Donna Brorby, State Bar #75936
Office of the Special Master
605 Market Street, Ninth Floor
San Francisco, CA 94105-3211
(415) 348-0853
(415) 495-7204 (facs.)
lodb@earthlink.net

SUPERIOR COURT OF CALIFORNIA

CITY AND COUNTY OF ALAMEDA

MARGARET FARRELL,

Plaintiff,

vs.

RODERICK HICKMAN,

Defendant.

Case No.: RGO3079344

THIRD REPORT OF SPECIAL MASTER

Pursuant to paragraph 28 of the November 2004 Consent Decree, the Special Master submits for filing the attached report. The report reflects developments in this case through September 2006, with updates in the areas covered through November 2006. It was circulated to the parties' in draft, and reflects consideration of the parties' comments.

Dated: December 7, 2006

Donna Brorby
Special Master

SUPERIOR COURT OF CALIFORNIA

CITY AND COUNTY OF ALAMEDA

MARGARET FARRELL, Plaintiff, vs. RODERICK HICKMAN, Defendant.	)	CASE NO. RG03079344

THIRD REPORT OF SPECIAL MASTER

Donna Brorby, Special Master
Cathleen Beltz, Monitor
605 Market Street, Ninth Floor
San Francisco, California 94105
(415) 348-0853
(415) 495-7204 (facs.)
lodb@earthlink.net

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APPENDICES

I. INTRODUCTION

Since the Special Master's last report, DJJ has worked closely with experts, plaintiff's counsel and the Special Master to complete the revised Safety and Welfare and Mental Health remedial plans. This required nearly full-time, often overtime, effort by many of DJJ's headquarters staff. With the filings of these two final plans, DJJ has substantially discharged its responsibility under the Consent Decree to file remedial plans covering all six areas of deficiencies identified by the parties' jointly selected experts in 2003.[1] The six areas are safety and welfare,[2] education, medical care, mental health, sex behavior treatment, and access for wards with disabilities. There are still inconsistencies between some of the plans that will need to be resolved,[3] but the focus of this case now shifts from planning to the beginning of implementation and change.

The remedial plans are now the source of most of DJJ's substantive legal obligations in this case. Should disputes arise under or concerning the plans, the relevant Consent Decree provisions will be important. Further, there are extant interim plans prepared pursuant to the November 30, 2005 Stipulation concerning lockdowns, restricted programs in general and the Inyo temporary detention unit at the O.H. Close facility in particular. Finally, the Consent Decree provision concerning policies and procedures for the treatment and management of youth on suicide watch or with acute psychiatric needs will be operative until superceded either by an

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[1] In the Safety and Welfare and Mental Health remedial plans, plaintiff reserved her right to contend that the plans are inadequate under the Consent Decree as to two discrete issues, intake criteria (*see*, Consent Decree ¶¶ 7.f. and 10.j.) and health services staffing (*see,* Consent Decree ¶ 12.a). No finding is made or implied as to the initial sufficiency of the plans on these two points.

[2] The issue in the case now known as "safety and welfare" encompasses all of what was "general corrections" and some of what was "mental health" under the Consent Decree.

[3] The plans were developed over the course of almost two years. During that time, DJJ's strategy for reform evolved. The plans will have to be implemented in an integrated way, with inconsistencies identified and resolved as they come up.

interim plan pursuant to the November 30, 2005 Stipulation or by new policies and procedures developed pursuant to the Mental Health Remedial Plan.[4]

Section II.B of this report concerns the interim plan for O.H. Close temporary detention unit (Inyo unit). Consent Decree expert Barry Krisberg found DJJ to be in compliance with the interim plan.

Section II.C discusses Monitor Cathleen Beltz's systematic count of reported incidents of violence in DJJ for the periods January – June 2005 and January – June 2006. DJJ's highest priority is to reduce the level of violence in its facilities. Monitor Beltz's count is the best available evidence of the level of violence in DJJ facilities in 2005 and 2006.

