Report on

Access to Programs and Services

for Wards with Disabilities

in the

California Youth Authority

Prepared by

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Table of Contents **Page**

1. Executive Summary

This report is intended to evaluate access to the programs and services of the California Youth Authority (CYA) for wards with disabilities. The report is based upon site visits and interviews conducted at eight institutions from September through December, 2004, by the author. It also involves a review of applicable policy and procedure manuals, previous expert consultant reports, and other written documentation about the CYA's programs that affect wards with disabilities.

The term "wards with disabilities" includes all those who can be reasonably classified as "qualified individuals with a disability", as defined by applicable federal and state law, including the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973 (Section 504), and the Individuals with Disabilities Education Act of 1990 and the Amendments of 1997 (IDEA). While many persons may associate individuals with disabilities primarily as those with physical impairments, the broader range of qualified individuals includes those with mental and emotional disabilities, those who have certain infectious diseases or other limiting conditions, and those who may be treated or regarded as disabled through misdiagnoses or misconceptions. One of the recommendations of this report is that CYA staff should be made more aware of this broader aspect of disability and of the additional rights and protections individuals with all disabilities have under federal and state law.

The basic approach to the scope of inquiry required of the disability expert consultant and of this report has always been that it should be a cooperative effort that primarily attempts to improve the delivery of programs and services to wards with disabilities. While the questions posed as the major areas of inquiry are in a yes/no format, the reality is that few of them can be answered so simply.

In nearly all of the areas of inquiry, the CYA demonstrates a number of strong assets and policies that need to be continued and strengthened. In fact, my observations showed that the CYA has progressed in a number of areas since the onset of the *Farrell vs. Harper/Allen* litigation and in response to the other expert consultants' reports. Many within the CYA appear to be committed to making the changes necessary for appropriate reform.

However, there are still a number of program areas where policies and procedures, as well as the practical implementation these policies, do not meet accepted standards of delivery or care for medical procedures, mental health treatment programs, grievances, disciplinary activities, educational activities, and other program areas. While all wards within the system are negatively impacted by these deficiencies, wards with disabilities are disproportionately affected to a more significant degree than other wards, since many programs are not making the necessary modifications necessary for equal inclusion and treatment of wards with disabilities into the

programs. Accommodations for wards with disabilities, as required by the applicable laws and regulations, are often limited and inconsistently provided.

The root cause of many of the problem areas lies predominantly in the lack of resources and appropriate funding for the CYA and its individual programs. Ward population has decreased dramatically within the last several years. However, rather than using these decreases as an end toward strengthening program delivery, cutbacks have severely curtailed programs that were being developed and making a positive impact for wards. And again, most of the program cuts most negatively affect wards with disabilities, since these wards indeed need more specialized approaches to integrate them into regular institutional activities. Unless funding and resources for treatment programs, educational and vocational activities, and specialized programs are increased, recommendations for overall and long-term improvements in program delivery will be more difficult to achieve. During times of economic stress, a reallocation of resources toward more specialized programs for wards with disabilities will be necessary to make any appreciable gains in program delivery for this protected group.

The CYA's greatest asset lies in the expertise, dedication, and commitment of its staff, who for the most part, perform their functions with distinction. Both regular and special education teachers appear to be adept at modifying their teaching methods and tailoring the curricula to a wide variety of needs, including the individual needs of students with mental and learning disabilities. Psychologists work admirably on a day-to-day basis with an incredible array of challenges posed by so many wards with mental and emotional disabilities. These are just two examples where service problems can be primarily attributed to the simple fact that there are just not enough of either teachers for daily classes or psychologists for required treatment programs. Classes are too often cancelled for the lack of teachers, and the lack of consistency in the educational process most often negatively affects students with disabilities. Psychiatrists and psychologists carry caseloads that are dramatically above any acceptable professional standards of care, and treatment programs for wards with psychiatric disabilities are lacking because of it.

Efforts to promote progressive treatment options are usually stymied by a lack of resource commitment. An exception is the Specialized Behavioral Treatment Program for wards with mental disabilities at Sequoia Lodge at Preston Youth Correctional Facility. While the results are inconclusive as to the overall effectiveness of this program, the point to be made is that efforts for improvement can only occur with a shift in both resources and perspectives to foster change. For example, it has been suggested that a new treatment model for wards with serious developmental disabilities must be developed, as the current trend toward relegating such wards to more restrictive programs is clearly inappropriate and ineffective. Without the appropriate resource commitment, progressive solutions will be difficult if not impossible to implement, and these wards will be denied their legal right to equal treatment in the least restrictive environment.

While this report does not specifically address physical accessibility, a previous expert's report clearly documents the extent and nature of architectural barriers that are present at most institutions. There is a distinct parallel between physical accessibility and program accessibility, the subject of this report. For example, newly constructed visitation centers at two institutions, both reflecting positive reinforcement for family intervention as well as full accessibility, sit vacant and unused on visiting days because there is insufficient funding to adequately staff the facility, thus denying full access to the visitation program for wards and family members with physical disabilities. The architectural barrier items contained in the surveys should be prioritized and implementation begun to allow for full access to programs at all required locations.

In conclusion, despite excellent and dedicated professional staff and a stated commitment to making improvements in a number of program areas, many of these areas fall short of the standard of care necessary for the effective delivery of these programs to wards. And when program delivery standards are deficient and resources are scarce, the group most negatively affected is those with disabilities, who often require, and are guaranteed by law, modifications and accommodations necessary for equal treatment and program access. Such is the current state of affairs for wards with disabilities within the CYA. On a positive note, with a stated commitment to improve conditions for all of its wards, and with an appropriate reallocation and hopefully an improvement in resources, it is believed that the CYA can proceed on a positive track to bring about the needed improvements.

2. Introduction - Scope of Work (Inquiry), Methodology, and Acknowledgements

This report has been prepared to evaluate access for wards with disabilities to the programs and services of the California Youth Authority (CYA). The report has been prepared in response to the Complaint in the litigation entitled *Farrell vs. Harper* (Superior Court of California, County of Alameda, RG-03079344) and to the Consent Decree entered in the same case (now entitled *Farrell vs. Allen*).

Scope of Work (Inquiry)

This Consultant's basic scope of work was to prepare a detailed analysis addressing each of the areas of inquiry, as described below, at each of the identified institutions. In addition, this written report was intended to assess the overall performance of the California Youth Authority's provision of programs and services to wards with disabilities. Activities of the Consultant were identified as: (1) to work with CYA staff to develop, if needed, appropriate policies and procedures in providing access to programs and services to wards with disabilities; (2) to work with CYA staff to develop, if needed, appropriate polices and procedure to ensure that there is appropriate staff training and disability awareness training for staff and wards; and (3) to work with CYA staff to develop, if needed, appropriate policies and procedures to ensure that wards with disabilities are able to reach higher program phase or parole

The areas of inquiry identified in the Consultant's scope of work are listed below. This report has been organized to follow the specific categories in the content and order as listed below.

A. Do wards with disabilities have access to the following programs and services in a manner consistent with federal and state law? (Note: The exact order of the programs and services, as contained in the Consultant's agreement, has been revised to better reflect the order and extent of services provided.)
   (1) Screening and Assessment
      (a) Psychological Testing
      (b) Case Conferences
      (c) Board Hearings
   (2) Access to Medical/Dental Care
   (3) Treatment Programs
      (a) Sex Offender
      (b) Drug/Alcohol
      (c) Intensive Treatment
      (d) Special Counseling
      (e) Special Management
   (4) Disciplinary System
      (a) DDMS Hearings

(5) Ward's Rights Process (Grievance)
(6) Education
  (a) Special/Alternative Education
  (b) Vocational
  (c) General Academic
  (d) Library
(7) Recreation
(8) Communications
(9) Visitation
(10) Sanitation and hygiene
(11) Religious Services
(12) Emergency Services and Plans
(13) Food Service
(14) Transportation
(15) Other Programs

B. On a system-wide level, is there appropriate training to ensure that staff and wards will follow the policies and procedures designed to ensure that ward with disabilities are (1) provided with access to the above programs and services and (2) not subject to harassment or discrimination related to their disabilities?
  (1) Staff
    a) Working with Wards with Disabilities
    b) Disability Awareness
  (2) Wards
    a) Disability Awareness
C. Do disabled wards have a reduced ability to reach a higher program phase or parole?

Consultant Activities

Specific categories of activities were also identified to the Consultant for specific review and evaluation as part of this report. These include the following:

A. Review:
  (1) Disability Identification and Assessment
  (2) Youthful Offender Employment
  (3) Special Education Programs
  (4) Grievance Accommodation Procedures Requests
  (5) Public Input Programs
  (6) Emergency Evacuation and Fire Plans
  (7) Transportation
  (8) Auxiliary Aids and Services
  (9) Telecommunications

(10) Recreation
(11) Sanitation and hygiene
(12) Staff interaction
(13) Access to services
(14) Programs
(15) Supply and Maintenance of Equipment
(16) Notifications
(17) Medical/Dental Evaluations
(18) Policies and Procedures / Compliance Plans

B. Meet With:
(1) Disability Coordinators
(2) Health and Safety Officers
(3) Senior Psychologists
(4) Principals
(5) Wards with disabilities
(6) Chief Medical Officers
(7) Institutional Parole Agents
(8) Team Supervisors
(9) Personnel responsible for initial screening and intake of wards

C. Attend:
(1) Parole Board hearings
(2) Youth Authority Advisory Council (YAAC) hearings
(3) Initial screenings
(4) Individualized Education Plan (IEP) meetings
(5) Case management conferences
(6) Disciplinary Decision-Making System (DDMS) fact findings and hearings
(7) Ward grievance clerk's meetings
(8) Student Consultation Team Meetings
(9) Special and regular education classes

Documents Reviewed

As part of the Consultant's review and evaluation, the following documents were provided to the Consultant by the CYA and were reviewed by the Consultant in the preparation of this report:

(1) Access Unlimited Accessibility Evaluations (Robertson Expert Consultant Report), 2003
(2) Report of Findings of Mental health and Substance Abuse Treatment Services in the CYA (Drs. Turpin and Patterson Expert Consultant Report), 2003
(3) Review of Health Care Services in the CYA (Puisis and LaMarre Expert Consultant Report), 2003

(4) Education Program Review of the CYA (Drs. O'Rourke & Gordon Expert Consultant Report), 2003
(5) General Corrections Review of the CYA (Dr. Krisberg Expert Consultant Report), 2003
(6) Evaluation of Sex Offender Programs in the CYA (Thomas Expert Consultant Report)
(7) California Department of Education Initial Verification Review Report, 6/30/04
(8) Education Services Branch Manual
(9) Institution and Camps Branch Manual
(10) Educational Services Branch Manual
(11) Parole Services Branch Manual
(12) Department Operations Manual, Youthful Offenders with Disabilities (Draft, 8/03)
(13) Department of the Youth Authority Action Plan in the Area of Disabilities
(14) Assessment of the Mental Health System of the CYA (Stanford/Steiner Report), 2001.
(15) Wards Rights Handbook
(16) Individual Education Plans (IEPS) for some wards, when requested by the Consultant
(17) High School Graduation Plans for some wards, when requested by the Consultant
(18) Clinic Assessments for some wards, when requested by the Consultant
(19) Case Conference Plans for some wards, when requested by the Consultant
(20) CYA Supervisors and Peace Officers Training Documents

It should be noted that the following documents were originally listed as references for the Consultant's scope of work, but these documents were not actually provided to the Consultant and were not reviewed by the Consultant in the preparation of this report:

(1) California Youth Authority Access Compliance Reference Manual, Volume 2 (Policies, Interpretive Regulations, Guidelines)
(2) Portions of the Department of the Youth Authority Draft Mental Heath Remedial Plan that relate to identifying wards with disabilities and access to services
(3) Portions of the Department of the Youth Authority Draft Medical (Health Services) Remedial Plan that relate to identifying wards with disabilities and access to services
(4) Portions of the Department of the Youth Authority Draft Education Remedial Plan that relate to identifying wards with disabilities and access to services
(5) Portions of the Department of the Youth Authority Draft General Corrections Remedial Plan that relate to identifying wards with disabilities and access to services
(6) Integrated Treatment Delivery of Care System (ITDCS)
(7) CTC Action Plan
(8) 1993 ADA Self-Audit

Methodology

The basic methodology employed for the production of this report included the following:

(1) Review of all relevant documents made available by the CYA, as listed in the above section, as well as general disability and ADA reference materials as required.

(2) Site visits, attendance at various hearings and meetings (as described above), and interviews with appropriate staff and wards at the following CYA facilities (listed in order of visitation):

1. O.H. Close Youth Correctional Facility, Stockton, CA., Sept. 16-17, 2004.
2. N.A. Chaderjian Youth Correctional Facility, Stockton, CA., Sept. 27-28, 2004.
3. Ventura Youth Correctional Facility, Ventura, CA., October 7-8, 2004.
4. Southern Youth Correctional Reception Center/Clinic, Norwalk CA, Oct. 14-15, 2004
5. Heman G. Stark Youth Correctional Facility, Chino, CA., October 28-29, 2004.
6. El Paso De Robles Youth Correctional Facility, Paso Robles, CA., Nov. 3, 2004.
7. DeWitt Nelson Youth Correctional Facility, Stockton, CA., December 9, 2004.
8. CYA Training Center, Stockton, CA., December 9, 2004.
9. Preston Youth Correctional Facility, Ione, CA., December 16-17, 2004.

(3) Careful evaluation and categorization of all programs, activities, policies, procedures, and protocols, both agency-wide and at each facility.

(4) Preparation of this report, including recommendations for revisions to programmatic policies and procedures for inclusion in the disabilities remedial plan.

As a summary, it is believed that all ward living units within the CYA, with a possible exception of about five, were visited during the site visits, totaling about 95 living units. In addition, wards' visiting areas, dining halls, chapels, educational facilities, recreational facilities, temporary detention facilities, and medical and mental health treatment facilities and were visited at all correctional facilities. A total of about 120 staff members were either formally interviewed or involved in more informal discussions. Also, a total of about 45 wards, most with disabilities, were interviewed or individually evaluated. In most cases, names of staff or wards are not included in this report, for confidentiality reasons.

The general protocol for each site visit was that I was able to control the methods and locations of all review activities. While the CYA staff and the visit coordinator did indeed schedule various interviews, and not all activities were necessarily available at all times at all locations, it was I who determined what areas to see and whom to interview. All members of the CYA staff were gracious and helpful in accepting this concept.

I generally started each site visit with an introduction from staff members about the make-up of the programs and a tour of the facility. I attended any formal meetings or hearings that might be taking place. I met with the grievance coordinator and the disciplinary decision making system (DDMS) coordinator. I also usually spoke with the health and safety officer, the facilities and

maintenance manager, or other supervisors. I visited living units where wards were housed, as well as the chapels, dining halls, gymnasiums, and recreational facilities. I toured the school facilities, met with the principal at each, and visited regular and special education classes. I also reviewed wards' files and records and interviewed wards whom I selected.

It should be noted that, in general, the site visits were undertaken with a open dialogue about what was being observed, and that where conditions existed that might be readily corrected and resolved, sometimes those conditions were brought to the attention of those who could bring about appropriate solutions. Since the Consent Decree was in the process of being formally executed, it was not my intent to "catch" the CYA in possible "violations", but rather to work in concert to bring about the most effective policies for wards' access to programs. CYA staff indicated an interest in learning about better ways to do things and indeed exhibited an honest attempt to improve conditions whenever issues were raised. For example, at a comprehensive level, the CYA was quick to respond to the need for ADA Coordinators to become more active in resolving issues, as further described in Section 3.3. As another example at a more detailed level, when it was discovered that a ward with a hearing impairment had difficulties accessing closed captioning on television, the problem was immediately corrected. It should be also noted that some conditions I observed required further reflection and research, and those conditions are primarily described in this report.

Acknowledgements

I would like to personally thank and acknowledge the efforts of all CYA staff and others who accompanied me during my site visits and inspections, and who were instrumental in setting up the procedures that assisted in this report. First and foremost would be Holly Bowers, Treatment Team Supervisor at N.A. Chaderjian Youth Correctional Facility and the CYA's recently designated ADA Coordinator for Programs, who organized all of the site visits, took extensive site notes, and was invaluable in her assistance throughout the project. Attorneys from the CYA's Legal Department, Sherleen Redd, Nanette Rufo, Abel Ramirez, and Van Kamberian, were cordial and helpful when accompanying me on the site visits and in providing whatever information I requested. Krista Pollard, attorney with the Attorney General's office, was also helpful and assisted me throughout my site visits, inspections, interviews, and meetings. Everyone within the CYA provided me with the utmost respect and cooperation in the performance of my duties. I was able to visit every part of every facility that I wanted to see. I was able to review all of the documents and materials that I requested at each site, and at no time was any information or any part of a facility withheld from me. I met with either the Superintendent or the Acting Superintendent of each facility and was able to obtain information about the facility from the most senior personnel. I believe that everyone was striving to provide me with honest answers to my questions and with their honest evaluation of their functions and how the facility operated. I was able to privately interview or informally converse with all the wards that I requested interviewing, and I was able to attend Board hearings, CYA advisory

council (YAAC) meetings, case management conferences, and other meetings at my own discretion.

I would also like to thank the previous expert consultants, as listed in the subsection *Documents Reviewed*, who prepared expert reports on various aspects of the operations of the CYA in the *Farrell vs. Harper/Allen* matter. It should be noted that while the subjects of the other expert reports were different from the subject of this report, their subjects were nevertheless related to the overall area of services provided to wards, including those with disabilities, and there are overlapping issues and conditions that would affect both the general population and wards with disabilities. It should also be noted that I did not receive nor review the expert consultant reports until the first part of December, 2004, and therefore, I had completed most of my site visits and evaluations before reviewing the other expert reports. This may have been helpful in forming my own opinions as opposed to being swayed by the opinions and conclusions put forward by the other expert consultants. In general, it is not my intent to compare my opinions and conclusions with those of the other experts, and the reader of this report will need to compare the opinions and recommendations contained in this report with those of the other expert consultants to cover all of the parallels or differences between the various reports. However, in some cases, I do not share the same opinion as other expert consultants, and in those cases, my report might highlight differences between my opinions and those shared by another expert. In these circumstances, I acknowledge and apologize for a somewhat unfair advantage over the other expert consultants, since I have had access to their opinions while they did not have access to mine nor are given the opportunity to clarify or rebut. But I also believe that all parties are primarily interested in an open dialogue of issues and potential solutions.

Corrections and Errata

If there are any material facts contained or referenced in this report that are in error, please let me know immediately, and I will be happy to make the appropriate corrections and issue errata, if necessary.

3. Federal and State Requirements

This section is intended to describe some of the basics of disability regulations and policies. I feel that such a discussion is necessary before responding to the specific areas of inquiry. While it was my observation that CYA staff were generally concerned about the ADA and other disability regulations and attempted to meet their requirements, a number of staff members also had misconceptions or a lack of detailed knowledge about what the ADA and other state and federal regulations would require in the programs offered by the CYA. Many decision-making staff members tended to think of disability mostly in terms of physical and architectural parameters, or in terms of special accommodations that could be made for persons who might have easily identifiable special needs. There sometimes appeared to be a general lack of understanding about program access and how programs should be accessible to a wide range of disabilities, irrespective of whether persons with disabilities are actually engaged at the present time in the program. CYA staff seemed to understand that employees with disabilities would have the need for reasonable accommodation, but how wards would be accommodated within all of the programs that are offered to the general ward population was more difficult for some to comprehend. It is true that this distinction is a difficult one to describe and to understand, and yet it is also felt that it is a critical one in the treatment of wards with disabilities within the CYA. (I realize that some of the information discussed below is included in the 8/2003 Draft of "Youthful Offenders with Disabilities", but that document, as far as I am aware, has not been widely circulated to staff. In addition, the discussions below present the information from a different perspective than the Draft document.)

3.1 Qualified Persons with Disabilities

Most senior-level staff members were aware of physical disabilities, but it did not appear that some possess a working knowledge of the broad range of disabilities that might be covered by the ADA. This section is intended to describe how the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973 (Section 504), and other disability regulations should be used to determine which wards could be covered under the ADA or Section 504. The words "could be" are used above, because regulations do not dictate absolute inclusion or disability protection for a specified list of impairments, but rather gives objective criteria that requires an evaluation of an individual's specific situation and whether discrimination has occurred or can be a potential issue.

The ADA has a three-part definition of disability. This definition, based on similar definitions under Section 504, reflects the specific types of discrimination experienced by people with disabilities. Accordingly, it is not the same as the definition of disability in other laws, such as state workers' compensation laws or similar federal or state laws that provide benefits for people with disabilities and disabled veterans.

Under the ADA and related State regulations, an individual with a disability is a person who:

1. has a physical or mental impairment that limits one or more major life activities,
2. has a record of such an impairment, or
3. is regarded as having such an impairment.

Each of these criteria is described more fully below.

(1) An Impairment that Limits Major Life Activities

The first part of the definition has three major subparts that further define who is and who is not protected by the ADA.

A Physical or Mental Impairment:

A physical impairment is defined by the ADA as: "[a]ny physiological disorder, or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculo-skeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin, and endocrine."

A mental impairment is defined by the ADA as: "[a]ny mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities."

Neither the ADA nor Department of Justice (DOJ) regulations list all conditions or diseases that make up "physical or mental impairments", because it would be impossible to provide a comprehensive list, given the variety of possible impairments. Under the ADA, an impairment is a physiological or mental disorder; simple physical characteristics, such as eye or hair color, left-handedness, height or weight within a normal range, are not impairments. A physical condition that is not the result of a physiological disorder, such as pregnancy, or a predisposition to a certain disease would not be an impairment. Similarly, personality traits such as poor judgment, quick temper or irresponsible behavior, are not themselves impairments. Environmental, cultural, or economic disadvantages, such as lack of education or a prison record, also are not impairments. "Stress" and "depression" are conditions that may or may not be considered impairments, depending on whether these conditions result from a documented physiological or mental disorder.

A person who has a contagious disease has an impairment. For example, infection with the HIV virus is an impairment. Additionally, the Supreme Court has ruled that an individual with tuberculosis that affects the respiratory system had an impairment under Section 504 of the Rehabilitation Act.

Major Life Activities

To be a disability covered by the ADA, an impairment must limit one or more major life activities. These are activities that an average person can perform with little or no difficulty. Examples are:

- working
- speaking
- breathing
- performing manual labor
- sitting
- reading
- walking
- seeing
- hearing
- learning
- caring for oneself
- standing
- lifting

These are only a few examples. Other activities can be major life activities, and it is anticipated that the list can change from time to time as qualities of life and normal activities also change.

