

I. INTRODUCTION

The Special Master submits for filing the Seventeenth Report of the Special Master. This quarterly report reviews the *Farrell* Medical Experts' and the Safety and Welfare Experts' comprehensive reports for their rounds of audits in 2010 and summarizes and analyzes the status of the California Department of Corrections and Rehabilitation, Division of Juvenile Justice's (DJJ) compliance with the *Farrell* remedial plans. The fourth comprehensive report of the Medical Experts, Dr. Joe Goldenson and Madie LaMarre (site visits, February 2010 to December 2010) and the third comprehensive report of the Safety and Welfare Expert, Dr. Barry Krisberg (site visits, December 2009 to September 2010), are attached to this report.¹ The Special Master submits this report following careful consideration of the parties' comments on a prior draft.

II. MEDICAL CARE

The Medical Experts, Joe Goldenson, MD and Madie LaMarre, MN, FNP-PC, completed their third formal round of audits between February and December 2010.² Their comprehensive report was completed in February 2011 and is attached as Appendix A. The Experts' findings and recommendations are summarized in the report's executive summary and recommendations sections.³

¹Goldenson and LaMarre, *Farrell v. Cate*, Fourth Report of Consent Decree by the Medical Experts (January 2011) (Appendix A) and B. Krisberg, *Farrell v. Cate*: Update on Safety and Welfare Remedial Plan Progress (February 2010) (Appendix B).

² The Experts completed their facility monitoring during fiscal year 2009-2010; their Health Care Services Central Office audit was conducted in December 2010.

³ *Id.* at pp. 3-5 and 38.

A. Facility Compliance

As with the Medical Expertsø first and second rounds of formal compliance audits, the experts have assigned compliance scores to each DJJ facility for 18 aspects of medical care.⁴ Generally, facility compliance scores have increased from the previous audit round and DJJ facilities have achieved substantial compliance in most aspects of care assessed. The Special Master previously reported average facility compliance scores for the Medical Expertsø first and second audit rounds and the resulting percentage point increases in average scores.⁵ The following table depicts the same data plus (in bold) average facility compliance scores for the 18 aspects of care assessed and resulting percentage point changes from the Medical Expertsø third audit round⁶:

⁴ With the closure of Heman G. Stark Youth Correctional Facility in February, 2010, the experts conducted site visits to the five remaining DJJ facilities, Preston Youth Correctional Facility, Ventura Youth Correctional Facility, Southern Youth Correctional Reception Center and Clinic, NA Chaderjian Youth Correctional Facility and OH Close Youth Correctional Facility.

⁵ See Fifteenth Report of the Special Master, July 2010, p. 3.

⁶ *Id.* at pp. 3-4.

Average Facility Compliance Scores (%)

Aspect of Care	1st Round ^a	2 nd Round (% difference) ^b	3 rd Round (% difference) ^c
Peer Review	41	97 (+56)	100 (+3)
Facility Leadership, etc.	52	90 (+38)	95 (+5)
Quality Management	50	88 (+38)	95 (+7)
Health Records	38	75 (+37)	81 (+6)
Nursing Sick Call	45	72 (+27)	75 (+3)
Chronic Disease Management	68	93 (+25)	91 (-2)
Intra-system Transfer	65	89 (+24)	91 (+2)
Infection Control	62	83 (+21)	100 (+17)
Credentialing	79	98 (+19)	100 (+2)
Consultations	78	92 (+14)	96 (+4)
Medical Care	78	92 (+14)	88 (-4)
Medication Administration: Process	77	89 (+12)	95 (+6)
Outpatient Housing Unit	70	81 (+11)	88 (+7)
Medical Reception	58	67 (+9)	84 (+17)
Pharmacy Services	92	100 (+8)	96 (-4)
Urgent/Emergent Care	71	74 (+3)	79 (+5)
Medication Administration: Records	82	84 (+2)	88 (+4)
Preventive Services	85	87 (+2)	89 (+2)