As discussed in Section III.B, DJJ has not yet succeeded in implementing its policies and procedures for high-risk observation and suicide/crisis watch developed at the end of 2004. This illustrates both that the problems addressed in the Consent Decree are interrelated and structural, and that structural reform is required to solve them.

Progress under the Health Care Services Remedial Plan is discussed in Section IV. DJJ has developed its essential policies and procedures for the delivery of health care services in compliance with the Health Care Services Remedial Plan, and the Consent Decree medical experts have begun monitoring health care services at individual facilities. At this time, it is critical that DJJ strengthen health services management, fill key headquarters vacancies and devise a detailed Health Care Services Remedial Plan implementation strategy with internal auditing and tracking of progress. It is critical also that the interface between DJJ and CDCR be improved to ensure that DJJ's needs are met in the areas of contracting, information technology and any other support services that are to be provided by CDCR under the current organizational structure.

[4] *See,* Mental Health Remedial Plan, p. 63.

Section V provides an update on developments in sexual behavior treatment.

This report was provided to the parties in draft in September 2006. The parties' comments and concerns were received by October 31, 2006. The Special Master has taken the parties' comments into account in this final version, and added information obtained through November 2006 where indicated.

II. SAFETY AND WELFARE

A. Completion Of Safety And Welfare Remedial Plan

The revised Safety and Welfare Remedial Plan was completed and filed on July 10, 2006. It reflects both the soundness of the planning DJJ had completed before the parties agreed to engage experts to assist with a revision as well as tremendous progress in the planning since the experts were retained in December 2005. The Consent Decree experts and other expert consultants will devise standards and criteria for monitoring compliance with the remedial plan, in consultation with the parties and the Special Master. The Special Master and Consent Decree experts will apply the standards and criteria to measure DJJ's performance relative to the requirements of the plan. The standards and criteria for the Safety and Welfare Remedial Plan are to be filed by October 31, 2006.[5]

B. DJJ Remains Compliant With Interim Plan For O.H. Close's Inyo Unit

The Special Master has previously reported that DJJ was substantially compliant through March 2006 with the expert-crafted January 2006 interim plan to limit the use of the Inyo temporary detention housing unit at the O.H. Close facility and modify practices and improve conditions there.[6] Specifically, the plan provides that Inyo will be used to house only (1) youth

[5] The standards and criteria indeed were filed on October 31, 2006.

[6] The interim plan was attached as Appendix B to the Second Report of Special Master, Compliance Status Interim Measures, Disability, Education, Sexual Behavior Treatment ("Second Report of the Special Master"). The compliance report through March 2006 was attached to that report as Appendix C.

in need of "temporary interventions" by staff to de-escalate potentially dangerous situations, (2) youth awaiting transfer to other facilities or to court proceedings and (3) youth charged with serious assaults on staff or assaults on other youth that involved the use of a weapon.[7] The plan also requires that the youth housed on the Inyo unit be afforded the same living conditions, program, treatment, privileges, property and state issued items as are youth housed on other units, and that the living quarters meet basic sanitation and habitability standards.[8] Consent Decree expert Barry Krisberg again found substantial compliance with the plan during a site visit in June 2006.[9]

C. Measuring The Incidence Of Violence In DJJ

The parties and their jointly selected experts agree that violence and fear of violence pervade DJJ facilities and that this is antithetical to rehabilitation. The Safety and Welfare Remedial Plan makes reducing violence DJJ's first reform step.[10]

As previously reported, DJJ has not had a comprehensive system for documenting the incidence of violence in its institutions.[11] It now is in the process of implementing one pursuant to its Safety & Welfare Remedial Plan; the system is due to be in place in early 2007.[12] For 2005 and 2006, it appears that the daily operational logs/reports kept by each institution are the most