Limits

An impairment is a "disability" under the ADA if it limits one or more major life activities. An individual must be unable to perform, or be limited in the ability to perform, an activity compared to an average person in the general population. The regulations provide the following three factors to consider in determining whether a person's impairment limits a major life activity:

- its nature and severity;
- how long it will last or is expected to last;
- its permanent or long term impact, or expected impact.

These factors must be considered because, generally, it is not the name of an impairment or a condition that determines whether a person is protected by the ADA, but rather the effect of an impairment or condition on the life of a particular person. Some impairments, such as blindness, deafness, HIV infection or AIDS, are by their nature limiting, but many other impairments may be disabling for some individuals but not for others, depending on the impact on their activities.

The determination as to whether an individual is limited must always be based on the effect of an impairment on that individual's life activities. Sometimes, an individual may have two or more impairments, neither of which by itself limits a major life activity, but that together have this effect. In such a situation, the individual has a disability.

Temporary Impairments

Public entities, service providers, and employers frequently ask whether "temporary disabilities" are covered by the ADA. How long an impairment lasts is a factor to be considered, but does not by itself determine whether a person has a disability under the ADA. The basic question is whether an impairment "limits" one or more major life activities. This question is answered by looking at the extent, duration, and impact of the impairment. Temporary, non-chronic impairments that do not last for a long time and that have little or no long-term impact usually are not disabilities.

Specific Exclusions

A person who currently uses illegal drugs is not protected by the ADA as an "individual with a disability". However, former drug addicts who have been successfully rehabilitated may be protected by the Act. (See also the discussion below for a person "regarded as" a drug addict.)

Homosexuality and bisexuality are not impairments and therefore are not disabilities covered by the ADA. The ADA also specifally states that the term "disability" does not include the following sexual and behavioral disorders:

- transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or sexual behavior disorders;
- compulsive gambling, kleptomania, or pyromania; or
- psychoactive substance use disorders resulting from current illegal use of drugs.

(2) Record of a Limiting Condition

The discussion in the previous subsection focused on the first part of the definition of an "individual with a disability," which protects people who currently have an impairment that limits a major life activity. The second and third parts of the definition protect people who may or may not actually have such an impairment, but who may be subject to discrimination because they have a record of or are regarded as having such an impairment.

This part of the definition protects people who have a history of a disability from discrimination, whether or not they currently are limited in a major life activity. It protects people with a history of cancer, heart disease, or other debilitating illness, whose illnesses are either cured, controlled or in remission. It also protects people with a history of mental illness.

This part of the definition also protects people who may have been mis-classified or mis-diagnosed as having a disability. Examples of individuals who have a record of disability, and of

potential violations of the ADA if a service provider relies on such a record to deprive the individual of a program or service, are included below:

- A person formerly was a patient at a state institution. When very young, she was misdiagnosed as being psychopathic and this misdiagnosis was never removed from her records. If this person is otherwise qualified for a service and is not provided the service, that is a violation of the ADA.

- A person who has a learning disability wants a position as a secretary/receptionist. The provider reviews records from a previous employer indicating that he was labeled as "mentally retarded." Even though the person's record shows that he meets all requirements for the job, the provider does not interview him because he doesn't want to hire a person who has mental retardation. This is a violation of the ADA.

- A person was hospitalized for treatment for cocaine addiction several years ago. He has been successfully rehabilitated and has not engaged in the illegal use of drugs since receiving treatment. This person has a record of an impairment that substantially limited his major life activities. If he is qualified to receive a service or perform a task, it would be discriminatory to reject him based on the record of his former addiction.

In the last example above, the individual was protected by the ADA because the drug addiction was an impairment that substantially limited his major life activities. However, if an individual had a record of casual drug use, the person would not be protected by the ADA, because casual drug use, as opposed to addiction, does not substantially limit a major life activity.

To be protected by the ADA under this part of the definition, a person must have a record of a physical or mental impairment that substantially limits one or more major life activities.

(3) Regarded as Limited

This part of the definition protects people who are not limited in a major life activity from discriminatory actions taken because they are perceived to have such a limitation. Such protection is necessary, because, as the Supreme Court has stated and the Congress has reiterated, "society's myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairments." The legislative history of the ADA indicates that Congress intended this part of the definition to protect people from a range of discriminatory actions based on "myths, fears and stereotypes" about disability, which occur even when a person does not have a limiting impairment.

An individual may be protected under this part of the definition in three circumstances:

- The individual may have an impairment that is not limiting, but is treated as having such an impairment. For example, a worker has controlled high blood pressure that does not limit his work activities. If an employer reassigns the individual to a less strenuous job because of unsubstantiated fear that the person would suffer a heart attack if he continues in the present job, the employer has "regarded" this person as disabled.

- The individual has an impairment that is limiting because of attitudes of others toward the condition. For example, an experienced assistant manager of a convenience store who had a prominent facial scar was passed over for promotion to store manager. The owner promoted a less experienced part-time clerk, because he believed that customers and vendors would not want to look at this person. The employer discriminated against her on the basis of disability, because he perceived and treated her as a person with a limitation.

- The individual may have no impairment at all, but is regarded by an employer as having a limiting impairment. For example, an employer discharged an employee based on a rumor that the individual had HIV disease. This person did not have any impairment, but was treated as though she had a limiting impairment.

This part of the definition protects people who are "perceived" as having disabilities from service decisions based on stereotypes, fears, or misconceptions about disability. It applies to decisions based on unsubstantiated concerns about productivity, safety, insurance, liability, attendance, costs of accommodation, accessibility, workers' compensation costs or acceptance by others. Accordingly, if a service provider makes an adverse decision based on unsubstantiated beliefs or fears that a person's perceived disability will cause problems and cannot show a legitimate, nondiscriminatory reason for the action, that action would be discriminatory under this part of the definition.

Qualified Persons with a Disability under the IDEA

Under the Individuals with Disabilities Education Act of 1990 and Amendments of 1997 and 2004 (IDEA), a person under 22 years of age is defined (in general) as a person with a disability if the person has one or more of the following limiting conditions:

(1) mental retardation
(2) is deaf or hard of hearing
(3) speech or language impairment
(4) visual impairment
(5) emotional disturbance
(6) orthopedic impairment
(7) autism
(8) traumatic brain injury
(9) other health impairment
(10) specific learning disability
(11) is deaf / blind
(12) is "multi-handicapped"

Since the CYA is a public agency required to provide a free appropriate public education to its wards and is thus subject to the requirements of IDEA, all wards with the above impairments should be included in the definition of "qualified persons with a disability". It should be noted that the ADA's definition is potentially broader than those contained in IDEA. Also, wards above the age of 21 would also be regarded as "qualified persons with a disability" under the ADA, even though required educational services under IDEA may lapse (in other words, the actual disability or its perception does not disappear just because a certain age is reached).

CYA Wards with Disabilities

Based upon the above definitions and discussions of "qualified persons with a disability", it is appropriate to apply ADA, 504, IDEA, and State disability regulations to wards under the jurisdiction of the CYA. Again, it is important to recognize that a disability must be evaluated based on the specific impairment, or perception of an impairment, of the individual. Still, it is appropriate to describe generalized categories of impairments that may be either currently exhibited by a number of wards, or may be expected to be present in the general population of which wards are a part, even if no current wards with such an impairment are housed at the CYA. This latter necessity will be made clearer after review of the next section concerning program accessibility.

These generalized categories include, but are certainly not limited to, the following:

(1) persons with mobility impairments (may be multiple categories):
  (a) persons with spinal cord injuries or congenital impairments.
  (b) persons using wheelchairs, scooters, etc., either on a full-time or part-time basis.
  (c) persons using other mobility devices, including prosthetic(s), crutches, cane, walker, etc.
  (d) persons with impaired manual dexterity, including possible use of manual aids or prosthetics.

(2) persons with visual impairments:
  (a) persons with no vision, or who are blind. (Note that the misnomer "legally blind" does not have particular application under the ADA.)
  (b) persons with low vision.
  (c) persons with other visual impairments or limiting conditions, such as cataracts, glaucoma, macular degeneration, reduced field of vision, myasthenia gravis, retinitis pigmentosa, etc.

(3) persons who are deaf or hard of hearing (It should be noted that the term "hearing impairment", and degrees of distinction between varying degrees of hearing, are avoided in this report, since these terms are potentially offensive to many deaf and hard of hearing individuals.)

(4) persons with speech impairments.

(5) persons with mental or emotional disabilities:

(a) persons with developmental disabilities, including mental retardation or perceived low IQ, traumatic brain injury, etc.
(b) persons with emotional disabilities, including anxiety disorders, depression, etc.
(c) persons with other psychological impairments or psychiatric conditions or disorders, including Tourette's syndrome, pervasive development disorders, anorexia nervosa, etc. (Note that DSM or "Axis" categorization of psychological impairment have no particular application under the ADA.)
(d) persons specifically covered by the Individuals with Disabilities Education Act (also called Individuals with Specials Needs (IWSN) in the Act).

(6) persons with specific long-term diseases or potential debilitating conditions, including AIDS/HIV, tuberculosis, chronic pain syndrome, etc.

It is also helpful to clarify the extent to which persons with disabilities as described above were either known or observed to be housed at the eight CYA institutions during my site visits. Again, the relative numbers are not necessarily relevant, because the CYA has a legal obligation to provide programmatic access to all such individuals, as described in the next section. However, such a discussion should be valuable in analyzing both the nature of the CYA compliance efforts to date and the extent of any additional services or program modifications that need to be effected. The actual numbers and percentages of the total of approximately 3,570 wards given below are approximate, and subject to change literally on a daily basis.

(a) Wards with mobility impairments

During my site visits, it is believed that there were eight individuals who had mobility or orthopedic disabilities. I had some degree of interaction and formally interviewed most of them. Three of the individuals had prosthetic limbs, one individual had permanent spinal injuries and resulting walking impairments, one individual had a physiological brain injury that limited upper body movement, one individual had a spinal injury and used a wheelchair during my visit (with an unknown prognosis of permanency), one individual had scolioses, one individual had an unknown condition but needed a cane, and one individual had a missing appendage with an associated lack of manual dexterity. These individuals were housed at Chaderjian YCF, Ventura YCF, SYCRCC/Norwalk, Stark YCF, El Paso de Robles YCF, and DeWitt Nelson YCF.

This number of eight individuals with mobility impairments (only 0.22%) is statistically lower than one would expect, given a total ward population of about 3,570. I made some general inquiries as to why such would be the case, but quickly realized that such an evaluation would be beyond the scope of this report. The answer relates more to the state of the juvenile justice system in California, and involves County courts and the California Department of Corrections (CDC) as much as the CYA. However, at a general level, the low number of wards with mobility impairments, while seemingly a positive sign since many of the older facilities exhibit architectural barriers that would make daily life at the CYA difficult in some cases, may also

represent an area of concern. If wards with mobility impairments are being denied entry into CYA facilities and its treatment and other special programs solely on the basis of their disability, or upon a real or perceived impression that the CYA cannot adequately house such individuals, that would be a violation of the ADA. (In other words, the question may be better put forward as: If wards with mobility impairments are not being sentenced to the CYA, where else are they going and what programs are available to them?) During my site visits, I found no creditable evidence that the CYA was party to such a policy. However, my scope of inquiry did not include an evaluation of the juvenile justice system to determine if other entities or agencies might be.

For the purpose of my areas of inquiry, I primarily evaluated the programs and services I observed and their affect on the known wards with mobility impairments, which albeit was a small number, but still represented a range of disabilities. However, at a secondary level, I also evaluated program access for those currently non-existent wards with mobility impairments that were underrepresented in the overall population, assuming that their presence could indeed be a reality at any time.

(b) Wards with visual impairments

During my site visits, it is believed that there were at least 25 and possibly as many as 50 wards with visual impairments. (It should be noted that CYA's Outcome Measure Report for the Fiscal Year 03-04 lists as many as 39 wards with vision impairments for the greatest incidence in one month, with as few as 16 in the lowest month. While fluctuations are to be expected, it is unclear why the fluctuations are this great.) The exact number is unknown, and relates to the larger issue of an accurate determination of a "qualified individual with a disability", as discussed previously. My work scope did not include a need to identify all such wards, even if such had been practically possible, which it would not have been. I had some degree of review or interaction with or formally interviewed about 12 wards with visual impairments. Three of these individuals were blind in one eye, one individual had macular degeneration, one individual had retinal nerve damage, and the remainder had varying degrees of low vision or other visual impairments. These individuals were housed at Close YCF, Chaderjian YCF, SYCRCC/Norwalk, Stark YCF, El Paso de Robles YCF, and Preston YCF.

In general, it appeared to me that the CYA was doing an adequate job of identifying and recording wards with visual impairments, with one major exception. This involves the ineffectiveness of low vision screening through the medical intake procedures, as discussed further in Section 4.2. Once such wards are identified, it is my opinion that the CYA is doing an inadequate job of providing accommodations and/or auxiliary aids to wards with visual disabilities. In addition, the medical services components are not proceeding effectively with appropriate treatment or other medical procedures, with long-term negative effects being a real possibility in a number of cases.

(c) Wards who are deaf or hard of hearing

During my site visits, it is believed that there were approximately 25 wards who were deaf or hard of hearing. (The CYA's Outcome Measure Report for the Fiscal Year 03-04 lists only the category "Hearing Aid" with between 3 and 11 wards listed, but I believe the number of those who are hard of hearing is actually higher.) There were two known wards who were deaf with no hearing acuity. My work scope did not include a need to identify all such wards, even if such had been practically possible, which it would not have been. I had some degree of interaction with or formally interviewed about 12 wards who were deaf or hard of hearing. These individuals were housed at Close YCF, Chaderjian YCF, Ventura YCF, Stark YCF, and El Paso de Robles YCF.

In general, it was unclear if the CYA was doing an adequate job of identifying and recording wards who are deaf or hard of hearing. Once such wards are identified, it is my opinion that the CYA is doing an inadequate job of providing accommodations, program modifications, and auxiliary aids and services to wards who are deaf and hard of hearing, as discussed in Sections 4.2 and 4.8. Also, the medical services components and the mental health treatment programs are not proceeding effectively with appropriate medical procedures and other treatment, with long-term negative effects being a real possibility in some cases.

(d) Wards with mental, emotional, or learning disabilities

Based upon statistics from special education records, psychiatric and psychological records, and my own observations, I have estimated that at least 1,400 and potentially as many as 2,000 wards have mental, emotional, or learning disabilities, as defined by the ADA and Section 504. While these disabilities are not necessarily similar and represent diverse needs, the intent of this section is to generally depict the numbers of wards involved, and my observations did not allow me to be able to break down these numbers more definitively. These numbers would generally include, but not be limited to, those wards who are currently identified and/or undergoing treatment programs, as well as wards enrolled in special education. It is possible that the number is higher, as the Stanford/Steiner Report seems to indicate. The exact number is unknown, and relates to the larger issue of an accurate determination of a "qualified individual with a disability", as discussed previously. My work scope did not include a need to identify all such wards, even if such had been practically possible, which it would not have been. I had some degree of interaction with or formally interviewed at least 35 wards who were believed to have mental, emotional, or learning disabilities.

In general, I found that the CYA was using reasonable efforts to attempt to identify such wards; however, due to the sheer numbers involved and the lack of necessary resources, there are certainly a number of wards that are not identified at all or who are mis-identified. Once identified, it is my opinion that the CYA is doing an inadequate job of providing services to

wards with mental, emotional, or learning disabilities, as discussed in Sections 4.3 and 4.6. Overall, the mental health components are not proceeding effectively with treatment programs, primarily due to a mis-allocation and/or a lack of available resources.

(e) Wards with specific diseases or other conditions

It is believed that that as many as 100, and possibly more, wards have disabilities related to their diseases or limiting health conditions, as defined by the ADA and Section 504. The exact number is unknown, and relates to the larger issue of an accurate determination of a "qualified individual with a disability", as discussed previously. My work scope did not include a need to identify all such wards, and such an extensive review of detailed medical files and diagnoses would have been impossible for my allocated extent of work. I had some degree of interaction with or formally interviewed several wards who were believed to have such disabilities.

In general, I found that the CYA was using reasonable efforts to attempt to identify such wards. However, there are certainly a number of wards that are not identified at all or are mis-identified. I do not have an informed opinion about the CYA's medical treatment of these wards, but do believe that many of these wards are not advised of their rights and protections under the ADA.

3.2 ADA Title II Requirements

As a state government public entity, the CYA has various obligations under Title II of the ADA, the part that regulates state and local governments. Title II of the ADA is similar to Section 504 of the Rehabilitation Act of 1973, but differs in that Section 504 applies only to government agencies that receive federal financial assistance. The purpose of Section 504 is to ensure that no otherwise qualified individual with disabilities shall, solely by reason of his or her disability, be discriminated against under any program or activity receiving federal financial assistance. The ADA specifically states an intent not to apply lesser standards than are required under other federal, state, or local laws; therefore, the law which is the most stringent has precedence. This intent has particular application with respect to the CYA's obligations under Section 504 or under Title 24 of the California Code of Regulations, which in some cases, exceed ADA requirements with respect to structural and physical changes.

Title II of the ADA mandates that public entities may not require eligibility criteria for participation in programs and activities that would screen out persons with disabilities, unless it can be proven that such requirements are necessary for the mandatory provision of the service or program. A public entity must reasonably modify its policies and procedures to avoid discrimination toward persons with disabilities. However, if the public entity can demonstrate that a modification would fundamentally alter the nature of its service, it would not be required to make that modification. The lone exception to these requirements would be because of undue hardship. "Undue hardship" is defined in the ADA as an "action requiring significant difficulty or expense" when considering the nature and cost of the accommodation in relation to the size, resources, and structure of the specific operation. Undue hardship is determined on a case-by-case basis.

Under Title II, public entities are required to prepare a self-evaluation and transition plan to assess its program and services to assure that all potentially discriminatory practices are identified and removed. They are required to designate a person to be responsible for coordinating the implementation of ADA requirements and for investigating complaints of alleged noncompliance. The ADA states that a public entity is required to make available to applicants, participants, and other interested parties information regarding the self-evaluation and transition plan and its applicability to the services, programs, or activities of the public entity.

A public entity is required to apprise its program recipients as well as the public of the protections against discrimination afforded to them by the Title II of the ADA, including information about how these requirements apply to its particular programs, services and activities. A public entity that employs 50 or more persons is required by the ADA to adopt and publish grievance procedures providing for prompt and equitable resolution of complaints alleging any action that would be prohibited.

DOJ regulations describe the requirements for "program accessibility". A public entity shall operate each service, program, or activity, when viewed in its entirety, so that it is accessible to and usable by individuals with disabilities. The ADA does not necessarily require the public entity to make all of its existing facilities accessible, nor does it require a public entity to take any action that would fundamentally alter the nature of a service, program, or activity. There are various methods that may be appropriate for providing "program accessibility".

Under Title II of the ADA and Section 504, the term "program or activity" embraces all of the programs, activities, and services offered by a covered entity in fulfillment of its mission. A public entity must also consider the entire scope of its overall operation as one program made up of several parts or elements. In conducting the program review, it should examine each of the parts or elements that make up the whole. The public entity should ensure that its entire program is readily accessible to and usable by individuals with disabilities.

With respect to existing facilities, a public entity may not make only one facility or a limited portion of facilities accessible if the result is to segregate persons with disabilities in a single setting. Also, where special programs offering different curricula or treatment techniques are available, the range of choice provided to persons with disabilities must be comparable to those offered to persons without disabilities. For support facilities, such as restrooms, drinking fountains, and parking spaces in existing facilities, sufficient numbers of these accessible elements should exist that are reasonably convenient, usable in inclement weather, and appropriate to the use of a facility. Usage of facilities is also an important factor in addressing program accessibility concerns. Buildings in which an individual may spend extended periods of time should meet a higher degree of accessibility than those in which an individual spends relatively short periods of time.

Although nonstructural methods of achieving program accessibility are acceptable, nonstructural solutions should not have the effect of segregating people with disabilities or compromising their dignity and independence. In choosing among various methods for achieving program access, a public entity must give priority to methods that offer programs or activities in the most integrated setting appropriate.

It is important to understand that whether a particular program or activity is accessible is determined not by compliance with an architectural accessibility standard but by considering whether the program or activity, when viewed in its entirety, is readily accessible to and usable by individuals with disabilities. However, in an assessment of program accessibility in existing facilities, facility accessibility standards such as the Americans with Disabilities Act Accessibility Guidelines for Buildings and Facilities (ADAAG) or the State of California Building Code accessibility code items (usually referred to as Title 24) may be used as a guide to understanding whether individuals with disabilities can participate in the program, activity, or service.

Before responding to the specific areas of inquiry as described in Section 4, it is appropriate to attempt a correlation between physical and programmatic access. In the context of the *Farrell v. Harper/Allen* matter, a previous review of architectural accessibility was undertaken and reports prepared by another expert consultant, Access Unlimited. These reports include detailed access barrier surveys for five of the facilities I visited (Ventura YCF, SYCRCC/Norwalk, N. A. Chaderjian YCF, O. H. Close YCF, Dewitt Nelson YCF), but did not include three of the facilities (Heman G. Stark YCF, El Paso de Robles YCF, and Preston YCF). My scope of work did not include any detailed architectural barrier identification, but rather, I was to utilize the previous reports. My scope of work involved access to programs and services, not access to facilities. Nevertheless, there are overlaps between the two areas, particularly where a physical location houses a necessary program or service in a unique location. My report typically will note, on a general level but not at the detailed level included in the architectural barrier reports, where physical barriers interfere with program access. It does not dictate final architectural solutions, or even indicate if alternate programmatic solution may be available. Therefore, it is incumbent upon the CYA to correlate the two reports (as well as complete architectural barrier surveys at the three facilities not covered in the Access Unlimited reports) and to prioritize the required barrier removal activities.

3.3 ADA Coordinator(s) Position and Duties

Under Title II of the ADA, any public entity with fifty or more employees must designate at least one employee to coordinate ADA compliance. The regulations refer to this person, or persons, as the "responsible employee or employees", but the more commonly used term is "ADA Coordinator(s)." It is important to note that public agencies that are subject to Section 504 and employ fifteen or more persons must designate at least one person to coordinate their Section 504 compliance activities. The same individual can coordinate ADA and Section 504 compliance activities.