The experts again report improvement in Health Care Services Remedial Plan implementation across aspects of care. All but four (78%) of the 18 aspects of care assessed now meet the 85% or above substantial compliance benchmark compared to only 7 of 18 (39%) aspects of care that met the benchmark as of the experts' previous audit round.⁷ DJJ health care staff is commended for achieving at least 90% compliance in more than half of the aspects of care assessed

^a. The data source for this column is the Ninth Report of Special Master (June 2009) pp. 2-4, based on *Farrell v. Hickman*, Second Report of Consent Decree by the Medical Experts.

^b. This column depicts the average of facility compliance scores from Goldenson and LaMarre Third Comprehensive Report, pp. 18-38. The average is calculated by adding the scores for all facilities for an area and dividing by the number of facilities scored on the area.

^c. This column depicts the average of facility compliance scores from Appendix A, pp. 19-37.

⁷ See Health Care Audit Instrument, pp. 3-4.

and for achieving fully 100% compliance in three aspects of care including Peer Review, Infection Control and Credentialing. For each of four aspects of care that did not meet the 85% benchmark, including Health Records, Nursing Sick Call, Medical Reception and Urgent/Emergent Care, average facility compliance scores increased by at least three percentage points (Nursing Sick Call) and as much as 17 percentage points (Medical Reception).

In addition to auditing facilities for implementation across aspects of care, the experts provide overall compliance scores for each facility audited. The Special Master previously reported that four of five DJJ facilities met or exceeded the 85% substantial compliance benchmark.⁸ The Medical Experts again report progress at facilities, but only identify one facility as having achieved overall substantial compliance. Preston Youth Correctional Facility (øPYCFö) received a score of 92% overall compliance and achieved substantial compliance with Health Care Services Remedial Plan.⁹ Ventura Youth Correctional Facility (øVYCFö) achieved an overall compliance score of 87%, up from 79% for the previous audit round.¹⁰ Despite improvements, the experts did not find VYCF in substantial compliance pending the reduction of unnecessarily high medical appointment volume and appointment rescheduling and cancellation rates.¹¹ Southern Youth Correctional Reception Center and Clinic (øSYCRCCö) received a lower overall compliance score for this round than it did for round two.¹² The facility's overall compliance score reduced by two percentage points from 88% for round two to 86% this round.¹³ Despite the reduction, the facility's score

⁸ See Sixteenth Report of the Special Master, November 2010, p. 22.

⁹ Appendix A, p. 19 and see Fifteenth Report of the Special Master, July 2010, p. 6.

¹⁰ Compare Appendix A, p. 23 with Goldenson and LaMarre Third Comprehensive Report, p. 33.

¹¹ Appendix A, p. 23. The medical experts report that the closure of Heman G. Stark Youth Correctional Facility and problems related to the subsequent transfer of youth to VYCF, resulted in an unexpected spike in violence which caused or increased the frequency of medical appointment rescheduling and cancellations.

¹² Compare Appendix A, p. 40 with Goldenson and LaMarre Third Comprehensive Report, p. 28.

¹³ Appendix A, p. 28.

exceeds the 85% substantial compliance benchmark. However, the Medical Experts do not find SYCRCC in substantial compliance this audit round, noting problems in the areas of Medical Reception and Urgent/Emergent Care in particular. Lastly, Northern California Youth Correctional Complex (ñNCYCCö) received an overall compliance score of 84%.¹⁴

B. DJJ Central Office Compliance

In addition to facility ratings, the Medical Experts again provided ratings for DJJ Central Office on twenty ñquestionsö or topics under two categories: (1) organization, budget, leadership and staffing (13 topics) and (2) statewide pharmacy services (seven topics). Ratings are reported in cumulative compliance percentages of the 13 and seven topics that the experts find in substantial compliance.¹⁵ DJJ has achieved substantial compliance with five (38%) of the 13 topics related to organization, budget, leadership and staffing and with five (71%) of the seven statewide pharmacy services topics.¹⁶