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[7] *Id.*, at pg. 2
[8] *Id.*, at pg. 5.
[9] *See,* Krisberg, Brief Report on Site Visits to DeWitt Nelson (DWN) and O.H. Close (OHC) (July 19, 2006), p. 4. Dr. Krisberg noted that a water damaged portion of ceiling required repair, but that otherwise the physical conditions were clean and adequate. This represents an enormous improvement over conditions documented in the First Report of Special Master, Compliance with Interim Measures Provisions of Consent Decree and January 31, 2005 Stipulation ("First Report of the Special Master"), pp. 40-41. Only four youth had been housed overnight at Inyo in the two months preceding Dr. Krisberg's site visit.
[10] *See*, Safety and Welfare Remedial Plan (July 10, 2006), p. 23.
[11] *See,* First Report of Special Master, Compliance with Interim Measures Provisions of Consent Decree and January 31, 2005 Stipulation ("First Report of the Special Master"), pp. 17-18.
[12] *See*, Safety and Welfare Remedial Plan, p. 31.

comprehensive record of the occurrence of incidents of violence.[13] Monitor Cathleen Beltz designed a methodology for counting the incidents of violence that were reported in the daily operational logs/reports for the first half of each of 2005 and 2006. Her extensive memorandum describing the methodology and the results is attached as Appendix A. The results provide a baseline that may assist DJJ, the Special Master and experts in assessing the success of efforts to reduce violence.

Monitor Beltz counted a total of 4,671 incidents in the twelve months reviewed. There were 2,379 reported incidents of violence in DJJ facilities in January – June 2005 and 2,292 in January – June 2006. The majority of these incidents (3,777) were one-on-one fights between youth, followed by 341 attacks of two-or-more youth on one youth victim, 185 fights involving three or more youth, 142 group disturbances, 100 batteries on staff, 81 staff gassings, 5 sexual assaults and 40 suicide attempts.[14]

Monitor Beltz depicts the breakdown by types of incidents for each period by Table 2 in her memorandum,[15] which is replicated here:

[13] *See,* First Report of Special Master, pp. 17-18. The new system that DJJ has developed and is implementing is based on daily operational reports. The reports will be revised and all facilities will use the same report form and follow the same instructions as to the incidents and information to be reported.
[14] *See,* Appendix A, pp. 7-8. The types of incidents are defined at Appendixs A, p. 2.
[15] *See,* Appendix A, p. 8.

Incidents of Violence by Type of Incident: January - June 2005 & 2006

Count

		Year		
		2005	2006	Total
Type of Incident	1-on-1	1889	1888	3777
	2 (or more)-on-1	169	172	341
	3-or-more	105	80	185
	Group Disturbance	79	63	142
	Staff Battery	58	42	100
	Staff Gassing	46	35	81
	Sexual Assault	2	3	5
	Suicide Attempt	31	9	40
Total		**2379**	**2292**	4671

Source: CDCR-DJJ Daily Operational Security Reports

In order to compare the amount of violence between time periods and among facilities, Monitor Beltz calculated the number of incidents of violence reflected in daily operational reports per 100 youth.[16] For all of DJJ, daily operational reports reflect 9.6 percent more violent incidents per capita in the first half of 2006 (82.3 per 100 youth) compared to the first half of 2005 (75.1 per 100 youth). Nonetheless, two facilities reported substantially fewer violent incidents per capita in the first half of 2006 than in the first half of 2005: N.A. Chaderjian with 46 percent fewer and O.H. Close with 23 percent fewer.[17] The remaining six facilities all reported more violent incidents per capita in the first half of 2006 compared to the first half of 2005, from 37 percent more violent incidents at Paso Robles to 5 percent more at Southern Reception Center.[18]

[16] Monthly "actual population" totals were averaged for each facility for the two six month periods. The average population for all of DJJ was 12 percent lower in the first half of 2006 than in the first half of 2005. At Stark, the average population was 3 percent higher in 2006. All other facilities had decreases in population, with the greatest decreases at Chaderjian (42 percent) Paso Robles (20 percent) and Ventura (15 percent). See Appendix A, Attachment C for DJJ population data.

[17] *See* Appendix A, p. 12, Table 4.

[18] *Ibid.* Comparisons may be affected by changes in reporting practices over time or differences in reporting practices among facilities.