The ADA Coordinator is the key player in ensuring ADA compliance. The ADA Coordinator's role includes planning and coordinating overall compliance efforts, ensuring that the implementation is completed, and receiving and investigating complaints related to discrimination on the basis of disability. To fulfill the job duties, the ADA Coordinator must have the authority, knowledge, skills, and motivation to implement the regulations effectively.

One purpose of this requirement is to ensure that members of the public (or in this case, wards and guardians) can readily identify a person who is familiar with ADA and Section 504 requirements and can communicate those requirements to other key staff. It is expected that this employee will have the authority to take whatever action is needed to correct problems. It is also required, however, that the agency make an effort to prevent violations by ensuring that all of its employees and agents are familiar with their obligations. In order to ensure that individuals can easily identify the ADA Coordinator, a public entity must provide the ADA Coordinator's name, office address, and telephone number to all interested individuals.

California Youth Authority's ADA Coordinators

As described in Section 2, Methodology, it was our usual procedure during the site visits to discuss issues and procedures openly. One issue that arose, and was routinely discussed with the Superintendents at each institution, was the need for an active ADA Coordinator to oversee ADA compliance at each facility. One of the most positive of all of the CYA's responses to issues raised during the site visits was for the CYA to institute a system of interim ADA Coordinators at both the agency-wide and individual facility levels.

Effective November 10, 2004, Yvette Marc-Aurele, Deputy Director of the Institutions and Camps Branch, named Holly Bowers, Institutions and Camps Branch, and Nick Giannini, Facilities Planning Division, to serve as the Department's interim ADA Coordinators. Questions and concerns regarding ward access to programs, services and activities were to be referred to Holly Bowers, and all issues regarding physical plant accessibility were to be referred to Nick Giannini.

The recent CYA policy memorandum did not specifically address the responsibilities and duties of the two agency-wide ADA Coordinators. They should oversee a variety of tasks related to implementation of the ADA regulations and organize the CYA's on-going compliance efforts. Specific duties that I would recommend for inclusion in the ADA Coordinators' job descriptions include the following tasks (how these are divided between the two ADA Coordinators should be determined by the CYA):

1) Coordinate the development, refinement, and implementation of the policies and plans for complying with the requirements of the ADA, as well as other disability laws. Collaborate with staff from various departments in developing and reviewing plans and policies in their areas of responsibility under the ADA.
2) Develop strategies for informing employees, managers, and other groups about policies concerning the accommodation of wards, parents and guardians, employees, applicants, and visitors with disabilities.
3) Monitor and evaluate compliance with the requirements of the ADA and other disability laws. Advise and consult with managers, supervisors, principals, and the heads of the units about areas of concern and possible non-compliance with regulations. Recommend appropriate corrective action, as needed.
4) Maintain a working knowledge of legislation that is specifically related to the treatment of persons with disabilities. Maintain a working knowledge of architectural accessibility regulations and codes, including those in the Americans with Disabilities Act Accessibility Guidelines and the California State Building Code (Title 24) Accessibility Standards. Monitor federal and State of California legislation and regulations, rulings by governmental enforcement agencies, and court cases for developments that might affect policies and procedures.
5) Investigate and resolve complaints and grievances alleging either failure to comply with ADA regulations or discrimination on the basis of disability.
6) Assist legal staff or outside attorneys in response to any civil litigation on ADA matters.
7) Prepare periodic reports in response to requests by government agencies, staff, other offices, and the public.
8) Maintain liaison with the Parole Board, the Superintendent's Office, school site principals, and other administrators to promote coordination of compliance approaches, policies, and procedures regarding equal access and accommodation of persons with disabilities.
9) Collaborate with the Personnel / Employment offices to implement employee reasonable accommodation requests regarding physical access issues for staff and potential employees.
10) Collaborate with the public information office regarding issues related to press releases and public relations related to the ADA.

It was also requested in the memorandum that each Superintendent designate a person at each correctional facility that is currently in a managerial/supervisory position to serve as the Facility ADA Coordinator. As of December 10, 2004, the following have been named to these positions:

Preston YCF	Mike Roots, TTS
O.H. Close YCF	Hector Amezquita, Captain
DeWitt Nelson YCF	Scott Miller, TTS
N. A. Chaderjian YCF	Holly Bowers
El Paso de Robles YCF	Jim Bonnefield, HSO
Ventura YCF	Rod Basinger, TTS
SYCRCC/Norwalk	Liam Cowan, Program Admin.
Heman G. Stark YCF	Sandra Huyg, TTS
Pine Grove Camp	Larry McGuire, TTS
Washington Ridge Camp	Sandra Wrigth, TTS
Ben Lomond Camp	DaVirto Artis, TTS

The above Facility ADA Coordinators will be responsible for identifying wards assigned to their facility that may have a disability or impairment that would require a special service or accommodation, as well as ensuring that appropriate services are provided. The ADA Coordinator will assume a leadership role in preparing the facility for monitoring tours and compliance reviews and act as a liaison with the Department's ADA Coordinators.

A description of the Facility ADA Coordinator responsibilities, as given by the CYA in its correspondence initiating this system, is listed below:

1) Coordinate and monitor the facility's overall compliance with state and federal laws and the Disabilities Remedial Plan.
2) Establish a system to ensure communication between custody, medical/clinical, treatment and education staff regarding the needs of wards with disabilities in the facility.
3) Act as liaison between the facility and headquarters staff and other state entities.
4) Assume a leadership role in preparing the facility for monitoring tours and compliance reviews.
5) Ensure that all pertinent staff is present for monitoring tours.
6) Assume overall responsibility for the disability verification process at facilities and/or reception centers/clinics.
7) Ensure that all staff receive training and follow up training on ADA compliance and disability awareness.
8) Monitor the facility's tracking system and ensure that appropriate staff is aware of ward needs under the Disabilities Remedial Plan.
9) Ensure that the facility maintains a contract for sign language interpreter services, as well as a record of use of this service.
10) Maintain a file of all ADA complaints, grievances and appeals. Conduct periodic file reviews to identify ADA issues raised and evaluate the facility's performance.

One aspect that was unclear from the CYA's November 10, 2004, memorandum was how the current workload of those named to be Agency-wide or Facility ADA Coordinators would be modified so that they could also assume the new duties. My evaluation of the positions already held by these persons indicates that most are already at or beyond the limits of what their existing job functions entail. Acting as an ADA Coordinator should not add additional time constraints to the already stressed staff schedules. The CYA should clarify this point, and provide additional staff to take on some of the other duties of the ADA Coordinators and reduce their current workloads.

Since the November 10, 2004, memorandum came from the Institutions and Camps Branch, the application to the Parole Branch was not covered. Interviews with parole agents indicated that there were concerns even from these agents about ADA compliance. Therefore, I would recommend that at least one and possibly two (one for the north and one for the south) ADA Coordinators also be named for the Parole Branch.

Recommended Policies and Procedures

1. Make the interim Agency-wide ADA Coordinator positions, one for Program Access and one for Physical Access, permanent designations. Allot at least half-time hours to the fulfillment of the duties as described above.
2. Make the designations of the Facility ADA Coordinators permanent. Allot at least quarter-time hours for the fulfillment of the duties as described above.
3. Provide in-service training for both the Agency-wide and Facility ADA Coordinators, with training provided by outside trainers/consultants (see Section 5.1).
4. Name at least one and possibly two (one for the north and one for the south) ADA Coordinator(s) for the Parole Branch.

4. Specific Areas of Inquiry - Do wards with disabilities have access to programs and services in a manner consistent with federal and state law?

The primary scope of work for this task involved 15 specific areas of inquiry regarding access to programs and services within the CYA for wards with disabilities. The specific areas of inquiry were posed as 15 subdivisions of the basic question posed above, worded to receive either a "yes" or "no" response. As is usually the case, such questions cannot really be answered as a definitive "yes" or "no", but are best answered by gradations between. The fact is that for all of the 15 distinct areas of inquiry regarding wards programs and services, the CYA provides a reasonable degree of access in some areas and falls short of providing access consistent with federal and state law in other areas. This report has been prepared to describe those programs and policies that appear to work well for wards with disabilities, so that these can be continued and properly funded. It has also been prepared to pinpoint those areas where deficiencies are present and where the lack of compliance with applicable regulations make access to programs and services difficult or impossible for wards with disabilities. The distinction between "difficult" and "impossible" as used in the preceding sentence is a crucial one, because as explained in Section 3.1, disability regulations should revolve around the needs of the person, not a particular disability or impairment. What might be accessible for one person with a disability might not be accessible to another with a similar disability.

These 15 specific areas of inquiry are answered in the following subsections. There are often overlaps between the various areas of inquiry (for example, education and communications), and therefore some areas may be covered in other sections, with the intent being to avoid duplication.

4.1 Specific Area of Inquiry - Wards' with Disabilities Access to Screening and Assessment

(a) General Intake and Assessment

Initial screenings, assessments, and testing are currently given at the three intake facilities (SYCRCC/Norwalk, Preston YCF, and Ventura YCF), and these include a battery of interviews, forms, and tests intended to gauge a variety of potential problems and issues for incoming wards.

When a ward first enters the CYA, males currently enter either the southern intake unit at Norwalk or the northern unit at Preston. Females enter the only women's facility at Ventura. Procedures are generally standardized, although there are variations at each facility. At Norwalk, for example, medical exams are administered first, while at Preston, these are administered later in the process. Medical screening is discussed more fully in Section 4.2.

The initial orientation for a ward each facility is individual, with a case management specialist meeting with the ward to explain basic procedures. I sat in on several of these and found the CYA staff member to be cordial and effective. The standard procedure is that the ward fills out a number of forms and is also initially evaluated at this juncture. Even though IEP's and general needs are discussed, there is no specific mention of the ADA and the ward's rights under federal and state requirements. I feel that this would be a good time to briefly discuss the ADA and related disability regulations and to obtain formal consent that the ward was so instructed, preferably by one individual at each intake facility properly trained to undertake this task. However, this would not substitute for more extensive ward ADA training, as discussed later.

I will forego a description of all the procedures for screening and assessment, as there are a battery of forms for these purposes. I was not able to sit in on any actual screenings, and to do so would have most likely been inappropriate. Therefore, I do not know what procedures are followed at this juncture to assure that wards with communication issues are accommodated appropriately, or if wards are advised that they have the right to alternative formats if needed. I felt that all staff serving as initial screeners were sincere in their stated desire to accurately assess the wards' abilities and issues, and have no reason to believe that necessary accommodations are withheld at this point. Nevertheless, since the process is an extensive one anyway, I would suggest that an new initial screening form be prepared that analyzes both the ward's and the staff members ability to communicate effectively for the intake process (see also Section 4.8).

One particular form that needs amending is the Referral Document YA 1.411 that comes from headquarters. The form has a box that reads: "Medical: Communicable / Chronic Diseases / Suicidal / Handicap", with a small area for data entry. As discussed later in Section 4.2, the inclusion of "Handicap" here is inappropriate. There should be a separate box for "Disability" ("Handicap" is not a commonly accepted term and offensive to some persons with disabilities), with the most readily available information included, but certainly revisable by initial screeners.

As described in Section 4.2 regarding medical and dental services, Section 4.3 regarding treatment and mental health programs, and Section 4.6 regarding educational programs, screenings and assessments continue at various times and intervals for each individual program. I believe that one of the strengths of a number of programs is the CYA's goal to continuously assess the needs of its constituency. Probably the major issue that I had with many assessments is that wards with disabilities are not continuously apprised of their rights under the ADA and other disability laws and regulations.

Perhaps one of the best places to begin this process is during joint orientations with all wards. A model for this already exists at SYCRCC/Norwalk. At this institution, the Wards Rights Officer independently prepared a Microsoft Power Point presentation on a number of policies and procedures for new wards. This was an excellent effort that should be commended. I recall that the presentation had only a small portion dedicated to ADA and disability rights that covered some basics, but it could also be expanded to inform new wards of their rights under the ADA and describe the CYA's programs under the ADA. This presentation (with due credit to its author) could also be presented at ward orientations at the other two intake facilities and at other locations as appropriate. This topic is also discussed in Section 5.2.

(b) Psychological Testing

Psychological testing at the initial screening includes various written and verbal components, including the Suicide Risk Screening Questionnaire (SRSQ) as part of the Suicide Prevention Assessment and Response (SPAR) program. It is this form that usually triggers an incoming ward's referral to the chief psychiatrist or staff psychologist, although some ward may be referred for various other reasons, including the use of psychotropic medications, history of prior psychiatric hospitalization, or recent disturbed behavior (per TDO #03-18). While the issue of suicide is indeed a major issue that cannot be taken lightly, it appears that suicide risk or a documented history is the guiding force in further psychological evaluation. Whether or not other wards (as well as the entire institution) could benefit from an initial psychological assessment is unknown, but I would suggest that it is a process that should also occur, given the pure statistics on the number of such wards discussed elsewhere in this report and in other expert reports. The only reason this does not occur appears to be largely based on staffing resources. It should be noted that wards are sometimes referred for psychological analysis at other various times, whether by the treatment team, teachers, or other staff, so this does not represent the only opportunity for evaluation, although it would appear to be the best opportunity.

(c) Case Conferences

I attended a number of case conferences with wards with disabilities, at which a ward's progress in all treatment areas is reviewed in detail with the ward at regular intervals (at least every 120

days, and sometimes more frequently if changes to the ward's program occur). I believe these are extremely important exercises that give wards a good sense of what is expected of them.

Due to the relative informality of the meeting, I got the sense that a ward's disability would be accommodated within the meeting parameters. The conferences for wards with disabilities that I attended appeared to be appropriate in that the major issues were covered and the wards usually had the opportunity to express their own personal needs, although the wards' specific disabilities were rarely discussed. The only exception was one case conference discussed further in Section 4.8, in which the ward was never really allowed to be involved in the conference, in my opinion, largely due to a hearing disability.

(d) Parole Board Hearings

Of all the activities and meetings that I reviewed and attended, I was most impressed with the Parole Board hearings. I attended about 12 of these, both before the northern and southern Boards. These Board members have a daunting task, and I feel that they properly put the safety of the public first when arriving at the difficult decisions they must make. Beyond that, I felt they were extremely fair and open-minded, and gave deserving wards every opportunity to succeed, if they were willing to take the steps to do so.

At least seven of the hearings I attended involved wards with disabilities. I saw no evidence of any improprieties in the Board's decision-making process with these wards. In fact, the Board seemed concerned about each particular ward's disability and how the disability affected the progress made while at the CYA, albeit at a somewhat informal level.

My only concern with Board hearings is more procedural than practical. At the beginning of each hearing, the supervising Board member would sometimes ask a ward if the ward had a disability that would prevent the ward from participating fully at the hearing. This is a paraphrasing of the actual words used, which varied and sometimes did not use the most appropriate terminology. I would recommend that a more formal written question to this effect be prepared and read either by the Board member or the clerk prior to each meeting. For example, the question could read: "Do you have any physical, mental, or other disability that could prevent you from fully participating in and understanding all that is being said today at this meeting, and if so, is there any accommodation that we can provide to assist you at the meeting?"

Recommended Policies and Procedures

1. During the initial ward interviews, advise wards of their rights under the ADA and Section 504, and receive formal documentation that they have received and understood this information.
2. During the initial ward interviews and screenings, ask and determine if alternative formats for written data, auxiliary aids, or other communication accommodations are needed either for the interview itself or for subsequent screenings and assessments.
3. Provide appropriate accommodations as needed for wards with disabilities in the initial assessments and psychological testing.
4. Revise the Referral Document, YA 1.411, to include an area to describe an initial determination of "Disability", and remove the term "Handicap".
5. To the maximum extent feasible, expand the number of wards undergoing initial psychological evaluation, not limiting these evaluations to just those wards who score high on the SRSQ or are currently "high risk".
6. Expand the wards' orientation at the intake centers to include specific information about the ADA, IDEA, and wards' with disabilities rights (see also Section 5.2).
7. Provide for an open exchange of ideas during case conferences, and specifically discuss a ward's disability and how it is being accommodated at the CYA, as well as any lack of access to programs that the ward may encounter.
8. Prepare a written inquiry about a ward's potential inability to effectively take part in a Parole Board hearing due to the ward's disability, to be formally read and answered by each ward at the beginning of each hearing.

4.2 Specific Area of Inquiry - Wards' with Disabilities Access to Medical/Dental Care

An extensive and detailed health care expert's report, dated August 22, 2003, was reviewed as part of my scope of work. In the interest of brevity, I will not reiterate much of what is in that report, except to say that my observations and findings were very similar. Unfortunately, while I saw consistent improvements in a number of other areas since all of the other experts' reports, I could not document many specific improvements in the area of medical services and felt a greater degree of defensiveness of the part of medical staff than with any other group. This should signal the need for additional ADA training for medical staff. One marked exception to this statement was the medical facility at El Paso de Robles YCF. Perhaps a reason is that the new medical treatment facility there has caused the staff to re-evaluate how its services are delivered to wards, and as architects can attest, new, state-of-the-art facilities can dramatically change perspectives and related services. But under times of economic uncertainty, it must be realized that programs must still function effectively with less than ideal physical facilities, as is the case at most of the other institutions, and certainly improvements in health care delivery must be taken seriously.

Within the context of programs for wards with disabilities, an important introductory distinction needs to be made between medical care and disability. It is true that some persons with disabilities may have greater medical needs due to conditions associated with their disabilities. For example, a person with spinal cord injuries who may use a wheelchair needs to be concerned about upper body movement and exercise, as well as monitoring blood pressure and circulation. However, many persons with disabilities are very "healthy" and only need basic health care support for specific issues associated with their disabilities. This distinction is important, because often within the institutional context, "healthcare" and "disability" become almost synonymous. This can negatively affect persons with disabilities in a number of ways: (1) stereotypes about medical dependence can hamper the basic right and practical need for independent living, (2) sometimes persons with disabilities are relegated to the medical setting, a restrictive environment that may be inappropriate and unnecessary, and (3) persons with disabilities are afforded additional protections under the law, and following medical policies alone may be inadequate to afford persons with disabilities equal rights.

The above distinction is made herein, because during my visits within the CYA, while I did not document any irrefutable instance where a ward with a disability was subject to discrimination due to a misconception about the person's medical needs, it can be a problem that must be addressed. I did receive some general feedback from senior staff that medical solutions may be appropriate when really the issue was a disability access issue, but future training will hopefully provide additional insight into this perception.

There were also two instances (one at Ventura and one at Norwalk) where wards with physical disabilities were detained in the medical outpatient housing unit (OHU). I would not begin to

second-guess the medical diagnoses, and it is probable that such placement was warranted and appropriate, at least for a period of time. However, there might have also been a possibility that this physical placement was deemed necessary due to the lack of other appropriate physical locations within the facility to house these wards. (It should be noted that given the choice, most wards would possibly choose an outpatient living situation over other placements. However, such a placement, if medically unwarranted, would still be improper since the ward could be deprived of needed services as well as beneficial social intervention.)

Another issue raised during discussions with medical staff, and recommended by the health care experts, was the possibility of additional outsourcing of various medical services (including ophthalmology, pharmacy, etc.). While I am in no position to agree or disagree with how the services are rendered, I would raise some caution due to the fact that under Title II of the ADA, contractors assume the same legal requirement for full program access as the public entity contracting for the services. This raises a range of issues, such as contractual clauses, documentation, and monitoring. Traditionally, many smaller private companies are not prepared to accept and provide their services under these requirements, as Title III ADA obligations for private businesses are very different. Therefore, if indeed medical services are outsourced, procedures should be established to assure full access to these programs for wards with disabilities.

Beyond the general discussions above, there are several other on-going conditions within the institutions visited that exhibited consistent problems on a system-wide basis. These are itemized below:

(1) There does not appear to be a suitable prioritization procedure for high profile medical issues. Serious and long-term vision conditions are among the main problem areas, and these seriously affect wards with visual disabilities. Two wards I interviewed had potentially serious problems with optic nerve damage and/or macular degeneration that had not been treated effectively for some time. In addition, the health services experts' report documents two wards with serious eye problems that could result in loss of vision (it is unknown but doubtful that these are the same cases). These types of cases need to be given special handling, and procedures for identification and documentation of effective treatment need to be improved.

(2) The CYA medical clinics do not appear to be taking adequate steps to provide the most appropriate auxiliary aids (including prosthetics) to wards with disabilities under their jurisdiction. On a number of occasions, parents of wards were asked to privately provide and pay for such aids, and wards are provided with ineffective products by the medical clinics. For example, one ward at Norwalk was without the prescribed prosthetic limb, and the ward's father was reportedly attempting to procure one. Under Title II of the ADA, if a ward with a disability needs any auxiliary aid to take part in a program, such as attending school or treatment programs, participate in recreational activities (even if they are adaptive physical education programs), or

work in free venture programs (note that a ward could not legally be excluded because of a physical disability), the most appropriate auxiliary aid must be provided.

(3) The CYA Temporary Departmental Order #03-12 regarding the wards' vision examination process and the issuance of glasses poses numerous problems for wards with disabilities. (A review of Section 3.1 regarding the ADA's definition of persons with visual impairments should be reviewed for additional background information.) This policy is generally overseen and implemented by the medical services programs at each facility, although the three intake facilities at Norwalk, Ventura, and Preston initially implement the assessment and procurement of glasses, if allowed by the policy.

First, the initial refraction test measures only distance vision and does not measure close reading. A distance vision of 20/50 is deemed to be acceptable by the policy, not meriting vision correction. (The policy references DMV policies, but the DMV is only concerned about a person seeing well enough to drive safely, and is not particularly concerned if a person can read a book. One would assume that the CYA is concerned how a student can see to read schoolwork, a program it offers that DMV does not.) If the CYA offers a program to wards, it must provide appropriate auxiliary aids so that wards with disabilities can take part in the program as effectively as all wards. It should be noted that the educational services assessment team at Preston does administer close vision testing for wards; however, the purpose and outcome is unclear, since it is not known that wards who demonstrate a need for glasses for reading are actually provided with them as a result of this activity.

Second, the policy allows a limited number of glasses over various time periods, with limits on how many refractions a ward may have. This policy appears to be largely punitive in nature. Even if glasses were broken by a ward due to misconduct (a rare occurrence from my observations), certainly even that would not allow the deprivation of an essential auxiliary aid necessary for daily functioning. One ward interviewed stated that he left his glasses in his locker when at the dormitory and did not take them in to his bunk to read or study at night, as other wards did, for fear of breaking them. My own opinion, which will undoubtedly appear excessive to some, is that wards should be issued two pairs of glasses, and encouraged to use them. The minor additional costs would far outweigh the greater potential costs for extra instructional time for missed work, the inability to perform work tasks properly, and extra security costs for wards who cannot see effectively.