Notably, Central Office ratings are substantially lower overall than facility ratings. This difference is explained by the lack of progress and, in some cases, a decline in ratings of Central Office implementation measures since the Medical Experts' last audit round.¹⁷ In the previous round, DJJ achieved substantial compliance ratings for 12 of the 20 Central Office compliance measures and partial compliance for the eight remaining measures. This round, DJJ's Central Office achieved substantial compliance for 10 measures, partial compliance for nine measures and

¹⁴ On Defendant's request, beginning this audit round, the Medical Experts assess for and assign a single compliance rating for NA Chaderjian Youth Correctional Facility and OH Close Youth Correctional Facility, which are now identified in the experts' reports and the Office of Special Master's report as, ñNorthern California Youth Correctional Complexö.

¹⁵ Appendix A, p. 7.

¹⁶ *Id.* at pp.14,18.

¹⁷ Compare *ibid.* with Goldenson and LaMarre Third Comprehensive Report, pp. 17, 21. This is the source for the remainder of the paragraph.

noncompliance for one staffing measure that requires the appointment of a Clinical Record Administrator to ensure compliance with health record policies and procedures.

C. Areas for Improvement and Implementation Successes

The experts identify several Central Office Health Care Services Remedial Plan implementation problems that have persisted through at least two audit rounds.¹⁸ These issues must be resolved in order for DJJ to achieve substantial compliance with the Health Care Services Remedial Plan:

Organizational Structure. The experts report that as of December 1 2010, DJJ still had not approved a final organizational chart that clearly identified reporting relationships and Health Care Services structure at Central Office and the facilities, an observation that was also made following the previous audit round.¹⁹ By December 31, 2010, DJJ finalized and approved an organizational chart that the experts note includes the chief dental authority consistent with their round three recommendation.²⁰ The experts note that as DJJ continues to undergo change, shifts in leadership and reporting structure are expected, but that staff must be clear at all times about the reporting structure and lines of authority and accountability.

Staffing. Following their second round of audits, the experts recommended that DJJ monitor health resource utilization and assess whether the number and type of Health Care Services staff were sufficient, with the goal of adjusting personnel resources consistent with the needs of DJJ's changing patient population.²¹ They make the same recommendation this round.²² Failure to

¹⁸ *Id.* at 3-19.

¹⁹ *Id.* at 3 and Goldenson and LaMarre Third Comprehensive Report, p. 7

²⁰ See Letter from William Kwong, January 24, 2011, to J. Goldenson and M. LaMarre, p. 2 and Appendix A pp. 3-4. This is the source for the next sentence.

²¹ See Goldenson and LaMarre Third Comprehensive Report, p. 4.

²² Appendix A, pp. 3-4. As of the filing of the experts' last comprehensive report, Heman G. Stark Youth Correctional Facility had been closed and resources redistributed significantly. As of this Seventeenth Report of the Special Master
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properly monitor and assess staffing needs coupled with high turnover in health care leadership result in poor management and what the experts believe is an unsustainably high health care budget.

Quality Management Plan. The experts again recommend that DJJ's Quality Management Plan allow for and require DJJ facilities to focus on issues unique to facilities in addition to the current focus primarily on the Health Care Services Remedial Plan requirements.²³ Failure to identify and remedy issues unique to individual facilities places at risk for compromise the provision of services overall and ultimately DJJ's compliance with Health Care Services Remedial Plan requirements.

Nursing Sick Call. Lastly, following the second audit round, the experts recommended that DJJ improve implementation of nursing sick call requirements. Requirements are still not fully met as of this filing.

The Special Master also notes areas of continued progress as reported by the Medical Experts over two audit rounds including, at facilities, highly motivated staff in the provision of quality services, custody and medical staff cooperation and health care and housing unit sanitation. In the provision of services generally, the experts note continued success in the areas of pharmacy and preventative services, chronic disease evaluation and management and clinical evaluations. DJJ is commended for continued progress in these and other areas of successful implementation.