III. MENTAL HEALTH CARE

A. Completion Of Mental Health Remedial Plan

The revised Mental Health Remedial Plan was completed and filed on August 25, 2006. The Consent Decree experts and other expert consultants will devise standards and criteria for monitoring compliance with the remedial plan, in consultation with the parties and the Special Master. The Special Master and Consent Decree experts will apply the standards and criteria to measure DJJ's performance relative to the requirements of the plan. The standards and criteria for the Mental Health Remedial Plan are to be filed by December 15, 2006.

B. Policies And Procedures For Youth With Acute Psychiatric Needs And Potentially Suicidal Youth

The Consent Decree required DJJ to "develop policies and procedures to immediately provide for the treatment and management of wards on suicide watch and those with acute psychiatric needs" by November 1, 2004. It required that these policies and procedures "be adopted to provide interim treatment and management of these wards pending the development and implementation of the remedial plans in this area." It required that they "be in the form of criteria that institutions must meet for these wards, including number of hours of clinical intervention per week and maximum number of in-room hours per day."[19] The Consent Decree required implementation of the policies and procedures by December 15, 2004. The parties extended that date to June 1, 2005 by the Mental Health and Rehabilitation Interim Plan filed in April 2005.

As the Special Master previously has reported, DJJ developed policies and procedures approved by the Consent Decree experts by November 2004 and provided training to staff on

[19] Consent Decree ¶ 7.c.

these policies and procedures by December 2005.[20] The current versions of the policies and procedures (TDO ## 06-38 Suicide Watch and 06-39 Wards Requiring Acute Psychiatric Care, effective April 14, 2006) are attached as Appendices B and C.

The observation/watch policies and procedures require non-clinical staff to place a youth on high risk observation status in an observation/watch room, under surveillance and with only suicide prevention bedding and clothing, whenever they perceive a risk that the youth will engage in physically self-injurious behavior.[21] Within 24 hours of the youth's placement on high risk observation, and every 24 hours throughout the observation/watch period, a mental health clinician must see him or her and determine whether he or she should be retained on high risk observation, placed on suicide watch or crisis watch and/or transferred to a licensed facility for inpatient care.[22] If the clinician retains the youth on high risk observation or places him or her on suicide or crisis watch, then the clinician must determine what restrictions are clinically appropriate for the youth. The youth is to be allowed as much time and activity outside of the observation/watch room as the clinician determines is clinically appropriate. The possible level of restriction ranges from full-time confinement and surveillance in an observation/watch room with only suicide proof clothing and bedding, to part-time confinement in an observation/watch room with out-of-room activities and regular clothing and possessions, including up to full-time regular activity in other areas of the facility.[23] Staff must keep the youth under direct line-of-sight supervision when he or she is outside of the observation/watch room. A youth whom the

[20] First Report of Special Master, pp. 32-33.
[21] Staff are trained to err on the side of caution, in order to prevent suicides from occurring. This means that non-clinical staff must place a youth on high-risk observation in response to any suicidal gesture and/or expression of suicidal ideation.
[22] The Consent Decree mental health experts advised DJJ approximately a year ago that the 24-hour period for clinical evaluation needed to be reduced to 8 hours. DJJ has not yet implemented that change in policy and procedure. The parties are addressing this in consultation with the mental health experts.
[23] Out-of-room activities may include meetings with clinicians or counselors, meals and shower and program/activities like school or recreation.

clinician places or retains on suicide or crisis watch for being either a danger to self or gravely disabled must be housed in an observation/watch room in facility infirmaries ("OHUs" for "Outpatient Housing Unit") if possible, and otherwise in an observation/watch room within certain residential mental health program (Intensive Treatment Program or Special Behavior Treatment Program) units. Youth on high-risk observation may be in observation/watch rooms in any housing unit that has such rooms. Facilities must inform headquarters of the condition and progress of any youth who remains on crisis or suicide watch (but not high risk observation) for more than 72 hours. Facilities must update headquarters staff about any youth designated for inpatient transfer every 24 hours until the youth is transferred. Serious incident reports must be completed and provided to headquarters for all off-facility transfers for emergency or inpatient services. For a youth who has been on suicide watch (but not high risk observation), the clinician must prepare Post Suicide Watch Precautionary Plans and the assigned casework specialist/parole agent must develop or update an Identified Treatment Issue ("ITI") that addresses the underlying treatment issues that resulted in the placement on suicide watch.[24]