This TDO needs to be updated with particular emphasis on a ward's with a disability rights under the ADA and Section 504. The policy tends to exacerbate or possibly even create a ward's disability by not providing a reasonable degree of visual acuity.

(4) It is unknown what effect the use of mace has on wards with visual disabilities. A number of wards who had documented vision problems complained that macings caused a marked decline

in their visual acuity. It should be realized that this report is not intended to evaluate either general correctional practices or medical diagnoses. However, where a particular activity has the potential of negatively affecting wards with disabilities to a greater (and possibly debilitating) extent when compared to the affect on other wards, that must be a concern of this report. I would recommend that the CYA take steps to medically evaluate these affects and take the necessary steps to implement alternative measures of restraint on these wards, when and if appropriate.

(5) For the purposes of this report, wards with diseases and conditions covered by the ADA are not being advised of their rights and of the CYA's obligations under Title II of the ADA. HIV testing and protocols are out of date. Counseling and treatment programs for many of the covered conditions are non-existent.

With respect to the dental services provided to wards, it appeared that the programs were no less effective for wards with disabilities than for the general population, and there was no evidence that wards with disabilities had less than equal access to these services.

Recommended Policies and Procedures

1. Train medical staff to recognize the nature of disability issues and independent living goals, as well as protections afforded to patients with disabilities under the ADA.
2. Prepare an "action plan" for wards with mobility 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.
3. If any medical or pharmaceutical services are to be outsourced, institute training and monitoring for the private service providers to assure compliance with ADA Title II requirements.
4. Review and improve procedures for the identification and documentation of treatment for cases involving wards with disabilities who have serious, and potentially worsening, medical conditions.
5. Review and improve procedures for selecting and procuring the most appropriate and effective auxiliary aid, such as prosthetics, required for participation in programs due to a disability or medical condition, , and provide these at no expense to the ward or family.
6. Revise Temporary Departmental Order #03-12 to provide for the evaluation of close vision necessary for reading and completing schoolwork or other required written activities and to procure suitable glasses, contact lenses, or other aids for the ward's constant use, if needed.
7. Provide a medically appropriate evaluation of the effect of mace on wards with visual impairments and take the necessary steps to implement alternative measures of restraint on these wards, when and if appropriate.
8. Advise wards with medical conditions or diseases of their rights and of the CYA's obligations under Title II of the ADA.

4.3 Specific Area of Inquiry - Wards' with Disabilities Access to Treatment Programs

The CYA operates under the premise that all wards have the right to appropriate treatment necessary to assist wards in returning to a productive life after their commitment time is completed. I was consistently impressed that staff members exhibited a strong commitment to this objective. It was clear that staff were predominately interested in the rehabilitation of the wards and not in a punitive approach to their confinement.

Treatment programs were varied and often extensive. These programs include various degrees of mental health treatment and counseling programs, sex offender treatment programs, substance abuse treatment programs, and other treatment programs, as described in more detail below.

(a) General Mental Health Treatment Programs

I was provided with two previous authoritative mental health reports regarding programs for wards who have mental health issues (Stanford/Steiner Report, 1990, and Mental Health Experts Drs. Trupin and Patterson Report, 2003). As described in Section 3.1, federal and state disability regulations would classify the vast majority, if not all, of these wards as "qualified persons with a disability" under both Section 504 and the ADA, as well as an "individuals with special needs" under the IDEA. (Again, determination of a disability is dependent upon the individual, not the disability category.) Since these previous reports are extensive and have already been considered by the CYA in its ongoing remedial plans, it is not my intent to cover much of the same ground, since in general, I am in a basic agreement with much of the content of these reports. Rather, this section is intended to focus on the following:

(1) a review and evaluation of general mental heath issues from a disability perspective (i.e., how the applicable disability regulations require equal treatment of wards with mental disabilities) as opposed to a clinical perspective,
(2) a review and evaluation of those few areas where either polices have changed since the previous reports, or new procedures or information have been encountered,
(3) a review and evaluation of a few areas not covered in the previous reports, and
(4) a review and evaluation of those few issues where I am not in full agreement with the findings or recommendations of the previous reports.

Psychiatrists and Psychologists

I interviewed and reviewed the work of at least one, and in some cases as many as four, psychologists at each institution I visited. I interviewed only one psychiatrist, since usually there were no psychiatrists available during my site visits, as most work part-time. My general impression regarding psychologists is similar to that of the teachers that are discussed later. They are extremely dedicated and committed to treating the wards, and utilize exceptional skills in dealing with the extent of the daily problems they encounter with wards. The only real

problem regarding psychologists, again like the teachers, is that there are just not enough of them. CYA psychologists currently carry caseloads that are double to triple those of their counterparts in private practice or appropriately funded institutions. They all have their own techniques for dealing with the "onslaught", and given the limited resources they have, I would not question their individual approaches to their work. While the mental health experts' report cites a lack of a consistent approach as being a problem, a generalized situation with which I would probably agree, the reality is that when appropriate and consistent standards for the CYA are constructed, they will have to be based on accepted standards for allowable caseload. Unless substantially more mental health professionals are provided, the results will be far less than optimal. Most of the problematic issues described below are directly attributable to the lack of appropriate mental health staffing, and resolutions of these problems will not be realistic until staffing levels are increased or re-allocations of these resources are made.

Treatment Planning

The mental health experts' report deals with the issue of comprehensive treatment planning and states that effective planning was not evident at the time of the report. It is possible that the current Special Program Assessment Needs (SPAN) was not fully implemented at the time of their report, but is now in use at all three intake facilities (Norwalk, Preston, and Ventura, although of the three, Ventura's implementation appears to be more consistent). The assessment appears to be basically a good one. For the purposes of this report, the main drawback to the procedures and forms utilized in the SPAN process is that there is not a specific identification of disability, as defined under the ADA or Section 504. As discussed in other sections, while it is not appropriate to view how a disability is treated without focusing on the individual with the disability, there is nothing wrong, and it can certainly be advantageous, to clarify an individual's disability at this point of assessment. This is as advantageous for treatment purposes as it is for case management purposes, particularly with the newly implemented ADA Coordinator process - it is important for all staff to know that the ward in question has certain rights under the ADA and Section 504.

It also appears, as hinted at but not specifically stated in the mental health experts' report, that treatment options at this early planning stage are limited. Often, it appears that available programs take precedence over the specific needs of the individual. This is not to imply that whole new programs need to be developed for each individual ward with a mental disability. However, typical interventions must be modified as necessary.

Case Management and Conferences

The mental health experts' report found that case management standards were inconsistent. It appeared to me, based upon my attendance in case conferences and review of those records, that there have been some improvements in this area. However, while consistency of case

management is desirable from an administrative and possibly even a clinical standpoint, individual treatment for a ward with a disability can get lost. I sat in on a number of case management conferences with wards with disabilities and found that treatment and other issues specifically related to the ward's disability were not usually included in the assessment. While it would be potentially discriminatory to hold a management conference *because* of a ward's disability (when wards without disabilities did not have such conferences), it is certainly acceptable and advisable to focus a part of the case management conference on how a ward's individual disability is being accommodated in the treatment programs. At these conferences, a ward's disability was almost consistently avoided as an almost "taboo" subject, perhaps under a fear that discussion of it would somehow be improper. For example, one case conference with a ward who was severely hard of hearing never mentioned the subject to ascertain if services were being provided in a manner that the ward could easily access.

Psychotropic Medications

The use of various medications, including psychotropic, was potentially one of the most problematic of all mental health procedures that I reviewed. I agree with the mental health experts' report that standards for the review and usage of medications is cursory at best. But while that report and the CYA's approach takes a clinical approach of using medication to treat target symptoms, the overall effects on the individual is neglected. Measurement of the effect to the individual, as well as the target symptoms, is lacking. While the formalities of consenting practices appeared to be acceptable, it was not clear that wards really understood the overall effects of their medication. The majority of interviewed wards who were taking psychotropic medications did not seem to know why they were taking them. Wards also complained of a number of side effects, including sleepiness, general malaise, inability to concentrate, and in other cases, extreme agitation, most of which they felt (correctly or incorrectly) were directly attributable to their medication.

It was unclear that psychiatrists or psychologists had any serious concerns on growing universal concerns about the potential overuse and negative side effects of Selective Seratonin Reuptake Inhibitors or SSRI's (including increased agitation and at worst, suicidal tendencies, as well as severe withdrawal symptoms) for the treatment of moderate anxiety and/or depression for wards under the age of 20. Perhaps this concern is more pronounced in the context of my report, since wards with disabilities may be more often subjected to misdiagnoses because of manifestations of their disability. I would recommend that these prescriptions be re-evaluated and closely monitored on an on-going basis to assure that such medications meet the needs of the individual and are not used primarily for behavior or mood control.

Suicide Prevention

It is unclear if the current suicide prevention (SPAR) process was in effect at the time of the mental health experts' report. The diagnostic process and forms appeared reasonable, but I would not venture an opinion on the effectiveness of the procedures on such limited and short-term observation. The mental health experts' report (and other referenced sources) recommended not isolating youths with suicidal tendencies, but that technique appeared to be the normal intervention method at the time of my visits. The previously identified problems of overuse of SPAR's and chemical restraints, as well as the lack of alternatives such as verbal de-escalation, are of additional concern within the context of this report, since these problems tend to disproportionately affect wards with mental disabilities.

(b) Sex Offender Treatment Programs

Certainly many wards in sexual offender programs are also wards with disabilities, but as discussed in Section 3.1, applicable regulations and practices would not define the commission of a sexual offenses in the broadest context as a disability. It should be noted that several written psychological evaluations I reviewed contained the designation "Sexual Offender" after the heading "Disability:", which I would characterize as a mis-categorization, unless one could draw a direct parallel to a particular mental or physical impairment that would cause the behavior. However, one interesting question is whether such a designation, even if inappropriate, would meet the criteria for one "being regarding as an individual with a disability." My own opinion is that it could, but I also feel the better overall approach would be to provide additional guidance and training so that such designations can be more appropriate in the future.

I reviewed these programs in general, particularly within the context of wards with disabilities, but did not feel it appropriate or necessary to evaluate the details of each program. The programs appeared to be well organized and thoughtful, although I certainly could not evaluate their overall effectiveness. It is unfortunate that the "waiting list" for these programs is too long, again evidencing that more resources and funding are drastically needed. What was most important to my scope of inquiry was that the programs appeared to integrate wards with disabilities at an appropriate level, and I could find no evidence that any ward was denied access to these programs solely on the basis of their disability. In fact, many wards with physical disabilities that I interviewed (almost 30%) had either been or were currently in one of these programs.

(c) Drug/Alcohol Treatment Programs

Substance abuse may or may not be a determining factor in deciding if an individual has a disability, as discussed in Section 3.1. That discussion will not be repeated here, but suffice it to say that many wards in substance abuse programs are also wards with disabilities, either directly because of past substance abuse, of mis-characterization, or unrelated impairments.

I reviewed these programs in general, particularly within the context of wards with disabilities, but did not evaluate the details of every program. The programs appeared to be comprehensive, although I could not evaluate their overall effectiveness. Again, more resources and funding are drastically needed, since there are more applicable wards than program vacancies (it has been estimated by others that as many as 85% of all wards have substance abuse issues). What was important to my scope of inquiry was that the programs also integrated wards with disabilities at an appropriate level, and I could find no evidence that any ward was denied access to these programs solely on the basis of their disability. A number of wards I interviewed, with physical and mental disabilities, had either been or were currently in one of these programs.

(d) Intensive Treatment Programs (ITP)
(e) Special Counseling Programs (SCP)
(f) Special Management Programs (SMP)

I realize and am somewhat apologetic for the fact that evaluating these programs together is not fully appropriate and possibly does a disservice to the different approaches and techniques used to serve wards with the most serious range of both behavioral issues and mental disabilities. However, my evaluations of these programs are so similar that in the interest of lack of repetition, I am doing so.

The ITP's serve wards with the most critical behavioral concerns and mental disabilities, while the others programs serve less crucial needs. I interviewed a number of wards in these restrictive programs and reviewed the complete files of these and other wards. In some cases, it is apparent that such placements are warranted, as these wards either pose a real danger to either themselves or others or require an intensive degree of intervention on many levels. In other cases, the rationale for inclusion in these programs is less clear. There are certainly histories involved with each ward that transcend the written documentation or the limited contact that I was able to have with each program and individual wards. I would only raise a significant degree of caution to the CYA that criteria for inclusion in these programs should be reviewed in a detailed manner to assure that wards are not placed in these programs inappropriately.

For the purpose of this inquiry, I would stress caution, where wards with disabilities are placed in these programs, to assure that placement is not based either directly or indirectly on a ward's physical or mental disability, or upon manifestations of that disability. Two of the wards I interviewed who were in these restricted programs had physical disabilities, and it was unclear to me that such a placement would have been warranted, based on the limited information I had, if the disability had not been present. The CYA should make sure that wards with physical disabilities are not placed in these programs out of convenience or because accommodations are easier to provide in these settings. For wards with mental and emotional disabilities, it was much more difficult to gain specific information about specific wards and the extent of their

disabilities, but the same assurances should be included to make sure that wards with these disabilities are not placed in restrictive programs because of manifestations of their disabilities.

In this context, I have concerns about some items included in the August, 2003, Draft of the "Youthful Offenders with Disabilities" policy. (It should be noted that I have not specifically evaluated or relied upon information contained in this document in my evaluations, since it is labeled "Draft", and to my knowledge, has not been disseminated as policy to staff. However, at some level, I feel the material could represent the current thinking of the CYA with respect to these issues.) In "General Levels of Care", under "Specialized Counseling Program: Mental or Physical Impairments Level of Care: The youthful offender (a) exhibits either acute or long-term manifestation of mental or physical disorders at a level greater than what can be reasonably addressed within general population, (b) (omitted for brevity), (c) may be vulnerable to victimization by more sophisticated youthful offenders." These characterizations are discussed in Sections 3.1 and 3.2, but in general, it is unclear why manifestations of a disability could and should not be addressed in less restrictive settings and what would constitute "reasonably", as well as what degree of "protection" a person with a disability requires. I have similar concerns over some of the items included in the "Intensive Treatment Program Level of Care" and the "Intermediate Inpatient Level of Care". The entire section entitled "Impairments Classified and Placement Designated" should also be reviewed within the context of Sections 3.1 and 3.2 of this report. Again the ADA requires evaluation of an *individual* with a disability, not evaluation of an isolated impairment. The CYA should establish polices to assure that wards with disabilities are placed based upon the needs of the individual and that the individual actually requires restrictive placement.

Of all of these programs visited, the Sequoia Specialized Behavioral Treatment Program at Preston YCF stands out as an innovative approach to treating wards with severe behavior and violence problems. While the results are inconclusive as to the overall effectiveness of this program, such approaches should be strengthened and resources re-allocated to support similar restrictive programs at other sites. For example, such an approach could be effective for wards with serious developmental disabilities (those traditionally labeled as mentally retarded or with low IQ), as the current trend toward relegating such wards to more restrictive programs is clearly inappropriate and ineffective, and a new treatment model is needed.

Recommended Policies and Procedures

1. Evaluate how resources can be increased or re-allocated to increase the number of qualified psychiatrists and psychologists in nearly all treatment programs.
2. Focus a part of all case management conferences on how a ward's individual disability is being accommodated in the treatment programs.
3. Make sure that wards understand the rationale and side effects of prescribed psychotropic medications.

4. Evaluate and closely monitor the use of psychotropic medications, particularly SSRI's, for wards under the age of 20 on an on-going basis to assure that such medications meet the needs of the individual and are not used primarily for behavior or mood control.
5. Evaluate the potential overuse of SPAR's and chemical restraints, as well as the lack of alternatives such as verbal de-escalation, when dealing with wards with disabilities who may present suicidal tendencies.
6. When determining disability eligibility for wards who have been sex offenders or who have a substance abuse history, evaluate the individual ward's condition, as described in Section 3.1.
7. 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 upon manifestations of that disability.
8. Establish polices to assure that wards with disabilities are placed in restrictive programs based upon the needs of the individual and that the individual actually requires restrictive placement.
9. Encourage new treatment approaches, such as the Sequoia Specialized Behavioral Treatment Program at Preston YCF, to serve wards with severe behavior and violence problems, as well as those with serious developmental disabilities.

4.4 Specific Area of Inquiry- Wards' with Disabilities Access to Disciplinary System (DDMS)

The CYA handles ward discipline through the Disciplinary Decision Making System (DDMS). This provides a graduated system of ward discipline that incorporates statutory and constitutional mandates and provides essential due process guarantees to ensure fairness and equal application.

Level 1 is for minor misconduct that disrupts ward programs or institutional operations, and this level allows staff the discretion to respond to ward misconduct at the lowest level. The Level 2 process is for medium to intermediate misconduct; Level 2 dispositions cannot include extensions to a ward's projected Parole Board date. The Level 3 process is for serious misconduct that adversely affects the operation, safety, or security of the institution. A sustained Level 3 violation may result in an extension to a ward's projected Parole Board date.

The basic DDMS process is standardized throughout the CYA, although some details are applied somewhat differently at individual institutions. The process is monitored via the computerized tracking system. Each institution has a DDMS Coordinator, often the program administrator or a treatment team supervisor. The initial disciplinary action report may be instituted by any staff member, but most often comes from a youth correctional officer at the living unit where a particular word is housed. The DDMS Coordinator or an authorized representative undertakes a process of fact finding, beginning with informal fact finding hearing with the ward. The word "informal" is used because there are no other persons typically present at the fact-finding hearing, although details of the hearing and the fact finder's decision are put into writing and made a part of the permanent record. The ward has the opportunity to appeal the findings of the DDMS Coordinator by appealing to the Superintendent of the institution and to an independent mediator if necessary.

Youth correctional officers and other staff member should be trained and monitored on a regular basis to assure that a particular action or behavior potentially considered as a disciplinary issue for a ward with a disability is not mis-categorized as such. For example, a ward with a communication disability may not hear particular instructions, or may not fully understand what they are supposed to do. This type of action can mistakenly be written up as a disciplinary action because of the ward's or the officer's inability to communicate effectively. Likewise, the ward may he engaged in a certain activity purely as a manifestation of the specific disability, particularly those wards with emotional disabilities, and some correctional officers may relate the behavior to disciplinary problems. This is the ongoing concern that was also discussed in the mental health experts' report, and those who deal with these wards on a daily basis need to be training to identify disability-related behaviors from actions requiring disciplinary referral. It must be acknowledged that sometimes the distinction between the two is a gray area. However, wards with disabilities need to the assured that those behaviors that are casual manifestation of the disability, for example, uncontrollable language, inability to concentrate on instructions

given, and similar manifestations, are not evaluated and disciplined purely because the disability. During my interviews with wards with disabilities, particularly those who were deaf or hard of hearing, several wards relayed a number of instances where their inability to communicate effectively appeared to be a proximate cause of the event and the resulting disciplinary action. Certainly, the possibility exists that some of these could be biased and self-serving accounts of the events, but it is likely that some of them have validity. Perhaps the best way to monitor these circumstances is for the newly appointed facility ADA Coordinators and potentially, on random occasions, the agency-wide programmatic ADA Coordinator to review selected DDMS cases involving wards with known disabilities to assure equal treatment.

I sat in on a number of fact-finding hearings during my site visits to the various institutions, and I felt that fact-finders were fair and attempted to go about their duties in an impartial manner. I believe that some of the wards had disabilities, and I felt that's that the ward's disability did not negatively impact the fairness and impartiality of the hearing. Of course, since this is an individual procedure, the possibility does exist that an individual fact-finding coordinator either might not recognize an individual ward's disability and take that into the appropriate account if necessary, or might potentially discriminate against a ward with the disability by misconceptions about that ward's behavior or other issues. However, since the ward has a right to appeal, I feel the likelihood of such improper activity is remote, and for matters of expediency, agree that the current process is acceptable. My observations and interviews with DDMS Coordinators also confirmed that wards with disabilities were generally accommodated for any communication needs that might be necessary.

Recommended Policies and Procedures

1. Provide additional training on the ADA and Section 504 to DDMS Coordinators and other fact finding staff so that they can better identify those wards with disabilities in the fact-finding hearings, and so that there is no unintentional discrimination against the ward in the fact-finding process due to the ward's disability.
2. Once a ward's disability is identified during the DDMS fact-finding process, the ward should be advised of the rights afforded to the ward under the ADA and Section 504.
3. Include in the list of duties for the facility ADA Coordinators and potentially the agency-wide programmatic ADA Coordinator to review selected DDMS cases involving wards with known disabilities to assure equal treatment.

4.5 Specific Area of Inquiry - Wards' with Disabilities Access to the Wards' Rights Process

Wards rights and grievance procedures within the CYA generally involve a formalized system of computerized grievance forms and the review of those forms by selected staff. The system is standardized among all institutions; however, variations occur from facility to facility. Each individual living unit typically has a ward grievance clerk. This ward's main task is to distribute and collect grievance forms from other wards. The ward grievance clerks are generally selected from among those at the highest level of acceptable behavior and independence at each living unit. The clerks are provided with a number complaint forms that must be accounted for at all times; the grievance forms cannot be destroyed or unused, as each has its place within the computerized tracking system. Once a ward fills out a grievance form, it is given back to the ward grievance clerk who forwards it either to the senior correctional officer on the unit or directly to the institution's Grievance Coordinator. There are some exceptions to this, such as ward grievances against that staff; these are usually given back to the senior correctional officer at the housing unit, although at some institutions they are sent directly by the wards to the Superintendent.

As described in the ward grievance policy in Form YA 8.451, the ward grievance clerk may discuss the grievance with the ward before the form is accepted. This could be problematic, in that ward grievance clerks may use their own personal judgment or other subjective ideas they may have in an effort to influence or dissuade a ward from submitting the grievance. While there is no definitive evidence that this is a rampant problem, there was some indication that this might be occurring at some level.

The Ward Grievance Form YA 8.450 appears to be a reasonably good form, with one possible exception. There is no place on the form to distinguish whether a particular grievance is based upon or is the result of a particular ward's disability. There are some overall basic issues regarding grievances as these procedures are required and described under the ADA and Section 504. Whether or not the grievance procedures required by ADA and Section 504 are required to be separate from the other grievance procedures is and has been an unresolved issue ever since the advent of the ADA. While the ADA may not specifically require that disability grievances be separated, there are indications that such is preferable under ADA regulations. Furthermore, anecdotal and procedural evidence from a wide variety of public entities indicates that a disability grievance procedure is difficult to implement and monitor unless it is indeed a separate process. Usually, for most public agencies, I feel that a separate grievance procedure is warranted. However, in this instance, since such a formalized grievance procedure is already in place and wards are familiar with it, I feel it could be acceptable to modify the current procedures by including disability-related information and reviewing such complaints in a somewhat different way.

