP provisions. | Four sites failed to hold or to properly document that IEP meetings were held within prescribed time frames or they failed to consistently maintain documentation that regular education teachers not present at the IEP meetings were made aware of the IEP provisions for students in their classes. |

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| Each IEP developed or modified at a CYA facility shall include documentation of the team's consideration of the student's need for related services and transition planning. | 5.19 | Review 10 or 10%, whichever is greater, of special education files at each site for consideration of need for related services and/or transition planning.<br><br>Interview teachers regarding consideration of related services and transition planning. | At 6 sites, consideration of students' needs for related services was documented in the IEP minutes.<br>In the IEPs reviewed at all sites, transition goals were not measurable. Teachers were aware of transition plan limitations and expressed optimism that revisions expected as a result of the new IDEA requirements would enable them to address this deficiency. |
| In-service training shall be provided to special education teachers in the following areas:<br><br>1) Alignment of goals and objectives<br>2) Periodic progress or benchmark reviews.<br>3) Use of the least restrictive environment<br>4) Transition services<br>5) Accommodations and modifications in the general education classroom<br>6) Compensatory services | 5.20 | Verify in-service training schedule including dates and outline of topics.<br><br>Verify staff attendance through inspection of in-service roll information and review of Principal's Monthly Report | All programs were able to provide sufficient documentation and verification of ongoing special education training. |
| The CYA shall develop and implement a system to provide for the documentation of student progress related to his/her IEP goals and objectives based on the dates identified on the IEP. The system will ensure that progress reviews are routinely practiced by each special education provider. | 5.21 | Verify that special education staff are provided with standardized formats for documentation of review.<br><br>Review 10 or 10%, whichever is greater, of special education files to verify that progress reviews meet the IEP schedule.<br><br>Interview special education teachers regarding progress reviews. | All of the sites documented that special education staff had been provided training on and given standardized formats for documentation of IEP progress review.<br><br>No site was consistently documenting review of IEP benchmarks. |
| Written policy, procedures, and practice require that compensatory special education services are provided to students if significant gaps of missed service occur or are projected to occur, and if such services cannot be made up during the course of the week or designated period of time. | 5.22 | Review Administrator's Compensatory Services Plan.<br><br>Through teacher and student interviews, verify that compensatory services are provided to students when required. | The Request for Compensatory Services form and log were identified in files at all sites. The formal Administrator's Compensatory Services Plan was available at each site.<br><br>Seven sites were unable to document consistent provision of compensatory services to eligible special education students. |
| The CYA shall establish an Education Stakeholders' Committee by August 2005 consisting of departmental, other interagency participants and community members including parents of CYA students. This committee will meet quarterly and serve as an advisory body to the Superintendent of Education and the Executive Team. | 5.23 | Review formal minutes of Stakeholders' meetings including dates, agenda, membership and recommendations. | Six sites provided full documentation of the establishment of an Education Stakeholders' Committee that met quarterly and included departmental staff, other interagency participants and community members, including parents of DJJ students. |

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| Training on special education will be provided by the CYA to all education staff and administrators, treatment and custody staff and administrators and other stakeholders starting July 2005. Training will use the approved Special Education Manual, approved forms and data collection systems. The frequency of the training scheduled will be dependent on each individual's role in the process and may vary from quarterly to annually. | 5.24 | Verify in-services schedule including date and topics. Verify staff attendance through inspection of in-service roll information and review of Principal's Monthly Report.<br><br>Verify schedule using CYA Master Calendar | Six sites documented efforts by DJJ staff to provide training on special education topics to all education staff and administrators, treatment and custody staff and other stakeholders beginning in July 2005. |
| The Regional Program Specialist shall conduct at least quarterly site reviews of each school's special education compliance efforts and status. | 5.25 | Review quarterly site review reports | The Regional Program Specialist assigned to 4 of the sites had not conducted quarterly site reviews of each school's special education compliance efforts and status. The remaining 4 programs had been reviewed once during the school year. |