The Special Master and/or Monitor interviewed clinical staff and youth who had been placed on high-risk observation and suicide watch at all facilities.[25] We reviewed medical records for some youth who had been placed on observation/watch.

Suicide and crisis watch are generally conducted in OHUs or appropriate residential mental health program units, as required by the policies and procedure. At some but not all facilities, high-risk observation also generally is conducted in residential mental health program units. Observation/watch rooms are equipped with cameras (which seemed to be functioning

[24] *See*, Appendices B and C.

[25] Interviews were conducted on site visits as follows: Stark, March 13, April 14 and September 13-15, 2006; Ventura, March 14, 2006; the Stockton complex (Chaderjian, Dewitt Clinton and O.H. Close), June 15, November 1-2 and 6-9, 2006; Preston, March 10, June 20, 2006 and October 24-26, 2006; El Paso de Robles, September 27-29, 2006; and Southern Youth Correctional Reception Center and Clinic, October 10-11, 2006.

well enough for surveillance on all facilities). Staff generally are aware of the policy requirement that they document 15-minute room-front observations and 5-minute camera checks and we observed staff making and documenting the required checks. Youth on observation/watch are limited to suicide resistant clothing and bedding while in the observation/watch room unless a clinician eases the restrictions (which is unusual for clinicians to do, though some allow some youth to have a book in the observation/watch room). Clinicians generally see youth on high-risk observation within 24 hours of their placement, and every 24 hours thereafter for as long as they are on watch or observation status.[26] Youth and staff generally thought that youth on observation/watch status were safe from self-harm behaviors while there.

Almost all youth on suicide or crisis watch status for more than a day receive a maximum of two to three hours out of room time for showers and unstructured day room time (often alone in the dayroom). Some have an hour or less out of their rooms in shower/holding areas. For the rest of the day and night, the youth generally are alone in observation/watch rooms, limited to suicide resistant clothing and bedding a perhaps a book.

Some administrative and clinical staff seemed unaware that current policy requires that youth on observation/watch status spend as much time out of their rooms as clinicians determine is clinically appropriate (under direct line-of-sight supervision to protect against self-harm impulses). Others were aware of the requirements of policy but felt that their facility did not have did not have enough staff to provide one-on-one supervision for youth for whom more normal activity would have been appropriate. A significant number of clinicians interviewed, at

[26] In reviewing approximately 15-20 health care records of youth who had been on high-risk observation or suicide watch, the Monitor found clinician's notes documenting the clinical evaluations and determinations in about half of the records. The notes were available in WIN, but should also have been printed and filed in the health care records. The Special Master will request the mental health experts to assess the record-keeping practices.

most facilities, felt that they did not have the power vis-à-vis custody staff to vary restrictions/activities for observation/watch youth based on clinical judgments.[27]

Thus, high-risk observation and suicide and crisis watch generally are characterized by isolation, idleness and deprivation that is not mitigated based on clinical judgment. In addition to the resource/logistical issues,[28] staff perception that most youth who threaten or engage in self-injurious behavior do so deliberately to force staff to move them out of their assigned housing unit is a major reason for the punitive conditions. Indeed, it is not uncommon for youth to threaten self-injury because they want to be moved out of their living units, often because they legitimately are afraid of the violence and threat of violence there. From a staff perspective, this "manipulation" will be encouraged unless youth lose privileges/amenities on observation/watch status. Also, because so many youth on observation/watch status are perceived to be presenting "custody" and not mental health issues, staff may come to see especially high-risk observation as a custody rather than mental health status.[29]

The November 2004 policies and procedures that DJJ has partially implemented were intended as "interim measures" under the Consent Decree. The parties and the Consent Decree mental health experts recently have agreed that DJJ will improve its observation/watch policies and procedures. DJJ has undertaken to provide a new draft developed in consultation with the experts, by early December. DJJ also is developing policies and procedures for addressing the housing/program assignment needs of youth who inform staff that they feel unsafe.