There are two additional issues regarding the current grievance process. First, the ward

grievance clerks have not been given ADA training to understand the types of grievances that are allowed by the ADA, and such training is needed since the ward grievance clerks are actively involved in grievance process. The facility ADA Coordinator should be responsible for conducting basic ADA training for this purpose, either as any new ward grievance clerk is appointed, or for all clerks at least once a year. Furthermore, it does not appear that facility Grievance Coordinators have been training specifically with the ADA-required grievance process; and this training is absolutely needed. Second, the facility ADA Coordinator is not currently involved at all in the grievance process. The ADA is clear that if a grievance is related to a disability, the ADA coordinator should monitor and ideally be involved in the initial determination of whether or not the grievance is accurate. Because of these reasons, I would recommend the following procedures being implemented, either as part of the current grievance procedure, or as a separate process, to assure that wards with disabilities have open access to the grievance process, as required by the ADA.

Recommended Policies and Procedures

1. Those ward grievance clerks and facility grievance coordinators involved in the distribution and collection of grievance forms should be trained in basic ADA grievance policy.
2. The grievance forms should be amended to include a section of questions that specifically ask if the ward feels that the grievance is based upon circumstances related to a disability, and if the ward is filing the grievance under the requirements of the ADA or Section 504.
3. All completed grievances for which the ADA and disability are listed as an issue or contributing circumstance should go directly to the facility ADA Coordinator at each institution for consultation, or more appropriately, for resolution.
4. Completed grievance forms should be randomly monitored by the facility ADA Coordinator to determine if indeed disability is an issue, even though it may not have been specifically cited side by the ward filing the grievance.
5. All grievances involving or against that any staff member should be submitted directly to the Superintendent and reviewed in a confidential manner, and not submitted through any other party, similar to the staff grievance procedure at SYCRCC/Norwalk.
6. All grievances should be reviewed by someone who is not a party to the grievance. For example, if a grievance alleges problems with a medical procedure, that grievance should not be forwarded to and reviewed by the medical services team, or anyone involved in the medical programs, although certainly, the medical services team should be contacted as part of the fact finding process.

4.6 Specific Area of Inquiry - Wards' with Disabilities Access to Education

One of the CYA's strongest assets lies in the expertise, effectiveness, and dedication of the teachers and administrators involved in the educational programs at all eight institutions visited. I was consistently impressed with the teaching methods, lesson plans, and overall objectives of the vast majority of teachers who were interviewed and whose classrooms were visited. The major problem involved with teachers is that there are just not enough of them, and educational staffing levels at all institutions are below what they should be, with some institutions being drastically below acceptable norms. Substitute teachers are almost non-existent, and retention of credentialed teachers is becoming a greater problem, as many are leaving for higher paying jobs in the public school systems.

The educational experts' report deals with a number of issues relating to the general education programs at all institutions. Again, it should be noted these programs also greatly affect wards with disabilities since over 80% of special education students are included in at least one regular education class. In the interest of brevity and conciseness, I will not reiterate many of the issues and recommendations included in that report, as I am in agreement with the vast majority of them.

At the outset, it should be emphasized that there are a number of strong points in educational programs for wards with disabilities that need to be stressed and continued. The management of a wide variety of educational plans (including individualized education plans, or IEP's) required by students with a range of abilities and needs is a significant task, and the CYA appears to be doing a good job in organizing these educational activities. Curriculum guides, both those prepared on an agency-wide and individual teacher level, are well-prepared and appear to be generally effective. Special day class teachers and resource specialists appear to be adept at modifying curricula to meet the variety of needs of special education students. Generalized procedures appear to be in compliance with local and state regulations and standards and appear to be comprehensive and, in most cases, effective. Case conferences appear to give the proper weight on educational goals, in concert with other (and sometimes more crucial) behavioral and psychological goals.

On the problematic side, the occurrence of classes not being held is a major cause of concern. Since I visited specific institutional high schools usually only on one or possibly two isolated days, it would be impossible to translate my own observations into defensible statistics. It was quite common, however, for at least some, or in some cases all, of the scheduled classes to be suspended. Statistics gleaned from various sources, and backed up by my own observations and the educational experts' report, indicate that about 15% to 25% of scheduled classes do not meet. Reasons are complex and varied, but generally include the following: classroom or facility-wide violence and security concerns, teacher absences, lack of substitute teachers, inflexible scheduling, and other causes. It should be noted that a lack of continuity in classroom activities

is a more critical problem for many wards with disabilities and special education students, since consistency and focused activity, as well as the psychological need of expectation, are an important prerequisite for students with learning disabilities, anxiety disorders, and other conditions.

The institution exhibiting the most problems with cancelled classes and teacher absenteeism appears to be O. H. Close YCF, although N.A. Chaderjian YCF, Ventura YCF, and El Paso de Robles YCF are not far behind. Problems at Close and Ventura have the greatest negative effect, since these institutions service the younger age populations (13 to 18) during the most formative years of the educational services offered. Consistency at SYCRCC/Norwalk is also critical because of the transitory nature of the facility, and lack of consistent educational programs can start incoming wards on a negative path with respect to their educational goals.

Ward attendance is also a growing cause of concern. Up to 30% of wards in regular and special education programs are absent each day. On the positive side, the overcrowded conditions discussed in the educational experts' report were not found to be a major factor during our site visits. However, the reason may be that there has been a shift from a policy of attempting to have all students attend to a policy of keeping more potentially disruptive students away from classes. A focus on other daytime activities, such as group therapy, Board-mandated activities, and special programs like the "Feast" program at Preston YCF, is definitely a factor, and these activities should, to the maximum extent possible, be scheduled at times other than during the school day, or an extended school day should be offered. On the whole, it appears that the main reason for attendance problems revolves around real or perceived violence and gang activity by wards, an overall topic that is beyond the scope of this evaluation. One recommendation made by the educational experts' report with which I am not in agreement is that wards receive disciplinary consequences for not attending school. Certainly, wards (particularly those under 18) must be made aware that school attendance is required. However, such a policy would have a greater and disproportionate negative effect on wards with disabilities, particularly those with anxiety disorders and learning disabilities. Until such time as special programs necessary to deal with these disabilities are fully and effectively implemented, and until such time as wards can be guaranteed that they will not be the object of violent activity during school activities, such a policy would, in my opinion, be discriminatory in nature and from a practical standpoint, less effective that a system of positive reinforcement.

Listed below are specific issues related to various sub-programs, as identified in the original scope of work, and as subsequently discovered.

(a) Special Education

Approximately 25% of all wards within the CYA are registered with Special Education and have individualized education plans (IEP's). This basic statistic also includes wards above the age of

22, meaning that for the age group predominately covered by the Individuals with Disabilities Education Act (IDEA), the percentage would be even higher. (It should be noted that some adult wards over the age of 22 are still included in Special Education programs for various reasons.) The approximate percentages by institution are as follows:

O. H. Close YCF: 32%	SYCRCC/Norwalk: 33% (permanent only)
N. A. Chaderjian YCF: 28%	Heman G. Stark YCF: 15%
DeWitt Nelson YCF: 30%	El Paso de Robles YCF: 33%
Ventura YCF: 25%	Preston YCF: 28%
All institutions: 23%	

As indicated in Section 4.1, Screening and Assessment, the vast majority of wards with IEP's come into the CYA with an active IEP from their previous school district. The CYA has a rigid policy of not accepting a ward with an IEP unless a copy of the IEP is with them upon entrance. It appears that the CYA does a good job of enforcing this policy, and I am in agreement that such enforcement should be continued, within reason, since having a ward's IEP at the initial assessment is crucial to effective placement. The potential negative aspect of such a policy is that an incoming ward with a disability might be denied timely admission to the CYA solely because of errors of others (where those wards without IEP's would not be subject to such a policy) and thus subject to unintentional discrimination. What happens to a ward that is denied acceptance (e.g., whether the ward is sent back to County juvenile hall and thus also denied services others receive) is beyond the scope of this report. Therefore, I would recommend that the CYA continue the current policy but also investigate alternative ways to resolve issues of inadequate IEP records with the Counties.

As discussed in Section 4.1, initial screening and testing given at the three intake facilities (SYCRCC, Preston, and Ventura) include a battery of tests intended to gauge a variety of potential problems and issues, both general and educational. While these do not specifically pinpoint special education needs, it appears that the identification of such needs is usually a by-product of the tests and referrals are usually made, if warranted.

It is also at this point that wards are advised of their rights under IDEA. Each of the three intake facilities use the standard form YA 7.432 (1/90), "Special Education Rights Verification", in conjunction with "My Special Education Rights". (It should be noted that it appears that this form has not been updated in about 15 years, and not since IDEA 97 came into effect.) I was not able to sit in on any intake sessions where these forms were described to incoming wards. However, the forms are somewhat cursory and do not themselves convey all of the necessary information incoming wards should have about potential positive aspects of special education. Wards may have misconceptions about the process and may not be aware of the programs that special education offers. Therefore, I would recommend that an additional orientation about special education be provided, either at the general educational intake level, or at the ADA orientation level as described in Section 4.1, or both.

In general, the CYA appears to be attuned to the legal and procedural requirements of holding IEP meetings and preparing IEP's for wards enrolled in special education. As discussed in the educational experts' report and in the CDE Initial Verification Review Report, some procedural inconsistencies and irregularities were documented with respect to the timing of both initial and regular IEP meetings, particularly for those wards placed into restrictive programs, and while these were also observed by me, they will not be repeated herein. However, it appeared that improvements have been made, and in general, I found no additional pattern of neglect or abuse in holding IEP meetings on a timely basis, and irregularities were about at the same level, or possibly even less frequent, than public school systems, based upon my experience with reviewing these. Where such timing irregularities were noted, there was usually a reason having to do with correctional or behavioral issues (again, not to imply that such reasons are fully acceptable, particularly with respect to those wards placed in restrictive programs).

My main concerns with IEP's and IEP meetings do not relate to particular procedural failings, but rather with more subjective issues of providing the most appropriate settings, curricula, and accommodations for wards with disabilities. These include the following:

(1) IEP meeting times: It appears that many IEP meetings occur during school hours. These meetings should be scheduled at times when a ward does not have to miss scheduled classes. This change in policy should not create a problem with teachers or administrators involved in the IEP, since they are expected to work more than the prescribed 240-minute instruction time.

(2) General tenor of meetings: Before broaching this subject, a general discussion of meetings attended by wards is necessary. One positive aspect regarding CYA activities lies in the fact that there is a reasonable amount of dialogue with wards about their treatment and progress. These include DDMS hearings and fact finding interviews, case conferences, YAAC hearings, Board reviews, etc. Many of these meetings are undertaken because of behavioral and/or program placement issues. The demeanor at many of these meetings is authoritative, that is, wards are expected to "get with the program". In most cases, this demeanor is understandable and defensible. Such an approach, when used properly, can be a part of an effective treatment and behavioral management plan needed to make defiant and oppositional wards (of which there are many) understand that expectations while at the CYA, as well as society's expectations when they are released, are that they must conform to certain standards of behavior and expectations of progress.

However, of all the meetings held with wards, IEP meetings should be the second most open (behind psychological therapy sessions) in terms of ward involvement. From my observations, wards were rarely involved at a personal level at their IEP meetings. I do not recall that wards were specifically asked if they were getting all of their accommodations, or if other accommodations would be helpful. However, the main concern is that even if such questions

were asked, it would be extremely difficult for a ward to respond openly and effectively. Wards that I privately interviewed expressed a reluctance to express opinions at these meetings, and they exhibited a general confusion about what they could discuss and request. Furthermore, wards tended to think of the IEP meetings as another "progress evaluation" meeting. Specifically, they saw such meetings in the same vein as behavioral management meetings, and they often characterized their lack of academic progress and "grade-level" goals as "bad behavior". They also felt that their educational options were limited, a feeling with which I generally concur, as described in a later section.

I realize that much of this is extremely subjective, and certainly approaches toward wards should vary, depending upon the wards specific circumstances (thus the "individualized" in IEP). I did not sense that any indirect coercion on the part of any staff member was mean-spirited, and if it did occur, it was predominately unintentional. The most probable reason for such an approach is that IEP meetings tend to be highly procedural, with an obvious attempt to follow approved format and legal requirements. Certainly full legal compliance is necessary, but individualized attention should not be conceded as a result.

Wards need to be better informed as to the purpose, protocol, and regulations regarding IEP meetings. Additional orientation should be included as part of the ADA orientation described in Section 4.1, before IEP meetings, or both. Also, in order to rectify the concerns described above, I would recommend a stronger ward "advocate" position during IEP's, as discussed in a following section.

(3) Parent, Surrogate, or Advocate Involvement: IDEA requires that all students under 18 must be represented during IEP meetings by at least one parent or legal guardian. If a parent or legal guardian waives this right of appearance or is not available, the educational entity is required to provide a surrogate parent for purposes of the IEP. If a student is over the age 18, there is no requirement for parent, guardian, or surrogate involvement, although the student may have a representative if the student chooses. It should be noted that within the context of public school districts, it is not uncommon for students to have either legal representation and/or their private psychologists present during IEP meetings.

As described in the subsection above, it was my observation that wards typically had little input at IEP meetings. The same would be true for parents, who were usually communicating by speakerphone during IEP meetings. There was only one parent actually present for all of the IEP meetings that I attended. It was my observation that the use of a speakerphone during IEP meeting was almost totally ineffective. Parents did not have any records to review and seemed generally removed from the evaluation process. (When the word "evaluation process" is used, it not only refers to the evaluation of the student's progress under the IEP, but also to an evaluation of how well the school is meeting the individual needs of the student.) Furthermore, while it appeared that parents either had already signed or would sign the appropriate forms, most parents

appeared to otherwise possess very little knowledge about the IEP process. This is not meant to imply that the CYA or any public school district is required to undertake extensive parent training on IDEA and IEP's, although certainly more informational materials for parents seem to be warranted in these cases. The point intended is that most parents, particularly those who are generally uninformed about the process, tend to pick up most of the salient points by their physical presence at IEP meetings, and without this presence, cannot function effectively.

I have researched a reasonable amount of applicable sources and case law to determine if a school district is liable for providing the means of actual attendance for a parent at IEP meetings as part of their obligation to provide a free appropriate public education. I found several circumstances where such was provided, but the issue does not seem to be a prevalent one since most parents live within the locale where services are provided. However, I also could find no evidence that such an obligation is not required. If indeed such a legal basis for not providing parent access to IEP meetings exists, I would revise my opinion, but in the absence of such, I feel that the use of a speakerphone is not a realistic alternative for parent attendance at IEP meetings, and recommend that the CYA provide the means of travel to IEP meetings for any parent or legal guardian of a ward if requested. Also, all relevant records should be made available to the parent or guardian a reasonable time before the meeting.

I had the opportunity to meet only one surrogate parent during my site visits. This particular surrogate was a volunteer who served in other volunteer capacities at the institution. He was one of two surrogates at the institution, had been a surrogate for about 12 years, and supported about 25 wards. While he was clearly dedicated, he was mostly "self-taught" through the years of service and indicated he had received no actual training on the ADA or IDEA.

My observations of parent and surrogate participation in IEP meetings, together with the tenor of the meetings, further reinforces the need for a wards to have a more active advocate during IEP meetings. Such a concept is not unprecedented. When a ward goes before the Parole Board for consideration, the institutional parole agent basically serves as an advocate for the ward. I am recommending no more extensive representation beyond this degree of advocacy. The advocate could be a CYA staff member (correctional officer, treatment team member, staff psychologist, institutional parole agent), but the advocate should not be involved in the educational program. Each institution should have a number of such advocates, and a ward should be able to select from these. Advocates should be appropriately compensated and not burdened with these additional responsibilities without adjustments to other job duties. The presence of the advocate would not alleviate the legal requirement for parent, guardian, or surrogate presence for wards under eighteen. Advocates should meet with each ward in advance (not the same day) of IEP meetings to review the ward's concerns and any specific requests the ward may have. Completion of a pre-prepared form or worksheet by the ward and the advocate at this time would help to facilitate the actual IEP meeting.

(4) Modifications and accommodations: On the positive side, special day class teachers and resource specialists appeared to be adept at providing accommodations on a day-to-day, as-needed basis. These teachers seemed interested in meeting individual needs, and when questioned, seemed generally knowledgeable about each student's IEP, and perhaps even exceeded the accommodations listed in the IEP in special cases. The extent to which regular education teachers allowed for IEP accommodations is less clear, since it was not possible or appropriate to question them on these topics during the school visits, but I had no specific concerns in this area since most teachers had extensive lesson plans geared toward various learning levels.

On the negative side, IEP's tend to focus more on "standardized" accommodations, geared toward the specific disability than the student with the disability. The general discussion above on the tenor of IEP meetings is related to this subject. The standard IEP Form YA 7.486 (01/00) has only a small area for program modifications, and most of those provided fall into a prototypical range of accommodations (extended time, small group testing, clarification of instructions, etc.). There is little variation in accommodations described, leading one to surmise that other individualized accommodations are rare. Modifications provided usually fall within relatively narrow limits. For example, additional time for tests seems to be the most operable solution, with alternative to tests themselves (individual exercises, writings, or laboratory activities) being rarely considered.

I would recommend that the California Education Authority revise its Educational Manual to include more extensive types of program modifications that facility IEP teams could utilize in the IEP process. However, at a more philosophical level, IEP teams should be made more aware of the necessity to accommodate the individual students needs with whatever reasonable modifications that may be appropriate, irrespective of their inclusion in the types of typical accommodations recommended.

Without making transition plans a separate category, most of the same discussions as above could just as easily apply to transition plans (also covered in YA 7.486), which again tend to be more of a generalized, "fill-in-the-box" type, rather than individualized. One suggestion would be to prepare a series of sections on the form, with a first section asking, "What will make this student's transition experience unique from others?" and with a second section asking, "What activities or strategies could assist in making this transition?"

(b) Section 504 Programs

This particular subject was not included in my original scope of work, but it should be realized that a school district has obligations to students with disabilities under Section 504 of the Rehabilitation Act of 1973, in addition to IDEA and ADA. Historically, at some public school districts, a student with a disability may be excluded from appropriate services and

accommodations because the student may not meet what some feel are the more restrictive requirements of IDEA, but still are a "qualified person with a disability" under the ADA or Section 504. I did not specifically observe that such was the case at CYA school sites, but an active 504 program can sometimes be more efficient and effective for some students with specific disabilities. Furthermore, a number of students may sometimes be misplaced into special education when a 504 program may better suit their individual needs and create a greater degree of inclusion and mainstreaming.

During my site visits, I found some active 504 programs, albeit very limited. These programs may be helpful in providing alternatives to the more restrictive special education programs, particularly for those students who are over the age of 21. I would recommend that the CYA institute a program that will increase the awareness of students, parents, and facility administrators to 504 programs, and coordinate school site 504 programs so that there is consistency agency-wide.

(c) Alternative Education

This item was included in my original scope of work. Alternative education, in its most accurate form, consists of specific and well-described alternatives to standard curricula. It may include independent study programs, but is usually more precise in defining basic goals and objectives to serve a wider range of student needs. It is sometimes confused with special day classes held as part of special education programs, but its goals are vastly different, and it should be part of the regular education program (although certainly special education students could be included in alternative education programs). These programs are particularly applicable and effective for students with disabilities.

During my site visits, I saw little evidence of the presence of an effective alternative education program. There is also no significant mention of alternative education program in the Education Manual or other documents provided to me. Certain teachers and instructors had classes (mostly quasi-vocational in nature) that could be part of an effective alternative education program. However, there was no cohesive program integrating overall student goals and objective in these classes.

I would recommend that the CYA establish an active alternative education program, with an overall full-time coordinator, and develop goals, objectives, and model curricula in this area.

(d) Vocational Education

The educational experts' report cites the vocational offerings at the various facilities as being exemplary. I was also impressed the content and curriculum of vocational courses offered, the vocational facilities, and expertise and dedication of vocational teachers. I have no significant

concerns with these programs, nor would I offer any specific recommendations for improvements in these three areas.

Unfortunately, I do have major concerns about the financial and staffing cutbacks to these programs in the recent past. As good as these vocational classes are, the only problem with them is (like several other programs) that there are just not enough of them. Cutbacks have worsened even since the educational experts' reports, which is disheartening since these experts lauded the programs so highly. I was not able to ascertain the exact dollar value or percentage of recent cutbacks, and such a detailed monetary analysis is most likely beyond the scope of this inquiry. But it is clear that recent cutbacks have been major, with severe quality of education consequences. It is also clear that cutbacks have partially been the result of general downsizing and a decrease in ward population. Instead of cutting back these vocational programs in proportion to population, it would be preferable to use this opportunity to increase vocational coverage to a wider range of wards. This has not happened.

Vocational facilities are in generally good physical condition, and despite some architectural barriers that could be readily remedied, they are generally accessible to persons with disabilities. Yet during my visits, most of the vocational classrooms were not in use during the school day. Excessive school violence and greater need for security in non-classroom facilities is certainly a valid concern, but hopefully, additional funding or appropriate reallocations can help to alleviate these issues.

For the purpose of this inquiry, the effect of underutilized vocational programs has its greatest negative impact on wards with disabilities. Vocational programs can make up an important part of alternative ways of learning for many students with specific learning disabilities and other mental or speech impairments that make traditional learning methods difficult. For example, in one excellent carpentry/building vocational class at Preston YCF, the teacher effectively integrated math and reading comprehension into the daily vocational activities. Also, students with disabilities can learn valuable life and vocational skills, similar to curricula in more traditional occupational therapy programs, and gain justifiable high school credits for doing so.

It was also unclear if the Trade Advisory Committees at each facility were actively meeting per Section 4500 of the Education Manual. It appears that the cutbacks have also affected this mandated activity. If so, these committees should be re-established to deal with the declining enrollment and availability of vocational programs at each facility and to make recommendations on how these programs can be reinstated and improved.