| VI. California High School Exit Exam | | | |
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| The state assessment program is conducted according schedules and procedures established by the CYA and the California Department of Education. State mandated tests are administered according to the guidelines prescribed by the CYA and the DOE.<br>Each eligible student in CYA shall have access to each mandated educational assessment. | 6.1 | Verify the use of the state mandated testing schedule through observation and interviews.<br><br>Through student interviews and file reviews, verify access of eligible students to the state mandated exam. | All sites were in substantial compliance. The statewide testing schedule was followed and it was verified by observation and interview. |
| Instruction provided to students is relevant to all areas tested on California Graduation Test. | 6.2 | The CYA will provide written verification that the content of its curriculum guides in English-language arts and mathematics is related to items on the California Graduation Test. | All sites were in substantial compliance. Written verification was provided that the curriculum guides in English/ language arts and mathematics were related to items on the California Graduation Test. |
| Students have multiple opportunities to pass the CAHSEE according to state regulations. | 6.3 | Through student interviews and file reviews, verify that eligible students have appropriate opportunities to pass the state mandated exam. | All sites were in substantial compliance. File reviews and student interviews verified that students were provided with appropriate opportunities to pass the state mandated exams.. |
| All students who are eligible for accommodations in testing will be provided the accommodations specified by their IEPs or Section 504 plans. Test variations are also available to English learners who regularly use them in the classroom. Students who are eligible for test variations must adhere to the CDE guidelines for test variations. | 6.4 | Verify by records review of students taking state mandated exams that appropriate accommodations, modifications or variations were provided as a part of testing procedures (in accord with CDE guidelines.) | Five sites demonstrated that they were fully compliant with the requirement that students receive appropriate accommodations and modifications as a part of their testing procedures in accord with CDE guidelines. |
| Students who take the CAHSEE with a modification and receive the equivalent of a passing score are eligible for the waiver request process. Students who are eligible will be granted waivers based on the SBE (State Board of Education) process and policy. | 6.5 | Verify by records review of students taking state mandated exams that waivers were requested for students with modifications who receive equivalent passing scores (in accord with CDE guidelines.) | Students who were eligible were granted waivers based on the SBE process. All sites were given ratings of substantial compliance or not applicable. |
| Schools are required to provide remediation to students at risk of not graduating from high school due to the test requirements. Each site principal has a plan to track student progress on the test and provide direct remediation to any student failing one or both test sections. | 6.6 | Verify by records review of students taking the test that students failing at least one part of the exam were provided specific remediation related to test items. | At 5 sites students failing at least one part of the exam were being provided remediation through a test preparation class or enrollment in a course designed to review and specifically remediate areas where remediation was needed. |

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| Student achievement on the CAHSEE is monitored and evaluated. School improvement plans address efforts to improve student achievement in the areas tested. | 6.7 | Review and evaluate data on student achievement on the CAHSEE to determine whether school improvement plans are based on test achievement data. | At 4 sites review of the School Improvement Plans indicated that achievement data was used to develop school wide goals. |
| Students who are unable to pass the CAHSEE have additional options to complete their education. Students may pass the GED or California Proficiency Exam. Students unable to achieve a high school diploma or pass an equivalency exam are awarded a Certificate of Course Completion. | 6.8 | Review and evaluate data on students to determine whether they are being provided the full range of alternatives available (diplomas, equivalency tests, certificates of completion). | Seven of the sites failed to provide a full range of additional options for students to complete their education when they are unable to obtain a high school diploma. |

## California Remedial Plan Site Compliance Report

Area : EDUCATION  Reviewers: Dr. Tom O'Rourke, Dr. Robert Gordon  From September 2005 through April 2006