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[27] O.H. Close stood out as an exception to this rule. The superintendent there directed one-on-one supervision for one youth she feared was at risk for self-harm, and clinicians interviewed there generally felt that their clinical judgments were respected. The Special Master was told that direct line-of-sight supervision was arranged for two youth at Preston but did not learn enough about those cases to report on them.

[28] The Special Master did not attempt to assess these issues. At least one facility was challenged by a high level of unfilled YCO and YCC positions which made it at least very difficult to provide coverage for one-on-one escort and direct line-of-sight supervision there. DJJ will need to assess and confront these issues, in the first instance.

[29] Custody staff put youth on high-risk observation status pending clinical evaluation. When clinicians retain youth on observation status rather than put them on suicide or crisis watch status, it may appear to staff that the youth are not thought to require mental health treatment.

The slow and incomplete implementation of the observation and watch policies and procedures illustrates the need to build the "capacity for change" as highlighted in the recently filed Safety and Welfare Plan.[30] The deficiencies in DJJ's management resources, policies and procedures,[31] training,[32] management information systems[33] and systems for holding staff accountable all played a role in the failure to implement fully the policies and procedures. Finally, many facilities have had critical vacancies in clinical mental health positions.[34] These vacancies likely contributed to the slow and incomplete implementation of the high-risk observation and suicide watch policy.

IV. MEDICAL CARE

The Consent Decree medical experts, in consultation with the parties and the Special Master, completed draft standards and criteria for measuring compliance with the Health Care Services Plan in the summer of 2006. They conducted an audit of the headquarters Office of Health Services ("OHS") based on site visits in June and August 2006, using the applicable standards and criteria. They will "field test" the standards and criteria in their first round of monitoring all facilities which they are scheduled to complete by the end of January 2007.[35]

DJJ has taken significant steps to improve central oversight of the delivery of health care services since the Special Master's First Report (March 2006). Most significant, on the timetable

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[30] *See*, Safety and Welfare Remedial Plan (July 10, 2006), Section 2.

[31] Not only are the policies difficult to read and understand, but they are not clear on key points, *e.g.*, the criteria for a clinician's retaining a youth on high risk observation rather than discharging him or her from observation or putting him or her on crisis or suicide watch and whether clinicians should restore normal clothing when clinically appropriate.

[32] Also, the training on the policies and procedures did not address practical implementation issues, such as how to implement the policy before the WIN system was appropriately modified. There was no training to develop staff skills in managing fearful youth and youth who pose a risk of self-harm behavior, nor guidance in strategies for handling youths' non-clinical needs.

[33] Staff have been hampered by the fact that the WIN database system has not been modified to permit them to document and track observation/watch designations and activities according the terms of the policies.

[34] Filled and vacant positions are depicted in the chart attached as Appendix D.

[35] *See*, DJJ Quarterly Report, Medical Remedial Plan (July 31, 2006); LaMarre memorandum emailed to the Special Master August 17, 2006; LaMarre and Goldenson, Medical Experts' Audit of Headquarters' Operations (September 10, 2006) ("Medical Experts' Headquarters' Audit").

set by the Health Care Services Remedial Plan and in consultation with the Consent Decree medical experts, DJJ completed the development of 30 of 32 essential health care services policies and procedures (not including all necessary forms which are still under development). The Office of Health Services disseminated the policies and procedures to all facilities for the development of local facility procedures. The remaining two of the 32 essential policies and procedures are under CDCR legal review. As of September 2006, 26 of the policies and procedures had formally been adopted.[36]