(e) Testing

Another problematic aspects of the overall CYA special education program lies in the inability to provide either (1) effective accommodations during testing for wards with disabilities or (2)

alternative assessments where it is clear that common testing accommodations are not effective. It should be noted at the outset that this is not necessarily intended to specifically be an indictment of the CYA, because sometimes, the CYA may be provided with limited choices of accommodations for certain standardized tests, as described below. However, the CYA does have some choices in the tests it administers, in the way test results are utilized, and in the ways waivers of test results are approved.

I was able to observe, on an informal basis, individual proficiency testing of two special education students. I also asked many of the special education students I interviewed about accommodations during testing. These observations and inquiries indicated problems with the accommodations - not necessarily that they were not provided (although that was a problem in several instances), but that those that were allowed were ineffective as auxiliary aids for the individual student in the testing process.

As an example, CASAS (Comprehensive Adult Student Assessment System) proficiency tests are routinely given to special education students for various purposes. After one of the testing sessions, the proctor indicated to me that accommodations were provided to all special education students in accordance with those allowed by CASAS requirements and that in some instances, alternate test forms were provided by CASAS. Such a situation is somewhat consistent with CASAS policy, as described in the CASAS document "Guidelines for Providing Accommodations Using CASAS Assessment Testing for Learners with Disabilities." (My report does not attempt to evaluate policies of CASAS with respect to recommending accommodations, as doing so would be beyond the scope of inquiry.) Nevertheless, the CASAS document clearly states that accommodation recommendations are just that, and the testing entity must take the responsibility for appropriate accommodations based upon the need of the student. Based upon my observations and interviews, it appears that the CYA falls short in providing reasonably effective testing accommodations for many wards with disabilities, similar to be limits placed on general educational accommodations described in the subsection (a) above. The document does state that CASAS test forms are not to be altered without CASAS approval, and it seems the only alternative for students who cannot appropriately use the test forms is to not take the specific CASAS test.

Another area of concern is the state-mandated California High School Exit Exam (CAHSEE). By law, special education students must be allowed to take the CASHEE with the accommodations or modifications specified in their IEP's. (Again, the discussion of these modifications in subsection (a) applies to these issues, and in many cases, it is felt that these are not sufficient.) The law also stipulates that if accommodations are provided, the school principal must ask the school's governing board for a waiver of the requirement for a passing score without modifications. I did not find that this waiver procedure was utilized effectively. I would strongly recommend that the schools request such waivers where appropriate (which should be, in effect, for all special education students with testing modifications) and that the school's

governing body approve these waivers appropriately so that students with disabilities can receive the equivalent of a passing score in these cases.

(f) Libraries:

Libraries appeared to be in good conditions and reasonably stocked with materials at all facilities, although some were more used than others. Funding cutbacks had reduced staff at several locations, and while this is certainly not a desirable scenario, libraries could still be usable with adequate supervision and security.

Most libraries were generally accessible to students with mobility impairments, except for relatively minor barriers that could be readily mitigated (refer to the accessibility barrier surveys for details). Most libraries were mostly inaccessible to students with visual impairments, with no Braille books, no large print books, and few books on tape. In order to serve these students, accommodations would need to be provided on a case-by-case basis, although there was no evidence that such had been done for students with vision problems, or could be done effectively in the short term. For example, one ward with a visual impairment had an ophthalmologist's report that recommended the student be provided with documents in at least 20-point type, but the student indicated that this had not been done. Students who were deaf or hard of hearing would have a significant decrease in materials available, with no effective substitute for audio tapes, CD's, audio computer programs, or other audio-visual materials.

While it appeared that most libraries had a sufficient amount of materials present for the population served, a number of wards interviewed mentioned a lack of the type of pleasure reading they liked. It seems that certain books or types of books are popular among groups, and there is often only one copy. Certainly the goal of the library should be to foster reading of any type, and such a service is particularly valuable for wards with specific learning disabilities, speech and language disabilities, and developmental delays. I would recommend that the library staff (or the most appropriate teaching staff) canvas wards on a regular basis to determine what specific books are needed and budgets prepared to support pleasure reading. It was also unclear how textbooks were distributed to wards for study at the living units, and it is possible that textbooks were not always readily available, although I could not verify the exact situation in this regard.

Recommended Policies and Procedures

1. Undertake a long-term, comprehensive study on ways to improve the salaries, benefits, and working conditions of credentialed general and special education teachers, and to improve teacher attendance.
2. Undertake a comprehensive study on ways to obtain qualified (not necessarily credentialed) substitute teachers on short-term bases.

3. Re-arrange the daily schedules of students who take part in special treatment or work programs so that they do not miss scheduled classes.
4. Prepare and implement a system of positive and constructive reinforcement for good attendance for students enrolled in special education (whether such a program would be advantageous for all students is beyond the scope of this report).
5. Investigate alternative ways to resolve issues of inadequate IEP records with the Counties, so that special education students can be admitted on a timely basis.
6. Provide additional ward and parent orientation, either at the time of initial testing or at the overall ADA orientation, or both, on special education programs and individualized education plans (IEP's).
7. Schedule IEP meetings at times when a ward does not have to miss scheduled classes.
8. Conduct IEP meetings to allow a significant degree of input from wards and parents, and foster a positive environment for open dialogue.
8. Provide the means of travel to IEP meetings for any parent or legal guardian of a ward, if requested, and use a speakerphone only as an emergency alternative.
9. Provide training for surrogate parents on the ADA, IDEA, special education programs, and IEP's.
10. Provide for a CYA staff member to serve in an "advocate" role on behalf of the student at IEP meetings.
11. Revise the Educational Manual to include more extensive types of program modifications that facility IEP teams could utilize in the IEP process, but also attempt to accommodate the individual students needs with whatever reasonable modifications that may be appropriate, irrespective of their inclusion in the types of typical accommodations recommended.
12. Institute a program that will increase the awareness of students, parents, and facility administrators to Section 504 programs, and coordinate school site 504 programs so that there is consistency agency-wide.
13. Establish an active alternative education program, with an overall full-time coordinator, and develop goals, objectives, and model curricula in this area.
14. Institute policies to deal with the declining availability of vocational programs at each facility and provide recommendations on how these programs can be reinstated and improved.
15. Increase effective accommodations during testing for wards with disabilities, and/or provide alternative assessments where it is clear that available testing accommodations are not effective, including for standardized proficiency tests.
16. Where appropriate, request waivers from the CAHSEE requirements (which should be, in effect, for all special education students with testing modifications), and assure that the school's governing body approves these waivers appropriately so that students with disabilities can receive the equivalent of a passing score in these cases.
17. Revise library policies so that students with communication-related disabilities have access to alternative formats.

4.7 Specific Area of Inquiry - Wards with Disabilities Access to Recreation

Recreational programs vary at each facility, but in general, wards are offered free time to use outdoor recreational areas (basketball courts, handball courts, exercise areas, etc.) on a consistent basis. Use of indoor facilities (gymnasiums, pools) was not prevalent during my site visits, and usage is reportedly limited due to security concerns.

The major exception to open recreation noted during the site visits was for wards in temporary detention at each facility, in which case wards would get only one hour out of the individual unit per 24-hour period. This is typically accomplished by placing these wards in outdoor fenced areas, usually about 10 feet by 25 feet in size. It is beyond the scope of this report to evaluate the effect of this policy, except as it would affect the recreational needs of wards with disabilities. For wards with mobility impairments, including those persons who use wheelchairs, crutches, prosthetics, or other mobility aids, confinement to small spaces could have long-term negative health implications. At a minimum, these individuals should have regular intervals of specific and repetitive body movements to counteract the inactivity of injured or unused muscles, joints, etc. Persons with mobility impairments have individualized requirements for physical therapy and most rely on physical therapists to continuously update the necessary regimen. The lack of recreation and therapy for these wards can and most likely will have long-term negative consequences on the physical improvement of disability-related conditions or general health.

For other wards with physical disabilities, there was little indication that any adaptive education programs were in operation, although there was mention of a past program at O. H. Close YCF. For example, the pool at Ventura YCF was in use during my site visit, and this would be an excellent opportunity for adaptive programs for those with both physical and developmental disabilities. This may have been occurring on an informal basis, but I could find no record of specific adaptive physical education programs in any IEP"s.

Recommended Policies and Procedures

1. Provide the opportunity for wards with physical disabilities to engage in individualized physical therapy exercises, including wards with disabilities in temporary detention.
2. Evaluate opportunities for the inclusion of adaptive physical education programs in special education students' IEP's, and provide for a recreation / adaptive physical education director at each facility to ensure that adequate programs are available and that wards with IEP's participate in these programs.

4.8 Specific Area of Inquiry - Wards' with Disabilities Access to Communication

General Discussion of Effective Communication

Before an evaluation of wards' access to communications can be begun, it is believed appropriate to discuss some of the requirements for effective communication for persons with disabilities. Under Title II of the ADA, public entities are required to ensure that all program recipients, including students, parents, employees, employment applicants, and members of the general public with disabilities are able to experience communication methods that are as effective as that provided to people without disabilities. Persons with visual, hearing, and speech disabilities must all have the opportunity to receive or present communications in a manner that is appropriate and effective. Communication support must be provided in a manner that enables persons with disabilities to participate on an equal basis with all others, unless the result would cause a fundamental alteration in the nature of a service, program, or activity or cause an "undue" financial or administrative burden. Such exceptions rarely apply. It is important to note that the fundamental alteration/undue burden exception does not apply to the provision of related aids and services that are necessary to ensure a free appropriate public education to qualified students with disabilities.

There are two major types of communication barriers that prevent or detract from communication effectiveness:

(1) Visual: Print materials, visual presentations and displays, and signage often present barriers to people with limited vision.
(2) Aural/oral: "Aural" refers to information that is heard; "oral" refers to spoken communication. A person who is deaf or hard of hearing experiences barriers related to aural communication. The same person may be able to communicate orally, however. A person who has a speech impairment or a cognitive impairment that affects speech may experience barriers in communicating orally but have no difficulty receiving information that is conveyed aurally. Each person may require different auxiliary aids and services in order to be provided equally effective communication.

Currently available technologies provide a variety of effective communication options, and this section suggests possible applications. The field changes rapidly and ADA Coordinators should keep abreast of emerging technologies. It is important to note that the specific method of providing effective communication may vary from program to program and from individual to individual. Therefore, the process must take into account the specific needs of the persons involved and their particular disabilities. The descriptions of technologies described herein are not exhaustive nor necessarily complete. The technologies presented here may also be used as related aids and services that are provided to qualified students with disabilities as part of their free appropriate public education.

Materials presented in a visual format can inhibit or prevent communication with persons who are blind or partially sighted. The following are ways that effective communication may be provided for such persons with these types of disabilities:

(1) Alternative Formats: It is essential that information be available in a variety of formats in order to be accessible to users with a variety of disabilities. For example, schools should ensure that persons who are blind or have low vision have access to materials in Braille, on audio tapes, in large print, or in other appropriate formats.
   (a) Braille: Braille is a tactile representation of written or printed language. It consists of characters made up of arrangements of raised dots. Not all blind persons read Braille, but many prefer it to tapes because it is easier to scan, easier to refer back to for information, and easier to reference.
   (b) Large print: Many people who have limited vision are able to read large print. Print is measured in "point" size. Standard print is usually 10-12 point. Large print can be produced at low cost using a photocopier that can enlarge. Many computer programs have the option of printing enlarged documents or formatting text in various sizes.
   (c) Audio tapes: Making audio tapes of such program materials as textbooks and course listings is often a good alternative to written information. Some people who are blind or visually impaired cannot read, or prefer not to read, Braille or large print. Tapes are also sometimes helpful to people with learning disabilities such as dyslexia.

People with various disabilities may be unable to receive or generate spoken communication. The following are some of the most widely used techniques and devices that can assist with communication:

(1) Interpreters: The use of interpreters is the most commonly used method for providing effective communication to persons who are deaf or hard of hearing. When sign language interpretation is necessary, Title II requires that it be provided by a "qualified interpreter." Under Title II, the term "qualified interpreter" is defined as an individual who is "able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary". To satisfy this requirement, the interpreter must have the proven ability to effectively communicate the type of information being conveyed. The interpreter qualifications most appropriate in each instance will vary. Certified interpreters should be used in nearly all cases; it is generally not appropriate to use a family member or companion as an interpreter. A person who is deaf or hard of hearing has the right to request an impartial interpreter.
(2) Writing: In some situations, there are simple alternatives to spoken communication. Pen and paper may be an easy form of communication in situations where communication is simple. In a more complicated situations, other methods should be considered.
(3) Computer-Aided Real-Time Reporting (CART): This service is generally used in meeting or conference settings, but the service may also be provided for students in classes. Real-time reporters type out words as they are being spoken in a meeting or class, and the text is simultaneously displayed on a computer monitor, video monitor, or projection screen.

(4) Assistive Listening Devices or Systems: These devices can be used to enhance hearing in one-on-one discussions or in meeting rooms. They can be fixed or portable. FM systems, for example, use a microphone connected to an FM signal-sending device that can be attached to the speaker. The listener wears a portable headset that can be used anywhere in the room and is able to receive the amplified sound. Multiple listeners can benefit simultaneously from this type of system.

(5) TTY's / Telecommunication Devices for the Deaf (also called a TDD or a text telephone, although the preferred acronym is TTY, standing for "teletypewriter"): Although Section 504 regulations does not specifically address TTY's, Title II of the ADA specifically requires that where public entities communicate with the students, parents, employees, employment applicants, or the general public by telephone, TTY's or equally effective means must be used to communicate with persons who have hearing or speech disabilities. These devices provide a printout or digital display (or both) that enables a person who is deaf or hard of hearing to hold a two-way conversation through the written word.

(6) Telephone relay services: In California, telephone conversations can be relayed from a TTY-user to a non-TTY user by the California Relay Service (800-735-2929 for TTY users; 800-735-2922 for voice use) free of charge.

(7) Telephone Amplification. Many hearing aids have a telephone setting that can amplify sound if an appropriate handset is used. The local telephone company can provide a handset with the appropriate magnetic field intensity to be compatible with this type of hearing aid setting. Battery-powered, portable handset amplifiers are also available. The amplifier can slip over the handset of most telephones. Accessible public telephones are required to have this feature built-in.

(8) Adaptations for Computers. Since operating a personal computer is essentially visual talk, users who are deaf generally do not experience significant difficulties with computer technology. However, schools and public entities should insure that important information conveyed by beeps or speech during computer-related tasks is also displayed visually for the user unable to benefit from the auditory information. Computer operating systems often have built-in options for visually displaying auditory alerts. If necessary, a flashing light signal should be installed that echoes the beeps.

(9) Electronic Speech Aids. A number of devices are available that support the exchange of information electronically. Among them is a small device that accepts and displays typed text. Such a device could be stored in a library for ready use by persons who are deaf. Speech synthesizers may also be used to facilitate communications with persons who have speech impairments.

(10) Captioning Television and Videotape Programming. Audio portions of television and videotape programming produced or played by public entities are subject to the requirement to provide equally effective communication for individuals who are deaf or hard of hearing. Closed captioning of such programs is sufficient to meet this requirement A school should be able to provide audio-visual materials used for class

work, or which are otherwise intended for public education, to carry captions. Closed captioning is an ideal format because the captioning is unseen unless it is needed.

(11) Decoders. When a "closed captioned" film or video is shown, a decoder is used to "open" the captions and make them appear on screen.

Where communication by telephone is a function of a particular component or program, TTY's should be made available to those persons who require them. TTY"s may be portable, but must be readily available. Appropriate staff should be trained in the use of TTY's. Where TTY-equipped pay phones or portable TTY's exist, clear signage should be posted indicating the location of the TTY.

In order to provide equal access to their programs and services, schools are required by Title II of the ADA to make appropriate auxiliary or related aids and services available when they are necessary to ensure effective communication. Furthermore, auxiliary aids and services are often required to provide equally effective programmatic accessibility in areas not specifically related to communications.

Auxiliary aids for people with visual disabilities include providing access to printed information through audio-tape cassettes, computer diskettes, Braille or large print materials, as described above. However, within a school setting, auxiliary services could be provided through the use of qualified readers, providing verbal descriptions of action and visual information to enhance the accessibility of performances and presentations, and making a staff member available to enable a person with limited vision to find his or her way along an unfamiliar route.

There may often be an overlap between the provision of auxiliary aids and services that are designed to ensure effective communication and related aids and services that are necessary to provide a free appropriate public education (FAPE) to qualified students with disabilities. Public schools must provide regular or special education students related aids and services designed to meet the individual educational needs of each qualified student with a disability. The concept of "related aids and services" applies to any supplementary aids, adjustments, and services, including those that are communication-related, that are necessary to ensure effective communication and that are necessary to ensure FAPE. A school system must give each person with a disability an opportunity to request the auxiliary aid or service of his or her choice. Furthermore, schools must honor this request unless they can demonstrate that another aid or service will be effective for the individual requesting the service, the proposed action would fundamentally alter the service, program, or activity, or that the action would result in undue financial and administrative burdens. Even where a school can demonstrate a fundamental alteration or an undue burden, the school must take other measures to ensure that it does not discriminate against individuals with disabilities. Deference to the request of the individual with a disability is crucial because of the range of disabilities, the variety of auxiliary aids and services, and the various circumstances requiring effective communication. It is important to

consult with the individual to determine the most appropriate auxiliary aid or service because the individual with a disability is most familiar with his or her disability and is in the best position to determine what type of aid or service will be effective.

Effective Communication within the CYA

Section 3.1 describes the wards with disabilities who might have communication needs within the CYA at the time of my site visits. These included wards who might be deaf or hard of hearing, as well as wards with varying degrees of visual, speech, or cognitive impairments.

During my site visits, there were two wards who had total loss of hearing, and I interviewed both of these wards. These wards were currently being provided with American Sign Language interpreters for most of their school day. Both were involved in school activities and reported no current problems with the lack of qualified interpreters during classroom activities. However, they both indicated that there had been some problems in the past, and it was good to hear that educational accommodations were improving and were no longer considered by them to be a significant problem. The availability of qualified interpreters during other activities appeared to be less frequent. It appeared that for treatment programs, case conferences, hearings, and other formal activities, interpreters were usually provided. However for social, recreational, and religious activities, it appeared that interpreters were much less frequent, and it could be difficult for these wards to participate fully in all of these programs. It should be noted that for wards in an institutional setting, there is a fine line between ward independence and the need to communicate through an interpreter. For example, neither of these wards indicated that they would want to have an interpreter "shadow" them for an entire day, as that would be more personally intrusive than having an interpreter available for just the required activities. With this in mind, these wards seemed to be reasonably comfortable with the current degree of interpreter support.

For wards who were hard of hearing but still had some degree of hearing acuity, the issue of interpreter support seemed to be more problematic. For example, one ward who had severe hearing loss that was worsening and who was still using hearing aids had difficulty getting an interpreter at all. Many persons who are hard of hearing still need an interpreter because even though there may be some auditory acuity, background noise and other environmental factors can make hearing, particularly within the educational or institutional context, extremely difficult. This particular ward mentioned that when she was not in the CYA, she was provided with an interpreter at her school and for other activities in which she participated. However, at the CYA, she was unable to convince the treatment team that an interpreter was mandatory. As a result, she found that hearing aids really did not fully solve her communication problems, and her reluctance to wear a hearing aid was cited by both the correctional and educational staff as an indifference to taking part in educational and treatment programs, which was most likely not the case.

There also seem to be some contractual and scheduling issues with interpreters at several institutions. How the CYA goes about contracting for interpreter services is beyond the scope of this inquiry. However, it is clear that an evaluation of how the services are contracted needs to occur at a number of facilities. While it is common to contract for these services through community service organizations, many public entities have found it advantageous from a financial standpoint to advertise for staff positions that include qualified American Sign Language interpreters. This may serve as a more economical and practical way to provide the interpreter services that are required.

Another common concern at a number of facilities involves the procedures for a ward's obtaining hearing aids or other auxiliary devices. Staff voiced several complaints that wards would not wear their hearing aids and that they used the lack of hearing as an excuse for not participating or for poor performance in classes and treatment programs. On the other hand, some wards complained that many of the hearing aids were bulky and not as effective as those that they had used before they entered the CYA. It is my opinion that the reality is probably somewhere in between these two different perspectives. In other words, it appears that the CYA needs to be more proactive in searching out more "user friendly" hearing aids or other auxiliary aids, such as personal assistive listening devices, that would be more effective in meeting the individual ward's needs. At the same time, it is also possible that some wards may attempt to gain some degree of leverage over their situation by citing the lack of appropriate aids as an excuse for less than ideal behavior or poor work. The CYA needs to evaluate these situations individually and become more adept at differentiating between the two perspectives.

Another issue involves the presence of wards who have been losing their hearing for a period of time such that the prognosis is that they will lose all hearing in the future. Such a condition can be a traumatic experience, particularly for a teen-ager, and since the CYA is responsible for providing counseling in a variety of areas, it seems appropriate for the CYA to counsel these wards on issues around total hearing loss. There are no current programs within the CYA that effectively address the extreme anxiety and practical issues involved with hearing loss. Therefore, I would strongly recommend that the CYA closely monitor the progress of these wards and take the appropriate steps to bring in outside treatment experts to assist in dealing with this potentially traumatic occurrence.

To summarize concerns and issues over communication with wards who are deaf and hard of hearing, it appears that the CYA is interested in taking steps to identify and provide some degree of accommodation and modification to programs that is required by the ADA in such circumstances. However, it appears that often the CYA does not take the most appropriate steps or provide accommodations in the most effective manner. One somewhat upsetting experience that I had during my site visits will perhaps serve as a good example of some of these issues. I interviewed one ward who was deaf prior to a case management conference that was scheduled

later in that day. During the interview, the ward was very open in expressing his problems, including those that might have been his own making, as well as those things that he hoped would come out of the case conference. I believe that after the interview, I had a relatively good sense of what issues were important to the ward and how the ward saw his own progress in his treatment, educational, and work programs. As I sat in on the case conferences, I was quite surprised that the ward's own interests were not really taken into account at any time throughout the case conference. Even though an interpreter was present, basic communication was the primary drawback, and the case management specialist allowed the lack of communication to thwart open dialogue between the parties. It was also common for the case specialist to refer to the ward in the third person; for example, asking the interpreter: "Does Joe think that...". While this is a common mistake for hearing people to make, it is still unacceptable. The case conference actually digressed into a less than cordial tone on the part of everyone involved, and from my observations, much of the reason was the ward's inability to communicate his concerns and needs effectively. I also believe that much of the reason rested on the interpreter, who tended to interpret emotions in what I felt was an inaccurate manner. During my earlier interview with the ward, I had asked the ward what he wanted to come out of the case conference that was to take place, and he mentioned some very practicable resolutions that did not appear to be unreasonable or excessive. However, during the case conference, the ward was never really allowed to communicate these. During my site visits, I never interacted with the activities I was observing, but I did make one exception here, and at the end of the conference, I interjected some questions that I thought would help to bring out some of the things the ward had told me. I found that these were quickly dismissed. This example is not necessarily intended to cast blame on any of the participants, but rather to show that while formal and procedural accommodations may appear to be in place, the reality is that it takes a concerted effort to assure that wards with disabilities are not deprived of the communication that other wards are afforded.