D. Transfer of Health Care Services Monitoring to DJJ

In November 2010, the Special Master outlined the plan to begin the transfer of monitoring responsibilities for certain items in each of the remedial plans from the *Farrell* Experts and the

filing, the PYCF closure has been announced along with plans for additional resource redistribution. The experts believe that DJJ can meet remedial plan requirements with reduced staffing. This is the source for the next sentence.

²³ *Id.* at p. 5 and Goldenson and LaMarre Third Comprehensive Report. This is the source for the next sentence and the following paragraph.

Office of the Special Master (OSM) to DJJ.²⁴ The OSM and experts reviewed each plan, their accompanying audit tools and corresponding compliance histories for items audited and selected those that were appropriate for transfer of monitoring. Initially, having completed only their second round of formal audits, the Medical Experts identified few areas that they believed would be appropriate for self-monitoring by DJJ Health Care Services and internal audit staff. Following this third audit round, the Medical Experts should now be able to utilize the patterns of successful implementation to select additional items or even plan topics that may be appropriately transferred for monitoring to DJJ. Items that might be particularly appropriate for transfer include but are not limited to those with compliance scores of at least 85% and that are neither the cause of nor impacted by an on-going systemic problem as identified by the experts.

III. SAFETY AND WELFARE

The Safety and Welfare Expert, Dr. Barry Krisberg, conducted a full round of site audits between December 2009 and September 2010.²⁵ Data referred to as "the round" indicates this time period unless otherwise specified. Dr. Krisberg provided his draft and final revised version of his comprehensive report to the parties and the OSM on February 1, 2011.²⁶ The comprehensive report for the third round of site visits is attached as Appendix B. The Special Master has organized this review of safety and welfare issues in accordance with the organization of the Safety and Welfare Remedial Plan ("remedial plan"). The remedial plan clearly identifies the areas that DJJ is expected to change or improve to achieve compliance with agreements negotiated by the parties and therefore sets the standard by which progress should be assessed. While this review focuses mostly on areas

²⁴ See Sixteenth Report of the Special Master, pp. 39-42.

²⁵ This will be the second round in which Dr. Krisberg audited all facilities and central office since the inception of the audit tool in October of 2006. In the first round, Dr. Krisberg audited three of eight facilities and central office. See OSM 13, p.1.

²⁶ See e-mail from Barry Krisberg to Nancy Campbell, January 7, 2011 (attaching draft report) and e-mail from Barry Krisberg to Nancy Campbell, et al, February 1, 2011 (attaching revised report).

monitored by the Safety and Welfare Expert, when assessing progress, it is important to review as many aspects of the remedial plan as possible. A summary of progress to date will be followed by an assessment of progress in each major section of the remedial plan.²⁷

A. Progress Overview

Progress in the area of safety and welfare can be difficult to measure. There are objective and subjective measures of issues like safety. The Safety and Welfare Remedial Standards and Criteria (‘standards and criteria’) which were developed by DJJ and the Safety and Welfare Expert and approved by the Plaintiff provides one measure of progress.²⁸ The Safety and Welfare Expert uses these standards and criteria to audit DJJ facilities and Central Office. At the Special Master’s request, the *Farrell* Litigation Coordinator summarized the change in progress by action item and provided documentation. Recognizing that items vary in complexity, review of the major areas helps to develop a picture of DJJ’s safety and welfare progress. Based on Table 1 below, it is clear that with a few exceptions, progress was made between rounds two and three.

²⁷ There is a section in the remedial plan labeled ‘Other Issues.’ Where the Special Master believes a topic in this section is important to discuss, she has incorporated it into one of the other sections of the remedial plan. For example, Identifying a Rehabilitative Model is in this section.

²⁸ Recognizing the on-going dispute regarding weighting of issues, the standards and criteria while not a perfect measure of compliance are at this point the best guide for measurement.