DJJ's Medical Director has implemented quarterly statewide health care meetings for medical, nursing, mental health and dental staff. The medical experts find this to be a very positive development. These quarterly meetings encourage and facilitate communication, build teamwork and are opportunities for building and guiding systemic practices.[37]

DJJ sought and received funding for necessary new health services positions, including facility health care administrators, health care records technicians and psychiatric technicians for all facilities with residential mental health units. The positions were added effective July 1, 2006.[38]

Progress in the implementation of the Health Care Services Remedial Plan is faltering, however, due to problems with the leadership and management at health services headquarters. These problems are reflected in the absence of a detailed Health Care Services Remedial Plan implementation strategy, the limited tracking of compliance progress, the absence of formal

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[36] *See*, DJJ Quarterly Report, Medical Remedial Plan (July 31, 2006); Medical Experts' Headquarters Audit, p. 5; email from expert LaMarre September 22, 2006. By November 2006, three more policies had been adopted formally, for a total of 29. DJJ's Office of Health Services still was working with CDCR counsel on two draft policies, concerning peer review and credentialing. The policy on organizational structure and medical autonomy still was being reviewed for whether it would be formally adopted. E-mail CDCR counsel to the Special Master, November 29, 2006.

[37] *See*, Medical Experts' Headquarters Audit, p. 5.

[38] *See*, DJJ Quarterly Report, Medical Remedial Plan (July 31, 2006); LaMarre memorandum emailed to the Special Master August 17, 2006.

orientation for new headquarters staff, insufficient communication between the Medical Director/Health Care Administrator and subordinate staff and poor morale among health care services headquarters staff leading to attrition by transfers and resignations.[39] The attrition further weakens health services leadership and management. For example, DJJ OHS recently lost a highly skilled and motivated Clinical Records Administrator who now must be replaced.[40] Poor morale also has resulted in turnover and vacancies in headquarters mental health positions.

The headquarters Office of Health Services is plagued by what appear to be intractable staffing issues. The salary for the Pharmacy Services Manager position long has been non-competitive and insufficient to attract qualified applicants, as DJJ and CDCR concede. The coverage that DJJ has been able to secure for the position has not filled the need for leadership and management in the position. DJJ long has promised to add a Standards and Compliance Coordinator to the Office of Health Services by converting a position but it has failed to actually do so.[41] In late 2006, DJJ reported that it was converting a particular position and planning or taking steps to gain applicants and fill the position once it was created.[42] There is also a need for additional clerical support as health services headquarters manages implementation of the Health Care Services Remedial Plan.[43]

DJJ's efforts to cover vacant medical (and mental health) positions by contract have been hindered by the absorption of their dedicated contracts staff into CDCR. DJJ has not been able to tailor requests for proposals to its needs that differ from CDCR's needs, and it has not been

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[39] *See*, Medical Experts' Headquarters Audit, p. 2, 4, and 6.
[40] *See*, Medical Experts' Headquarters Audit, p. 4.
[41] *See*, Medical Experts' Headquarters Audit, pp. 4-5; statements of Madeleine LaMarre to Donna Brorby December 7, 2006; DJJ Response to Special Master's Office draft Third Report, October 31, 2006.
[42] DJJ Response to Special Master's Office draft Third Report, October 31, 2006; statements of DJJ counsel at meeting December 5, 2006.
[43] *See*, Medical Experts' Headquarters Audit, p. 2.

able to get timely service from CDCR staff responsible for contract relationships.[44] The interface between DJJ and CDCR for other support services is not yet working to meet DJJ's needs.[45]

DJJ correctly points out that it is largely dependent on CDCR and the Department of Personnel Administration ("DPA") to solve problems involving classification of positions, salary and contract coverage for positions that cannot be filled. Nonetheless, failures on the part of CDCR, DPA and other departments of state government ultimately will not excuse DJJ from its legal obligations.