With respect to telephone communications with families, all of the wards interviewed who needed TTY's for these activities stated that they were available, and when I asked to see TTY's at several locations, portable units were available.

As for wards with visual impairments, much of the discussion of visual communication has already been described in Section 4.2. I will not repeat those issues in this section, except to summarize the fact that while the CYA appears to be providing auxiliary aids for some (but necessarily all) wards with visual impairments, many of the aids appear to be ineffective and do not allow these wards to participate in programs at the same level as other wards.

Recommended Policies and Procedures

1. Alternative formats: Provide alternative formats (Braille, large print, audio cassettes, sign language interpreters, captioning, computer-aided real-time reporting, etc.) or auxiliary aids and services required by wards, students, parents, or the public. All programs that prepare and provide written materials should include a notice of availability of alternative formats in written materials. Site representatives may provide alternative formats independently, but securing and assuring that proper alternative formats are provided when requested is ultimately the ADA Coordinator's responsibility. A list of qualified Braillists, audio recording volunteers, and computer assistants should be developed and maintained by the facility and agency-wide programmatic ADA Coordinators.
2. Curriculum-related accommodations: Provide reasonable communication accommodations as required, including special assistive devices to mobility-impaired, orthopedically-impaired, hearing-impaired, or visually-impaired students in conjunction with the administering of curriculum, instruction, or extra-curricular activities.
3. Sign language interpreters: Provide a qualified interpreter when requested by a ward, parent, or member of the public who has a hearing or speaking impairment. The policy of providing interpreters should be incorporated into each school policy manual and specifically described on each meeting notice. Site representatives may secure qualified interpreters independently, but securing and assuring interpreters are provided when requested should ultimately be the facility and agency-wide programmatic ADA Coordinators' responsibility. A list of qualified interpreters should be developed and maintained by the ADA Coordinators.
4. Testing formats: All student programs, including comprehensive testing programs, should develop alternative formats of testing where necessary due to students' disabilities.
5. TTY's: Each facility should have at least one, and probably more, readily available TTY's at appropriate locations as may be required for the use of wards. Appropriate staff should be trained as to their proper usage.
6. Monitor the progress of those wards experiencing significant hearing loss and take the appropriate steps to bring in outside treatment experts to assist in dealing with this occurrence.

4.9 Specific Area of Inquiry - Wards' with Disabilities Access to Visitation

Visitation by family members and friends is one of a typical ward's most awaited activities. The value of positive reinforcement from family members and friends is a major part of the treatment program at all of the institutions that I visited.

The architectural barrier surveys also relate to this particular aspect of program accessibility. There is an additional element, however, that is also involved that makes it different from other program access issues that also have architectural barrier implications. For a ward with a disability to access the program of visitation, family members and friends who might have a disability and are coming to visit the ward would also need to have access to the visiting area in order for program access to be provided. Therefore, for this particular inquiry, program access for persons with disabilities other than words should be considered in the evaluation.

At each of the facilities I visited, I conducted a general review of the visitation facility in order to evaluate what items, either physical or program-related, would either enhance or reduce program access for wards with disabilities. Four of the facilities visited had newly constructed or renovated visitation areas that were very accessible and that should provide excellent program accessibility for both of wards with disabilities and visitors. This would include accessible parking spaces, entranceways, security gates, restrooms and drinking fountains, and seating areas. However, two of these facilities at Ventura YCF and Preston YCF were not in use at the time of my site visits to due funding cutbacks for security and correctional officers during visitation. This is very unfortunate, because the older facilities for visiting at both institutions exhibited a number of accessibility barriers that would make visitation difficult for both of wards and visitors with disabilities. The other four facilities visited had varying degrees of accessibility.

All facilities visited had an adequate number of accessible and van-accessible parking spaces properly located in front of the exterior entrance to the visitation areas, and these areas need little upgrading. The security gates at three facilities were too narrow and would not be accessible for a visitor using a wheelchair or other mobility aid to enter the facility without some type of assistance. The restroom facilities both for wards and visitors at all of the older visitation areas were generally not fully accessible, and these need to be upgraded for accessibility.

The accessibility barrier surveys depict the specific areas needing improvement at five of the facilities, and these should be prioritized and rectified as soon as possible. It should be noted that visitors' facilities at Heman G. Stark YCF and El Paso de Robles YCF have not been surveyed, and this should be accomplished to assure future access to these programs.

The programmatic access issues at visitation areas were deemed to be minor, and there were very few programs that took place during visitation that would require auxiliary aids or other assistive

devices for those who had communications needs, although if programs occur, accommodations should be provided.

Recommended Policies and Procedures

1. Secure the appropriate funding for security and correctional officers so that the new visitation facilities at Ventura YCF and Preston YCF can be properly utilized during visitation hours.
2. Review or complete the architectural barrier surveys for all visitation facilities, and upgrade entrances to the visitation areas and restrooms for both visitors and wards to be fully accessible as the highest barrier removal priority.

4.10 Specific Area of Inquiry - Wards' with Disabilities Access to Sanitation and Hygiene

Access to proper sanitation and hygiene for wards with disabilities is another issue that is related to the architectural barrier surveys conducted and reports prepared by a separate expert consultant. Toilet room and shower facilities are typically located at each living unit, and these are used on a rotating basis by wards on the unit. There are other restrooms used by wards throughout the various facilities, including schools and work areas. As evidenced by the architectural surveys, the vast majority of these do not meet federal and state accessibility codes and standards. The extent to which these non-complying facilities might be usable for an individual ward would depend upon the individual disability of the ward.

At toilet areas within the living units, the major barrier would be the consistent lack of grab bars at the rear and side of any toilet. This is not intended to minimize the need for a higher than normal toilet or additional maneuvering space around the toilet, but grab bars are essential for transfer to the toilet, and the addition of grab bars for at least one toilet per restroom should be an immediate priority, as such an addition is readily accomplished without much difficulty or expense, and with no foreseeable security concerns.

Wards typically shower and conduct other personal hygiene in shower rooms on the living units. The showers are similar to stall showers in that there are usually privacy dividers between showers, with the dividers are usually being only about three or four feet high for security reasons. Usage of these by a ward using a wheelchair or for others with mobility impairments would be difficult if not impossible since there are no hand held shower heads or seats.

At O. H. Close YCF, a new accessible shower had been recently constructed in one of the living units, although it was not yet in operation. At a number of other institutions, senior staff members mentioned that accessible showers were planned, but I did not see any other showers that had been in any way modified to be accessible to serve the wards with mobility impairments in the living units. There were a number of accessible showers at specialized areas, such as at the new outpatient clinic at El Paso de Robles YCF. However, the overall problem is greater than just providing one or two showers at each facility, which might seem to be a reasonable solution. The reality is that most facilities have different types of living units, and individualized programs are physically associated with these living units (for example, gang relinquishment programs, sex offender programs, new ward entry programs, etc.) Providing an accessible bathroom and shower facilities at a few of these programs, or at a general population program dormitory alone, would limit the choices that wards with disabilities would have for correct placement, and would therefore could be discriminatory in nature. An easy solution for such a problem is difficult to reach, because providing an accessible shower at every living unit within every facility of the CYA would require a significant outlay of capital and resources at a time when resources and funds are needed for a wide variety of programs that could be more beneficial to a larger population of wards with disabilities, and the reality is that such an

accessible shower might not be used by a ward with the disability. Perhaps the most reasonable short-term solution would be to construct one accessible shower at one of the general population living units at each facility and to purchase a number of temporary shower conversion kits that are commercially available. While such is not a reasonable long-term solution, it could help to provide an efficient way to insure that wards with mobility impairments are placed at the most appropriate program location, not just the most advantageous physical location, and still have a degree of access to proper hygiene at each facility. However, for the long-term, there does not appear to be any alternative to providing accessible showers and other restroom facilities at such time as other construction work or other improvements are also provided at each individual program location.

Recommended Policies and Procedures

1. Review the previous accessibility barrier surveys and prepare new surveys as required at the three facilities not surveyed. Prioritize sanitary facility improvements to provide program access to each individual program.
2. Provide immediate temporary and easily achievable barrier solutions, such as grab bars at toilet and portable accessible shower units, for at least one bathroom per living unit.

4.11 Specific Area of Inquiry - Wards with Disabilities Access to Religious Services

Each of the institutions visited had a building that served as the chapel for the facility. Most had two sanctuaries, one for Protestant services and one for Catholic services. The only institution without such a chapel was the SYCRCC/Norwalk, which used a multi-use auditorium for all church services. Native American services were typically held at sweat lodges which were located in more isolated parts of the facility away from other buildings. Muslim and other religious services were typically held at the chapels or various other locations throughout the institutions.

The architectural barrier surveys for five of the eight facilities that I visited describe the details of what types of non-complying items may be present at each chapel at each institution. My own observations indicated that the chapels were generally accessible at the primary entrance and would allow wards with mobility impairments to enter the building. The only exceptions were at Preston YCF, where a stairway provided the only entrance to the chapel, and SYCRCC/Norwalk, which had high door thresholds at the entrances. None of the chapels visited had at any specific areas within the sanctuary for integrated seating for persons using wheelchair, as most sanctuaries had fixed pew seating.

During several interviews that I had with wards who were deaf or hard of hearing, I asked if they attended religious services, and I received some input that interpreters were not provided to them for these activities.

Recommended Policies and Procedures

1. Provide an accessible entrance, either by ramp or wheelchair lift, to the chapel at Preston YCF that would allow a ward with a mobility impairment to enter the facility independently, as a first priority in accessibility upgrades at that facility.
2. Provide a new level door threshold at one entrance to the multi-use room at SYCRCC/Norwalk that would allow a ward with a mobility impairment to enter the facility independently, as a first priority in accessibility upgrades at that facility.
3. In each chapel, provide a level and open seating area that is integrated within the pews so that wards or visitors who use a wheelchair can sit with others who are attending the religious service, as a first priority in accessibility upgrades at that facility.
4. At each institution, canvass the wards who are deaf or hard of hearing around mid-week to see if any will be attending one of the religious services, so that an interpreter, assistive listening device, or auxiliary aid can be made available to that ward, with plenty of time to plan the accommodation (see also Section 4.8 on wards' access to communications).

4.12 Specific Area of Inquiry- Wards with Disabilities Access to Emergency Services & Plans

During 1999, the CYA prepared extensive emergency and evacuation plans in anticipation of potential Y2K problems. These plans are recent and provide a very good general level of emergency policies and procedures at all institutions. The only plan that I reviewed in detail for Preston YCF (perhaps the most difficult site from an emergency services standpoint) was an example of the typical plan, but it is my understanding that all other plans for the other seven institutions are similar. The plan I reviewed was thoughtfully prepared and appeared to cover most of the issues and topics necessary for a comprehensive plan.

However, the plan I reviewed did not have any specific instructions and procedures regarding wards with disabilities during emergencies, and in particular, for those wards who might have physical disabilities. According to the ADA and Section 504, this is an important component of emergency and evacuation plans, since wards with disabilities pose additional circumstances and issues during an emergency. I would strongly recommend that the existing plans for each facility be amended to include additional information on emergency policies and procedures for wards with disabilities, including routes and methods of evacuation, security and containment concerns, additional communication methods for assuring that wards with hearing disabilities are properly notified of procedures that must occur, etc.

Staff members who were interviewed indicated that they were thoroughly trained in evacuation procedures. Most common use and/or guard areas had emergency evacuation maps, but these were often placed in inconspicuous locations. None of the maps that I observed had information regarding evacuation routes or assistance procedures for wards with disabilities.

The basic procedures for releasing wards from individual living units, as well as lock-down units, during emergencies was demonstrated to me. The system involves the use of simultaneous door operating systems. Reportedly, the systems have been upgraded in recent years and are tested on regular basis. These systems appeared to be adequate for general purposes, but it is unclear if they provide the degree of appropriate evacuation necessary for wards with mobility impairments.

The living units and school areas had audible fire alarm systems. However, very few areas had visual emergency alarms (also called strobe alarms) at any locations, as also described in the architectural barrier surveys. At a minimum, such alarms should be provided, even on a temporary basis if necessary, within individual living units and other areas frequented by wards who are deaf or hard of hearing.

Recommended Policies and Procedures

1. Update and amend the emergency services and evacuation plans and other written emergency procedures at each institution to include specific instructions and procedures for the emergency services for and evacuation of wards with disabilities.
2. Continue testing and certification of emergency door releasing apparatus at each living unit to assure proper operation.
3. Install preferably permanent visual fire alarms (or if necessary to provide immediate coverage, temporary strobe lights may be necessary) at all individual living units housing wards who are deaf or hard of hearing. Prioritize those other areas frequented by these wards to receive visual alarms as soon as possible.

4.13 Specific Area of Inquiry - Wards with Disabilities Access to Food Service

Food service to wards is provided in a number of different ways and varies from facility to facility. Heman G. Stark YCF, Preston YCF, DeWitt Nelson YCF, Ventura YCF, SYCRCC/Norwalk and El Paso de Robles YCF have central dining halls, while N.A. Chaderjian YCF and O.H. Close YCF, and have smaller separate dining halls serving each living unit.

Meal service policies also vary from facility to facility and can also vary from time to time, depending on population trends, degree of ward violence, and other factors. At the present time, at Preston YCF, DeWitt Nelson YCF, O.H. Close YCF, Ventura YCF, SYCRCC/Norwalk and El Paso de Robles YCF, breakfast and dinner are served in the dining halls and lunches are delivered to wards in the living units. At Heman G. Stark YCF and N.A. Chaderjian YCF, all meals are served in the living units to wards in their rooms. Generally, all meals are served to wards in their living units at temporary detention units, intensive treatment program units, and specialized care units. I found no evidence that wards with disabilities were provided food service differently than other wards, although as discussed in Section 2, I encountered few wards with mobility impairments in the general population units.

The architectural barrier surveys indicate to what extent the dining facilities at five of the eight institutions that I visited are in violation with federal and state accessibility codes and guidelines, and therefore, I did not undertake any detailed architectural surveys of these buildings. However, I did conduct a general level of review at each dining hall and a general observation as to whether there were significant accessibility barrier barriers that would preclude usage of the hall by persons with mobility impairments, including those who might use a wheelchair. I observed that in general, most facilities would be usable to a large degree by persons with mobility impairments. However, there were a number of details that would make such usage difficult for those who use wheelchairs or for those who have manual dexterity impairments.

The facility that would be the most problematic would be El Paso de Robles YCF. In this case, paths to and from entrance and exit doors to the dining hall have steps that would preclude wards who might need to use a wheelchair or other mobility device from entering the dining hall independently. There is an entrance at the side near the kitchen that is not fully accessible but potentially usable. However, the use of that door would require security personnel to take additional steps every time the wards used the facility, and a ward with a disability would have to enter and exit the dining hall separately from the other wards. This may or may not be acceptable from a security standpoint, and much of that would depend on the particular ward in question. However, in the long term, such as segregated entry and exit would not be acceptable from a service delivery standpoint, and therefore, the entry and exit to this particularly dining hall should be made accessible at the earliest opportunity. The dining halls also have tray slides or tray pickups that would be higher than accessibility codes allow, and these would make it difficult for wards with mobility impairments to use the food pickup areas independently. These

should be modified as described in the architectural surveys as a second priority.
Most dining areas had fixed stools at tables, for obvious reasons. At least one, and preferably 5%, of all seating locations should have the stools removed so that a ward using a wheelchair could approach and effectively use the table.

While my site visits did not focus directly on architectural barriers, this is one situation where the architectural and programmatic access are relating in that if a ward cannot take part in the program in a manner substantially equal to that of other wards, it would not be an acceptable practice to have a ward eat meals at a location other than the dining hall if other wards in the same program have the ability to use the dining hall together. Such an exclusion to a ward with a disability would indeed be a discriminatory and an unacceptable practice.

Recommended Policies and Procedures

1. Review the previous accessibility barrier surveys and prepare new surveys as required at the three facilities not surveyed. Prioritize facility improvements to provide program access to each dining hall.
2. Provide an accessible entrance path, either by ramp or wheelchair lift, to the dining hall at El Paso de Robles YCF to allow a ward with a mobility impairment to enter the dining hall independently, as a first priority in accessibility upgrades at that facility.
3. Provide immediate temporary and easily achievable barrier solutions, such as removing fixed stools and lowering tray slides, at each dining hall.

4.14 Specific Area of Inquiry - Wards with Disabilities Access to Transportation

The CYA typically uses security vans to transport wards both between facilities and inside of facilities. In most cases, these are modified 9 to 12 passenger vans, and they do not have any special equipment for the transportation of wards who might have a mobility impairment, including those who might use a wheelchair. There was some documentation contained in the previous experts' reports that the CYA intended to work out a sharing agreement with the CDC to utilize one or more wheelchair accessible vans for the transportation of wards between facilities, if indeed such transportation was necessary. We mentioned this to some of the senior staff members during our site visits but could not receive any definitive confirmation that this policy had yet had been put into place.

For wards who might use a wheelchair or have other mobility impairments, it would be important that they be able to be transported easily and efficiently with a van that uses a wheelchair lift. It should be noted that it is not an acceptable practice under either Section 504 or the ADA for others to have to physically lift a person in order for that person to gain access to transportation or a facility, except under emergency conditions, and such a prohibition would certainly apply to CYA wards. Since accessible vans are readily available and do not entail significant costs over vans specially equipped for security concerns, I would recommend that the next purchase of transportation equipment for wards include at least one van for the southern area and one van for the northern area, and possibly more, subject to a needs analysis by the CYA.

As mentioned above, some institutions have buildings laid out over a relatively wide area and typically utilize vans or passenger vehicles for the transportation of wards within the facility. These facilities include Ventura YCF, Preston YCF, and potentially others. In these instances, the placement of wards with mobility impairments may be in part based upon the overall accessibility of the site. This practice would tend to apply restrictive placement criteria upon wards with disabilities and should not be an acceptable practice. In the short-term (prior to full site accessibility, a condition that will be particularly difficult to achieve at Preston YCF), it would also be necessary to provide a van equipped a wheelchair lift at the facility.

Recommended Policies and Procedures

1. In the next purchase of transportation equipment for wards, include at least one van for the southern area and one van for the northern area, and possibly more, subject to a needs analysis by the CYA.

4.15 Specific Area of Inquiry - Wards with Disabilities Access to Other Programs

The CYA has many special programs that provide a variety of activities, as well as educational and vocational opportunities, for wards. It would be too time-consuming and not necessarily productive to list each individual program at all institutions. Also, the program details, as well as their names, change from time to time. The purpose of this section is to describe the types of programs that exist and to evaluate how wards with disabilities are able to participate in these special programs.

Examples are the fire pre-camp at Preston YCF; "Free Venture" vocational programs at Heman G. Stark YCF; specialized culinary arts and food service programs at Preston YCF ("Feast"), DeWitt Nelson YCF, O.H. Close YCF, and N.A. Chaderjian YCF ("Delta Room"), Heman G. Stark YCF ("Eatery"), Ventura YCF (Culinary Arts); pet grooming and "Soap Vision" at Ventura YCF; and other on-site work programs. DeWitt Nelson YCF has had a variety of off-site work programs for a number of years, but these had been cut back to only a few during my site visits and have since been suspended.

As a summary, it is my opinion that wards with disabilities have a degree of access to the vast majority of these special programs offered within the CYA. However, advancement within these programs or the ability to enjoy the full benefits of these programs are commonly reduced because of either (1) eligibility criteria that in some cases screen out wards with disabilities, or (2) because of the lack of the program modifications for wards with disabilities. Of all the wards with physical disabilities that I interviewed, I believe that only two had been involved in what might best be termed a special program - that is, one which wards deemed to be a popular program and one that has either monetary or opportunistic value for the ward.

Eligibility criteria for special programs vary greatly from program to program. I was able to review only a sampling of the criteria for selected programs. But even this degree of review raised questions about whether criteria intended to provide safety and reliability for program participants actually excluded those who would have a legitimate ability to do the job. For example, the "Fire Camp Criteria" document requires no use of psychotropic drugs for at least 4 months. There is no definition of psychotropic drugs, and a participant might use a certain drug for a number of unknown reasons that may be related to that person's disability, with no real danger to the person or anyone else.

For wards with physical disabilities, including mobility impairments, visual impairments, or for wards who are deaf or hard of hearing, the majority of wards interviewed or evaluated indicated some degree of inflexibility or some barrier which preempted those wards from fully participating in special programs. Sometimes it was basically a lack of accommodation, and other times it was inflexibility on the part of the program administrator to make other arrangements that could have been simple and readily achievable.

In order to illustrate these points, I will give a few examples below. It should be noted that the actual names, institutions, programs, and other details are omitted because of my promise of confidentiality to the wards I interviewed. I also believe I used reasonable judgment in discerning which wards were giving truthful accounts of things that occurred. I certainly cannot guarantee absolute accuracy of all of the circumstances discussed below, but I can say that I have not included those occurrences where I have some questions as to their validity.

One ward with long-term injury to the lower back and associated mobility impairments was indeed admitted to a program that involved dexterity with animals. While the need for mobility would indeed be an advantage in effectively completing the necessary tasks, that particular ability was certainly not mandatory for the ward to carry out the tasks essential to the overall operation of the program. The ward requested on several occasions to be allowed to sit and take part in activities where mobility would not be necessary, but was generally denied that accommodation because it was deemed necessary that the ward be able to move about. The issue for this ward was not one relating to movement but rather to fatigue, and at some point, the ward became too fatigued and stress on the legs was too much for the ward to continue.

Another ward who was hard of hearing expressed a specific concern to me about taking part in a very popular "free venture" program. I made some inquiries as to why the ward could not have been admitted into that program. While the reason was never specifically given that the ward would have difficulty communicating, I surmised that that might have been a possible reason. That particular program involved an outside contractor whose criteria for selection, while not particularly excluding someone who was hard of hearing, was nevertheless restrictive and in some ways could tend to exclude such a ward.