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

| Site | Nelson | DeRobles | Ventura | Clark | Stark | Chad | Close | Preston |
|---|---|---|---|---|---|---|---|---|
| Date of Review | 9/16/05 | 10/14/05 | 11/18/05 | 12/13/05 | 12/16/05 | 2/03/06 | 3/17/06 | 4/14/06 |
| Items Reviewed | Compliance Ratings | | | | | | | |
| **I. Overview** | | | | | | | | |
| 1.1 Schools meet WASC accreditation standards | SC | SC | SC | SC | SC | NC | SC | SC |
| 1.2 Curriculum meets CA state standards | SC | SC | SC | SC | SC | SC | SC | SC |
| 1.3 High School Graduation Plans in records | PC | SC | SC | SC | NC | SC | SC | SC |
| 1.4 Semi-annual reviews of High School Graduation Plans | PC | SC | SC | NC | NC | PC | NC | NC |
| 1.6 Progress being made toward high school diplomas | NC | PC | PC | SC | NC | NC | NC | NC |
| 1.7 English Language Learner screening & services | NC | SC | SC | SC | NC | NC | SC | SC |
| 1.8 Transition planning (90 days prior to release) | PC | NC | PC | NA | PC | PC | PC | PC |
| | | | | | | | | |
| **II. Staffing** | | | | | | | | |
| 2.1 Teachers hold valid CA credentials and teach in-field | SC | SC | PC | PC | PC | SC | SC | SC |
| 2.2 Adequate credentialed staff in content areas for graduation | NC | NC | NC | SC | NC | PC | SC | NC |
| 2.3 Recruitment plan for education staff and 2 recruiters | NC | SC | NC | PC | NC | NC | PC | PC |
| 2.4 Time between education vacancy and hiring | NC | NC | NC | SC | NC | PC | PC | NC |
| 2.5 Pool of substitute teachers = 15% of teaching staff | PC | NC | PC | PC | NC | NC | PC | NC |
| 2.6 Class not cancelled due to teacher absence/lack of substitutes | NC | NC | PC | NC | NC | NC | NC | NC |
| 2.7 In-field teacher used for teacher vacancy of 45 days | SC | PC | NC | SC | NC | SC | PC | NC |
| 2.8 Psychologist and related service providers available for input | SC | SC | NC | SC | SC | SC | PC | SC |
| 2.9 Time from referral for testing and report completed | PC | SC | PC | SC | PC | SC | PC | PC |
| 2.10 Time from referral for related services to service delivery | SC | SC | NC | SC | PC | NA | NC | SC |
| 2.11 2 school psychologists for each restricted program | NA | SC | NA | NA | SC | NC | NA | SC |
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| Site | Nelson | DeRobles | Ventura | Clark | Stark | Chad | Close | Preston |
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| **III. Student Access & Attendance** | | | | | | | | |
| 3.1 Standardized Academic Calendar meets CA requirements | NC | NC | NC | NC | NC | NC | PC | PC |
| 3.2 Standardized Academic Calendar-basis of student services | NC | NC | NC | NC | NC | NC | PC | PC |
| 3.3 Policy & practice-all students enrolled within 4 days | PC | PC | PC | SC | PC | SC | SC | SC |
| 3.4 Registrars request records on new students within 4 days | SC | SC | SC | SC | NC | SC | NC | SC |
| 3.5 Students meeting GED criteria have GED opportunity | SC | NC | NC | PC | NC | PC | SC | NC |
| 3.6 SCT services for students with academic/ behavioral problems | SC | PC | NC | PC | PC | NC | NC | PC |
| 3.7 SCT records of interventions and referrals | SC | SC | NC | SC | PC | PC | NC | PC |
| 3.8 Students not making academic progress referred to SCT | NC | PC | NC | SC | PC | NC | NC | NC |