V. SEXUAL BEHAVIOR TREATMENT PROGRAM

The Sexual Behavior Task Force, comprised of program clinical staff from throughout DJJ, has continued to work diligently towards compliance with the Sexual Behavior Treatment Remedial Plan. It is committed to building a quality program.[46]

Following the strong recommendation of the Consent Decree expert, DJJ has provided for all members of the Task Force to attend the Association for the Treatment of Sexual Abusers International Research and Treatment Conference in Chicago, Illinois in September 2006.[47] The clinicians' participation in certain state and national conferences is necessary to enable DJJ to build and maintain a sexual behavior treatment program based on current developments and evidence in the field.[48]

DJJ has recognized the need to integrate the Sexual Behavior Treatment Remedial Plan with the recently filed Safety and Welfare and Mental Health Remedial Plans. Sexual behavior treatment is one of many treatment and rehabilitation programs that will be prescribed for youth

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[44] *See*, Medical Experts' Headquarters Audit, pp. 8-9.
[45] *See*, Medical Experts' Headquarters Audit, p. 11.
[46] *See*, Schwartz, Quarterly Report (August 2006), p. 4.
[47] *See*, Schwartz, Quarterly Report (August 2006), p. 2.
[48] Statement of Consent Decree expert Schwartz to the Special Master July 6, 2006.

based on their individual treatment and rehabilitation needs. Programming needs to be consistent and coordinated. Until now, the Sexual Behavior Task Force has worked independently of the teams developing the Safety and Welfare and Mental Health remedial plans and it has been uncertain where the Sexual Behavior Treatment Program would fit in the DJJ organizational structure. DJJ needs to clarify the organizational structure and devise a plan for developing consistency between the Sexual Behavior Treatment Program and other treatment and rehabilitative programs.[49]

The difficulty in the interface between DJJ and CDCR staff that has interfered with necessary medical contracts also has stalled progress on sexual behavior treatment curriculum development and implementation. The critical work of DJJ's sexual behavior treatment consultant has been stalled for at least nine months by delays in payment and contract renewal.[50]

VI. EDUCATION

The Special Master has nothing new to report in the area of education. The Consent Decree education experts have established a site visit schedule that will enable them to prepare a report by Spring 2007.

VII. ACCESS FOR YOUTH WITH DISABILTIES

The Special Master has nothing new to report in the area of access for youth with disabilities. The disabilities expert was intending to be on the same schedule as the education experts until delays in the process of renewing his contract prevented that. The contract has since been renewed and he anticipates filing a report after a round of site visits by Spring 2007.

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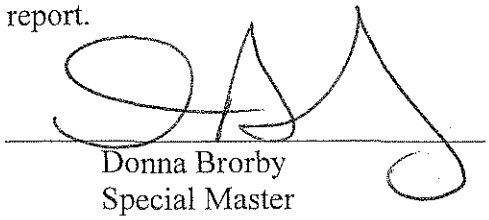
[49] *See*, Schwartz, Quarterly Report (August 2006), pp. 1, 2, 3 and 4.
[50] *See*, Schwartz, Quarterly Report (August 2006), pp. 1 and 3; DJJ progress reports on the contract through November 2006.

VIII. CONCLUSION

The Special Master respectfully submits this report.



Dated: December 7, 2006

Donna Brorby
Special Master

PROOF OF SERVICE

I, James Eno, declare that:

I am employed in the City and County of San Francisco, California. I am over eighteen years of age, and not a party to the within cause; my business address is 605 Market Street Ninth Floor, San Francisco, California 94105-3211.

On December 11, 2006, I caused to be served the attached THIRD REPORT OF SPECIAL MASTER on the parties in said cause by placing in a United States mailbox a true copy thereof enclosed in a sealed envelope, with postage thereon fully prepaid, addressed as follows:

Monica N. Anderson
Supervising Deputy Attorney General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, California 94244-2550

Donald Specter
Prison Law Office
General Delivery
San Quentin, California 94964

Michael Hanretty
California Department of
Corrections and Rehabilitation
Office of Legal Affairs
1515 S. St. Ste. 314S
Sacramento, CA 95814

I declare under penalty of perjury that the foregoing is true and correct, and that this declaration was executed on December 11, 2006 at San Francisco, California.

James Eno