Another ward who was hard of hearing was part of a grounds-keeping crew but was told that he could not use power tools as part of his activities. It was not fully documented as to why such would be a problem, although the rationale was most likely that the ward might not be able to hear or sense others around him during the use of the equipment. If this was the rationale, it relied more on the actions others rather than those of the particular ward. If the ward's own safety was the issue, there are accommodations (for example, using a power tool with a light that comes on when the machinery is that operation) that would allow the ward to utilize the equipment. I cannot state definitively that this activity with power tools could or should be allowed under the ADA for this particular ward, and it could very well be that there are other contributing factors of which I am not aware. Also, in some ways, the program should possibly be commended for not totally excluding the ward from the program, an action that is far too common with other public agencies and even private businesses. The point to be made is that program coordinators should objectively evaluate each ward's unique disability and situation, and detailed criteria should not be created arbitrarily or capriciously.

Many of the issues with special programs involve activities that are similar to the work environment in the everyday workplace. Therefore, it seems appropriate to apply some of the same standards and conditions of employment to these activities. These standards are detailed, and it would not be within the scope of this inquiry to describe all of the employment-related standards contained in Title I of the ADA. However, in general, when evaluating a particular job and task, one must evaluate the essential functions of the job and determine if a person with a disability can indeed perform those essential tasks, with accommodations if necessary. The exclusion of a person with the disability from a particular job or task simply because they may not be perceived as able to perform secondary functions should not preclude a person with a disability from being allowed to participating in those tasks.

It should be noted that I cannot accurately evaluate to what extent, if any, wards with mental, emotional, and developmental disabilities are excluded from special programs. It is probable that in a selection process there could be discrimination based upon factors related to disability, but I did not find any specific evidence of such.

Recommended Policies and Procedures

1. 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.
2. Provide reasonable accommodations or modifications to wards with disabilities if needed to participate in special programs and activities.

5.1 Specific Area of Inquiry - Appropriate Training for Staff

The actual wording for this specific area of inquiry is as follows: On a system-wide level, is there appropriate training to ensure that staff will follow the policies and procedures designed to ensure that wards with disabilities are: (1) provided with access to the above programs and services, and (2) not subject to harassment or discrimination related to their disabilities?

The CYA provides training to staff in a number of ways. The major training component is contained within the programs of the CYA Training Academy, located at the Northern California Youth Correctional Center at Stockton. As listed in Section 2, I visited that facility for only a short period of time during my site visits. However, my evaluation of CYA training programs extends beyond just that site visit and includes both an evaluation of the training policies and procedures contained in the various documents provided to me and an evaluation of the interviews and observations of a wide variety of staff functions at the eight institutions I visited. Training in its broadest context also includes numerous in-service seminars and meetings on various topics within the institutions and is not limited to just activities within the Training Academy.

During my visit to the Training Academy, we discussed the fact that changes in training are planned. These generally involve combining the training resources within the Youth and Correctional Agency to coordinate and integrate training for both the California Department of Corrections (CDC) and the CYA. I do not know the details of any proposed consolidation, nor if such is actually planned or is being implemented. My evaluation includes only those areas specific to the CYA, and it is possible that some procedures and curricula are subject to immediate or future change. I would not begin to comment on any proposed organizational changes of training components within the Youth and Correctional Agency, as such is beyond the scope of this inquiry. However, for this purposes of this inquiry, I would express some caution that the ADA, Section 504, and IDEA treat minors and students very differently from adults, and I would hope any consolidation of training would keep these disability requirements separate and distinct.

The Training Academy is an impressive, state-of-the-art facility that includes areas for new cadet and in-service training activities, staff development, and curriculum development. The programs are highly organized and efficiently managed by a dedicated and competent staff. There are over 90 separate basic academy courses, each with a highly developed curriculum. Of these courses, a number appear to contain elements related to the ADA and disability policy and procedures, as it is a topic that has applications in many areas. Of the course list provided to me, no courses are specifically limited to ADA or disability policy. There is a course on IEP's, and it was communicated to me that the ADA was most recently taught as part of a course entitled "Illness and Prevention Training." There is a part of Supervisor's Training on the ADA, and I was provided with the text entitled "Americans with Disabilities." There could easily be other courses that have been offered on the ADA and disability policy with which I am unaware.

(a) Working with Wards with Disabilities

My first opinion about these training courses and curricula is that there needs to be a distinct and separate course for both new cadets and existing staff (not just supervisors) on the ADA and general disability policy that specifically relates to the rights and treatment of wards (as opposed to employees). As stated above, this may be planned or may have occurred in the past, but I do not have any specific details of such. This opinion is primarily based upon my constant interaction and observations with staff for the almost 100 hours I spent within the eight institutions. I observed a marked degree of misconceptions and erroneous beliefs about the nature of disability, as well as a general lack of knowledge of what the ADA and other disability laws and regulations require. While "independence" within the correctional context is a complicated issue, many staff did not show an awareness of issues related to this concept. It is true that these disability-related topics will have application to many other areas of training, and a fundamental knowledge of the ADA and acceptable disability policy will apply itself to all of those unique conditions that arise in the process of working with wards with disabilities.

The text for the Supervisors Training entitled "Americans with Disabilities" is actually tailored almost exclusively for employees with disabilities, not wards. While some of the information could have application to wards, it is basically an "equal opportunity" manual, and it is primarily based on Title I of the ADA (Employment Provisions) and not on Title II of the ADA (Programs and Services of State and Local Governments). It is not within my scope of work to evaluate equal opportunity employee programs, so I did not review the material in detail to determine if it is appropriate, although it appears to be potentially acceptable for this use. However, it does not adequately address wards' disability rights nor effective policies and procedures for working with wards with disabilities, and it should not be used for this purpose.

The Instructor Guide for "Individualized Education Process (should be Plan)" used as part of the Peace Officer Training is generally a comprehensive (76 pages) and well-prepared document that is authoritative and very usable (although this is not intended to be a total endorsement of all information contained in it). It is interesting to note that this document appears to have been prepared, at least in part, in response to CDE's monitoring of special education and the litigation *Nick O. v. Terhune and Tillson* during 1989-90. During the 1990's, the CYA undertook a concerted effort to not only improve special education, but also to educate all staff on IDEA and State special education requirements. This course and guide appear to be one offshoot of that effort. As was discussed in Section 4.6, while I had some reservations about the tenor and content of IEP meetings, I did feel that CYA staff as a whole was cognizant of IEP's and special education, including those who were not necessarily directly involved in education. This points up the fact that training can be an effective tool in helping to bring about awareness and compliance agency-wide.

The Instructor Guide for "Special Treatment Needs" used as part of the Peace Officer Training has some content related to wards with disabilities, but it is not unique to this topic, and includes sex offender treatment and purely behavioral issues intermixed with disability-related treatment needs. Apparently, the guide that I was provided does not represent all that is actually offered in the course, as it is only 10 pages long and the overall guide appears to be at least 125 pages. I can only assume that what was provided to me is the portion that relates specifically to the ADA and disability. This portion of the guide has a number of mis-statements, has no tenor of the independence afforded by the ADA, and is cursory at best. It makes no attempt to provide insight into the nature of disability or the purposes and philosophies behind the ADA and other disability regulations. This document should not be utilized in the context of effective training on the ADA for wards with disabilities. Again, it is probable that there are additional materials, either Power Point presentations or other aids, that are used with this curriculum, but based on the limited amount I was provided, I would be cautious about the content of this material.

Based to a limited degree upon the training documents I reviewed (which were admittedly limited), but primarily upon my interactions with staff during my site visits, I would strongly recommend that the CYA Training Academy undertake an immediate and comprehensive course development effort for basic ADA and disability policy and regulations training for all staff, including correctional officers, teachers, treatment team members, and even office personnel on the topic of working with wards with disabilities. This training should be provided to new cadets as well as current staff. Because these requirements are highly specialized, and because attitudes are actually more important on a practical level than simple compliance, I would strongly recommend that these curricula and course materials be prepared by an outside consultant specializing in such training. A less desirable alternative might be that the curricula could be developed by CYA staff, but reviewed and edited by an accepted disability rights organization prior to implementation.

(b) Disability Awareness

As stated above, it is my opinion that a basic awareness and understanding of the philosophical rationale behind modern disability policy and regulations is less than it should be within the CYA. This manifested itself at various levels during my site visits.

For example, while the use of proper and generally accepted disability "terminology" is not within itself an accurate representation of attitudes, it can be a reflection of the extent to which staff is trained in disability issues. The use of inappropriate terms and categorizations by various staff members was not uncommon during my site visits. While we all slip and occasionally use an improper term in casual conversation, I found such lapses to be an indication of the need to focus on attitudes and some of the more subjective aspects of disability awareness.

Another more specific example, and one that may be also be highly subjective in nature, relates to a typical "accommodation" for wards who are hard of hearing. Often, such wards are accommodated by being placed in a front row of a classroom, or by being read instructions in a louder voice or another individualized manner. In certain situations, such accommodations may be appropriate and necessary. However, in general, requiring a ward to always sit next to a teacher or receive communication in a separate manner can, and over the long term definitely will, cause such a ward to be isolated and segregated. Within reason, all wards have a basic right to sit with peers and to generally be treated in a similar manner as other wards. This is where awareness and an understanding of the particular ward's needs, as well as the related disability, is important.

As part of the staff training for working with wards with disabilities as recommended in subsection (a) above, such training should include a major component to teach awareness and sensitivity.

(c) Harassment by Staff

I attempted to evaluate if harassment of wards with disabilities existed in two ways. First, I routinely asked the wards I interviewed if harassment had been directed toward them by staff. Second, I consciously observed staff interactions with all wards and occasionally asked staff about their dealings with wards. It should be noted that my intent in this particular scope of inquiry was limited to potential staff harassment based upon the disability of a ward, and it did not include potential harassment based on other factors, such as ethnicity, gender, gang affiliation, etc.

Wards generally indicated that they felt no pattern of harassment by staff based upon their disabilities. It should be noted that despite my statement of confidentiality to wards, I suspect that many would have been hesitant to go too far with this subject, since understandably, they did not have complete trust in my objectives. However, I used what I felt were reasonable techniques to evoke honest responses and feel that, in general, that is what I received. I did receive a very few isolated responses that a degree of harassment by staff might occurred on a occasion. While this is not justifiable or acceptable, it is nevertheless foreseeable to a certain degree. However, my general opinion is that there is not a significant degree of intentional and malicious harassment by staff toward wards with disabilities and that there is no definitive pattern of such harassment. My observations and interviews with staff also did not indicate that such harassment was pattern behavior by staff.

The degree with which discrimination by individual staff against wards with disabilities has occurred is far more subjective. This entire report has contained a number of examples of polices, procedures, and conditions that affect the treatment of wards with disabilities and of situations involving individual staff member's habits and attitudes in working with wards with

disabilities. In most of these cases, I do not believe I have the all of the facts or wherewithal to labels these policies and actions as "discriminatory", and I will have to let the reader make that determination based upon the information presented. I believe that in the vast majority of the cases where discrimination by individual staff members might have occurred, such discrimination was based on misconceptions, inadequate training, or for lack of a better word, ignorance. I do not believe (again, for the vast majority of cases) that potential discrimination was based on a conscious efforts to discriminate by individual staff members.

Nevertheless, in response to those isolated cases where harassment or intentional discrimination might have occurred, I would recommend that the staff training described in subsection (a) above include a component that discusses potential harassment of wards with disabilities, and that it include examples of potential staff actions that might be termed harassment and provide alternate procedures for staff to follow.

Recommended Policies and Procedures

1. Institute a distinct and separate training course and curricula at the Training Academy for both new cadets and existing staff (not just supervisors) on the ADA and general disability policy that specifically relates to the rights and treatment of wards (as opposed to employees).
2. As part of the staff training for working with wards with disabilities as recommended above, include a major component to teach awareness and sensitivity.
3. As part of the staff training for working with wards with disabilities as recommended above, include a component that discusses potential harassment of wards with disabilities, and include examples of potential staff actions that might be termed harassment and provide alternate procedures for staff to follow.

5.2 Specific Area of Inquiry - Appropriate Training for Wards

This specific area of inquiry is worded as follows: On a system-wide level, is there appropriate training to ensure that wards will follow the policies and procedures designed to ensure that wards with disabilities are (1) provided with access to the above programs and services and (2) not subject to harassment or discrimination related to their disabilities?

At the outset of the entire project, the topic of wards' own involvement in respecting the rights of other wards with disabilities, and not subjecting fellow wards with disabilities to harassment and discrimination, was one of the most intriguing aspects of my scope of inquiry. I tried to enter all of the various scopes of inquiry with no preconceived ideas about what I might find, but knowledge I have gained from other similar projects is something that I cannot preclude. And unfortunately, it has been my experience that at many school districts for which I have undertaken disability evaluations, students, particularly those in the teen-age years, can indeed inflict significant harassment upon other students with disabilities. Therefore, this was one of the areas in which I had serious initial concerns.

What I actually observed was the most surprising aspect to me of all of my evaluations. In general, I found an indefinable, and almost innate, universal empathy among all wards, both with and without disabilities, toward other wards with disabilities. The word "empathy" should not be confused with "sympathy", because wards appeared to possess a realistic awareness of how disabilities affect daily life, and these realizations were more "matter-of-fact" than internalized.

I undertook some degree of analysis as to why this condition existed, but came to realize that a complete analysis of this phenomenon would be too esoteric and complicated. Probably the main reason lies in the simple saying that wards "are all in the same boat". Despite the best efforts of any correctional staff, wards still basically see their condition as an "us versus them" situation. Another reason probably lies in the fact that so many wards come from disadvantaged backgrounds and understand the pressures of overcoming barriers. Another probable reason is that wards experience the "daily grind" of incarceration, since most have been in County lock-ups for extended periods of time before entering the CYA, and many see their daily life from a one-day-at-a-time perspective. Therefore, they know first-hand what effects their own personal, individual conditions, including possible disabilities, have on their progress through the system. There were a number of instances where a ward, when finding out the purpose of my visit, would tell me, "Oh, Joe (referring to another ward) needs a new hearing aid…" or "Joe doesn't like his meds…", and so on.

One might expect that gang activity would negatively affect this aspect regarding the rights of wards with disabilities. Certainly ward harassment based on gang affiliations, together with its frequent manifestations of violence and hatred, is prevalent. And wards with disabilities are certainly as susceptible to gang-related harassment and violence as any ward. However, upon

examination, harassment appeared to almost always be the result of gang or ethnic differences and not disability. I asked one ward who had been involved gang-related violence on numerous occasions if others used his obvious disability as an object of violence, and he said, "Nah, they wouldn't do that", implying that victimizing one's disability was "out of bounds" (where few other things were). Another interesting phenomenon that was described to me by a staff member, and that I also observed, is that two wards whose gangs were the most hated rivals, when removed from those gangs and the related peer pressure, would often individually establish an strange sense of camaraderie.

I was also expecting peer pressure to have a major negative impact on outward manifestations of a ward's disability, for example, the wearing of a hearing aid or glasses, picking up medications, etc. However, while certainly some wards might be self-conscious or embarrassed over these things, I did not find that it was a significant issue with wards. For several wards about whom staff reported that they would not wear their hearing aids or glasses as they should, I found the more likely reason to be that they were not the most appropriate accommodation, as discussed in Sections 4.2 and 4.8.

To summarize, I feel that all wards are in need of orientation (as opposed to training) on the ADA, IDEA, and disability policies and procedures within the CYA, as discussed in Section 4.1. And adding a component that addresses awareness and discourages harassment and discrimination is also advisable. However, the main objective to this orientation should be informational and to assure that wards with disabilities understand their rights under federal and state laws and regulations. For several public school districts in my other projects, I have recommended that an annual "Disability Awareness Day" be instituted. I would stop short of recommending such an activity for the CYA, although I would certainly have no objections to that degree of awareness training as long as the activities and curricula were carefully planned. Since conditions at the various institutions can change rapidly, I would recommend that both the facility and agency-wide programmatic ADA Coordinators monitor conditions that could lead to potential harassment and discrimination of wards with disabilities.

Recommended Policies and Procedures

1. Expand the wards' orientation at the intake centers to include specific information about the ADA, IDEA, and wards' with disabilities rights, as well as programs for wards with disabilities within the CYA (see also Section 4.1). Include information about disability awareness and the need to eliminate any harassment.

6. Specific Area of Inquiry - Do disabled wards have a reduced ability to reach a higher program phase or parole?

Before this question can be answered, it is important to fully understand the terms "higher program phase" and "parole". Since these two terms actually represent two distinct processes within the CYA, they would best be discussed separately.

(a) Higher Program Phase:

This term can actually have two different connotations within the context of programs within the CYA.

A less rigid definition would refer to the general level of programs provided to all wards. There are many programs within the CYA, and most individual programs are actually available to a small minority of wards. Examples are sex offender programs, free venture programs, fire prevention training program, etc. While it would be ideal for all wards to have full access to and participate in all available programs, practical allocations of resources make such a situation impossible. Furthermore, a ward's general behavior, tendency toward aggression or violent behavior, success in past programs, and sometimes even the committing offense all play a role in determining what programs are made available to a specific ward.

Some programs are by nature more advanced than others. By "more advanced", it is not implied that these programs are for wards who have greater intellectual potential or excel in academics. It is meant to refer to a general practice that those wards who have demonstrated success in a wide range of activities generally are more able to move on to more popular and more intensive programs. Reaching this ability to participate in the more advanced programs represents what could be termed a "higher program phase".

There are a number of criteria that determine whether or not a ward can reach this level of participation. The most critical factor is behavior, or in reality, the lack of Level 2, and 3 DDMS violations, as described in Section 4.4. Some programs have specific criteria for the number of DDMS violations a ward may have received; others are more subjective. For the more subjective programs, a decrease in DDMS violations, or an improvement in staff's perception of general behavior, helps a ward meet the criteria. There are various other criteria that can affect a ward's ability to reach a higher program phase, including completion of a high school diploma or G.E.D., number of units completed, past program success, etc. Likewise, these vary from program to program, and some have definitive educational or past work experience requirements.

A more literal definition would relate to the "phase" system utilized at the majority of living units, including specialized and separated (having limited or no contact with other wards) treatment programs. The phase system usually places wards in phases 1, 2, or 3, although some institutions use a letter system. The highest phase wards have access to special privileges and "perks". For example, general population wards at O. H. Close YCF have access to private rooms, where other wards live in a dormitory setting (although there are usually more highest phase wards than available private rooms).

For these two somewhat related ways to define and understand program "phases", the question of whether or not wards with disabilities have a reduced ability to reach higher phases comes down to whether or not wards with disabilities are treated equally to other wards under the daily operations of the CYA. Generally, there are no specific guidelines or any written documentation that wards with specific disabilities are not allowed to participate in higher phase programs or reach the highest phase designations at their living units. (There may be a few exceptions to this statement that involve eligibility requirements for special programs, as discussed in Section 4.15.)

An evaluation of a ward's with a disability access to higher phases is often individual. For example, one ward with a mobility impairment whom I interviewed and whose activities I reviewed in detail, had been able to participate in two unique special programs, had reached and stayed at the highest phase at the living unit, and had no serious DDMS violations; unless conditions changed drastically, this ward would almost certainly parole on the parole consideration date. Another ward with a mobility impairment had been in intensive treatment programs, had been extremely disruptive and violent with numerous level 3 DDMS violations (whether or not these behaviors were related to the disability was something that I could not ascertain), to the best of my knowledge had never been in an advanced program, and would likely have a hard time at the parole hearing. These are probably the two extremes.

As opposed to the two examples above, I believe that the "average" (non-existent) ward with a disability, throughout the term of the confinement, would most likely be to subject to one or more of the situations described in detail in Sections 4.1 through 4.15. It may be an accommodation that really does not appropriately solve a disability-related communication issue. It may be a youth correctional officer at a special management program who verbally communicates instructions to the group and does not realize that a hard of hearing ward is not following those instructions - and a Level 2 write-up may follow. The reality is that some wards with disabilities will individually find these situations no different than their other daily events, and for these wards, the ability to reach higher phases will not be reduced. But for more vulnerable wards, particularly those with less ability to communicate effectively what issues they have difficulty in overcoming, the types of conditions described previously can indeed greatly reduce their ability to reach higher program phases.

The only recommendations I would offer to solve any potential problems of reaching higher program phases would be to implement the recommendations contained in Sections 4.1 through 4.15 and 5.1. All of these issues can have a critical cumulative impact on a ward's with a disability ability to advance through the system to thee higher program phases.

(b) Parole

In discussing wards with disabilities ability to reach parole, one must differentiate between two separate but related processes. The first process basically involves getting before the parole board. The second process involves the Parole Board's granting of parole.

For the first process, a ward's ability to reach parole is similar to the discussion in subsection (a). In fact, getting to parole is really the ultimate "program phase". Certainly, there are conditions all along the way where a ward's progress toward parole can be derailed, in large part to actions that would have nothing to do with a ward's disability, but in some cases, these could be related to a ward's disability. Since an institutional parole agent acts, in some ways, as the ward's advocate in obtaining parole, a ward should have a greater chance of the parole agent reviewing the conditions surrounding any problems a ward with a disability has had in reaching parole. This is another reason why proper training on disability-related topics is critical for institutional parole agents.

A ward can have time added to the board consideration date for various violations. These are determined by the Youth Authority Advisory Committee (YAAC) at each institution, and upheld by the Parole Board if appealed. I attended a number of YAAC hearings and did not perceive any biases or procedures that would specifically reduce the ability of wards with disabilities to receive a full and fair hearing. On the other hand, I also do not recall any specific inquiries into a ward's disability at the hearing, or if that disability had any effect on the alleged violations that caused the ward to appear at the hearing to add time before a parole consideration date. The point to be made here is that if indeed a ward with a disability has a reduced ability to reach a parole consideration date, that reduced ability would have most likely been the result of conditions or events that occurred far in advance of the actual hearing, possibly even years before.

For the second process, I have discussed Parole Board hearings previously in Section 4.1(d), and I do not believe that Parole Board hearings, within themselves, constitute any reduced ability for wards with disabilities to receive parole.

Conclusion

In closing, I would again like to thank everyone who was so cordial and helpful during my site visits.

I would also like to acknowledge the cooperative spirit that the CYA has demonstrated in addressing issues and making recent improvements in a number of program areas, including a number of areas discussed during my site visits. I sincerely hope that the CYA will take all of the opinions and recommendations included in this report in the positive manner in which they are offered, with the objective being to reach that goal to which it is believed all parties aspire - full access to the programs and services within the CYA for wards with disabilities.

Sincerely,

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Logan Hopper