| 3.9 Development of SCT tracking system | SC | SC | NC | SC | SC | NC | NC | SC |
| 3.10 Documentation of progress reviews of SCT plans | PC | PC | NC | SC | NC | NC | NC | NC |
| 3.11 SCT logs show follow-through on eligibility testing | SC | SC | NC | NA | PC | NC | NC | NA |
| 3.12 Students referred from SCT receive special education testing | PC | SC | NC | NA | PC | NA | NA | NA |
| 3.13 SCT training (procedures, roles & responsibilities, forms) | SC | SC | NC | SC | SC | SC | SC | SC |
| 3.14 Teachers informed of missing student's whereabouts | SC | SC | NC | NC | NC | PC | NC | NC |
| 3.15 Document school attendance for previous 30 days | NC | NC | PC | NC | NC | NC | NC | NC |
| 3.16 Cooperative Agreements to ensure students' attendance | NC | NC | NC | NC | NC | NC | NC | NC |
| 3.17 Quarterly reviews of school attendance by Executive Team | SC | PC | NC | NC | PC | NC | NC | NC |
| 3.18 Plans (due 4/05) to remediate deficient attendance | NC | NC | NC | NC | PC | NC | NC | NC |
| 3.19 Quarterly corrective action plans for high absence rates | NC | NC | NC | NC | NC | NC | NC | NC |
| 3.20 Policy & procedure to eliminate class cancellations | NC | NC | PC | NC | NC | NC | NC | NC |
| 3.21 Teacher records indicate whereabouts of missing students | SC | SC | PC | NC | NC | PC | NC | NC |
| 3.22 Exclusion from school forms have complete data | SC | SC | SC | SC | SC | PC | NC | NC |
| 3.23 Observation of students not being sent to school | NC | NC | PC | PC | NC | NC | NC | NC |
| 3.24 Accurate attendance data in WIN database | PC | PC | PC | SC | PC | PC | PC | NC |
| 3.25 Mgmt team monthly review of attendance data | NC | NC | PC | NC | NC | NC | NC | NC |
| 3.26 Performance expectations on attendance (due 7/05) | NC | NC | NC | NC | NC | NC | NC | NC |
| 3.27 Training on attendance expectations | NC | NC | NC | NC | NA | NA | NC | NC |
| 3.28 Implementation of attendance policy & procedures (due 12/05) | NA | NA | NA | NA | NA | NA | NC | NC |
| 3.29 Incentives developed for increased school attendance | SC | PC | NC | NC | PC | SC | NC | PC |
| 3.30 Annual state school calendar implemented | NC | NC | NC | NC | NC | NC | PC | PC |
| 3.31 Yearly calendar w/44 student advising/case conference days | PC | PC | PC | NC | PC | PC | PC | PC |
| 3.32 Adequate instructional space | PC | PC | PC | NC | NC | SC | SC | NC |
| 3.33 Structured classroom behavior management system | NC | NC | NC | NC | PC | NC | NC | SC |
| 3.34 Alternative behavior management classroom at each site | NC | NC | NC | NC | NC | NC | NC | NC |
| 3.35 Staff training on behavior management system | NC | NC | NC | NC | NC | NC | NC | SC |
| 3.36 Behavioral goals for spec. ed. students-restricted programs | NA | NC | NA | NA | NC | NC | NA | SC |
| 3.37 Use of small classrooms (adequate size) in restricted settings | NA | PC | NA | NA | NC | SC | NA | NC |
| 3.38 Staff ratio & credentialed teachers in restricted settings | NA | PC | NA | NA | NC | NC | NA | PC |
| 3.39 Instructional program in restricted placements | NA | PC | PC | NA | NC | NC | NA | PC |
| 3.40 Training provided to staff in restricted settings | NA | NC | NA | NA | SC | NC | NA | SC |

| Site | Nelson | DeRobles | Ventura | Clark | Stark | Chad | Close | Preston |
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| **IV. Curriculum** | | | | | | | | |
| **4.1** Curriculum Guides & policies aligned with CA Education code | SC | SC | SC | SC | SC | SC | SC | SC |
| **4.2** Process to develop and revise curriculum on cyclical basis | SC | SC | SC | SC | SC | SC | SC | SC |
| **4.3** Curriculum guides for all core & vocational classes | SC | SC | SC | SC | SC | SC | SC | SC |
| **4.4** Core Curriculum Guides available in electronic form (due 12/05) | NA | NA | NA | NA | NA | SC | SC | SC |
| **4.5** Schools meet CA & WASC standards for books & materials | SC | SC | SC | SC | SC | SC | SC | SC |
| **4.6** Annual inventory & needs assessment of books & equipment | SC | SC | SC | SC | SC | SC | SC | SC |
| **4.7** Textbooks & library books available in classrooms | SC | SC | SC | SC | SC | SC | PC | SC |
| **4.8** Books available in mini-libraries on living units | SC | NC | NC | NC | SC | NC | NC | NC |
| **4.9** Professional development for school leadership personnel | SC | PC | NC | SC | SC | SC | PC | SC |
| **4.10** Training schedule on new procedures-educ & custody staff | SC | SC | SC | SC | SC | SC | SC | SC |
| **4.11** Training attendance-new procedures-educ & custody staff | SC | PC | SC | SC | SC | SC | SC | SC |
| **4.12** Formation of Trade Advisory Committees & quarterly meetings | NC | SC | SC | SC | SC | SC | NC | SC |
| **4.13** Annual surveys for vocational course planning (due 7/05) | SC | SC | SC | SC | SC | SC | SC | SC |
| **4.14** Annual Career Technical job studies to evaluate CTE programs | SC | SC | SC | SC | SC | SC | SC | SC |
| **4.15** Use of technology at each site (due 6/05) | SC | SC | SC | PC | SC | NC | SC | PC |
| **4.16** Distance learning courses meet CA Content Standards | SC | SC | NA | SC | PC | NC | NA | NC |
| **4.17** Use of Global Classrooms distance learning (due 6/06) | SC | NA | NA | NA | NA | NA | NA | NA |
| **4.18** Distance learning provided in restricted units | NA | NC | NA | NA | NC | NC | NA | NC |
| **4.19** Automated library system at each HS (due 6/06) | NA | SC | NC | SC | SC | NC | NC | NC |
| **4.20** Teachers use course syllabi & lesson plans | SC | PC | SC | SC | PC | SC | SC | SC |
| **4.21** Quarterly teacher observations using revised rubric | NC | NC | NC | NC | NC | SC | NC | PC |
| **4.22** 5 year strategic plan & reading initiative implemented | SC | SC | SC | SC | PC | PC | SC | SC |
| **4.23** Policies revised to reflect operational changes | PC | NA | NA | NA | NA | NA | NA | NA |
| **4.24** Education policies available electronically (due 6/06) | NA | NA | NA | NA | NA | NA | NA | NA |
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| Site | Nelson | DeRobles | Ventura | Clark | Stark | Chad | Close | Preston |
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| **V. Special Education** | | | | | | | | |
| 5.1 Special Education Policy Manual revised & available (due 9/05) | SC | SC | SC | SC | SC | SC | SC | SC |
| 5.2 Files transferred & services implemented in 4 days | SC | SC | PC | SC | PC | NC | NC | NC |
| 5.3 Screening provided and referrals for psychological testing | SC | SC | SC | PC | SC | SC | PC | PC |
| 5.4 Teachers identify special ed students in classrooms | SC | PC | SC | SC | SC | PC | SC | SC |
| 5.5 Referral for testing-update eligibility; reports complete & timely | NC | SC | SC | SC | PC | NC | SC | SC |
| 5.6 Site has full continuum of placement options | NC | PC | NC | SC | NC | NC | NC | NC |
| 5.7 Continuum of services available in restricted settings | NC | PC | NC | PC | NC | NC | NA | NC |
| 5.8 Segments & services listed in IEPs are provided | NC | PC | PC | PC | NC | NC | NC | NC |
| 5.9 Accuracy & completeness of special education data system | NC | SC | SC | SC | PC | NC | NC | NC |
| 5.10 Assessment procedures updated & standardized | SC | SC | PC | SC | PC | PC | PC | PC |
| 5.11 Training and reports of assessment completion rates | SC | SC | SC | SC | SC | SC | SC | SC |
| 5.12 Procedures standardized, including county intake (due12/05) | NA | NA | NA | NA | NA | NC | NC | NC |
| 5.13 Clinics-agreements with Intake & CS on providing IEPs | NC | NC | NC | NC | NC | NC | NC | NC |
| 5.14 Procedures for Intake & CS on providing IEPs | NC | NC | NC | NC | NC | NC | NC | NC |
| 5.15 Pre-existing valid IEPs implemented | NC | SC | NC | PC | NC | NC | SC | SC |
| 5.16 Changes in IEPs documented w/rationale | NC | SC | NC | NC | NC | NC | SC | PC |
| 5.17 Eligibility determined prior to IEP meeting | SC | SC | PC | NA | NC | NC | SC | SC |
| 5.18 IEP eligibility meetings held timely & with notices, participation | NC | SC | NC | NA | NC | NC | SC | SC |
| 5.19 IEPs include consideration of related svc/transition planning | NC | PC | NC | PC | PC | PC | PC | PC |
| 5.20 Training on specific topics for special ed teachers | SC | SC | SC | SC | SC | SC | SC | SC |
| 5.21 System of IEP progress reviews implemented | NC | NC | NC | NC | NC | NC | PC | NC |
| 5.22 Compensatory special education svc provided when needed | NC | PC | NC | PC | NC | PC | PC | SC |
| 5.23 Education Stakeholders' Committee w/quarterly meetings | NC | SC | SC | SC | SC | SC | PC | SC |
| 5.24 Training to education and custody staff on Spec Educ Manual | PC | SC | PC | SC | SC | SC | SC | SC |
| 5.25 Regional Prog Specialist site reviews of spec ed compliance | NC | NC | NC | PC | PC | NC | PC | PC |
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| **VI. California High School Exit Exam** | | | | | | | | |
| 6.1 CA assessment program provided to eligible students | SC | SC | SC | SC | SC | SC | SC | SC |
| 6.2 CYA curriculum in LA & math related to Graduation Test | SC | SC | SC | SC | SC | SC | SC | SC |
| 6.3 Students have multiple opportunities to pass state exam | SC | SC | SC | SC | SC | SC | SC | SC |
| 6.4 Students have appropriate test accommodations /modifications | SC | SC | PC | PC | NC | SC | SC | SC |
| 6.5 Students with equivalent passing scores- waivers requested | SC | NA | SC | SC | SC | NA | NA | NA |
| 6.6 Students failing test receive remediation | NC | NC | NC | SC | SC | SC | SC | SC |
| 6.7 Test data is monitored & basis of school improvement plans | SC | NC | SC | PC | PC | PC | SC | SC |
| 6.8 Students have range of alternatives to complete education | PC | NC | NC | PC | NC | NC | SC | PC |
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