Table 1²⁹

**Safety & Welfare Expert’s Compliance Percentages
by Audit Tool Sections and Round**

Add Central Office Resources				Clarify Lines of Authority				Improve MIS Capability			
2.1	Rd. 1	Rd. 2	Rd. 3	2.2	Rd. 1	Rd. 2	Rd. 3	2.3	Rd. 1	Rd. 2	Rd. 3
SC	100%	100%	100%	SC	14%	40%	33%	SC	0%	0%	0%
PC	0%	0%	0%	PC	86%	40%	50%	PC	0%	0%	100%
BC	0%	0%	0%	BC	0%	20%	17%	BC	0%	0%	0%
NC	0%	0%	0%	NC	0%	0%	0%	NC	100%	100%	0%
# Items	1	1	1	# Items	7	5	6	# Items	1	1	1
(#NA)	(0)	(0)	(0)	(#NA)	(0)	(2)	(2)	(#NA)	(0)	(0)	(0)
Add Resources at Each facility				Research				Reduce Violence and Fear			
2.4	Rd. 1	Rd. 2	Rd. 3	2.5	Rd. 1	Rd. 2	Rd. 3	3.0	Rd. 1	Rd. 2	Rd. 3
SC	100%	33%	80%	SC	0%	0%	50%	SC	45%	54%	72%
PC	0%	0%	20%	PC	0%	0%	50%	PC	40%	34%	23%
BC	0%	0%	0%	BC	0%	0%	0%	BC	8%	6%	5%
NC	0%	67%	0%	NC	100%	100%	0%	NC	7%	6%	0%
# Items	2	3	5	# Items	1	1	2	# Items	73	68	64
(#NA)	(4)	(4)	(0)	(#NA)	(1)	(1)	(0)	(#NA)	(2)	(2)	(7)
Identify Rehabilitation TX Model				Lay Foundation for TX Reform				Convert Facilities to Rehab. Model			
4.0	Rd. 1	Rd. 2	Rd. 3	5.0	Rd. 1	Rd. 2	Rd. 3	6.0	Rd. 1	Rd. 2	Rd. 3
SC	50%	67%	50%	SC	0%	0%	62%	SC	29%	36%	29%
PC	0%	0%	50%	PC	25%	25%	25%	PC	19%	29%	19%
BC	0%	0%	0%	BC	25%	25%	12%	BC	14%	14%	14%
NC	50%	33%	0%	NC	50%	50%	0%	NC	38%	21%	38%
# Items	2	3	2	# Items	8	8	8	# Items	21	28	21
(#NA)	(0)	(0)	(0)	(#NA)	(0)	(0)	(0)	(#NA)	(13)	(11)	(13)
System Reform for Females				Acceptance/Rejection Criteria				Orientation			
7.0	Rd. 1	Rd. 2	Rd. 3	8.1	Rd. 1	Rd. 2	Rd. 3	8.2	Rd. 1	Rd. 2	Rd. 3
SC	0%	0%	33%	SC	20%	20%	40%	SC	0%	0%	60%
PC	0%	0%	0%	PC	80%	80%	40%	PC	0%	0%	40%
BC	0%	0%	67%	BC	0%	0%	0%	BC	80%	80%	0%
NC	100%	100%	0%	NC	0%	0%	20%	NC	20%	20%	0%
# Items	3	3	3	# Items	5	5	5	# Items	5	5	5
(#NA)	(0)	(0)	(0)	(#NA)	(1)	(1)	(1)	(#NA)	(0)	(0)	(0)
Disciplinary System				Positive Incentives				Grievance System			

²⁹ Table 1 was created by the *Farrell* Litigation Coordinator at the request of the Special Master. Seventeenth Report of the Special Master
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8.4a	Rd. 1	Rd. 2	Rd. 3	8.4b	Rd. 1	Rd. 2	Rd. 3	8.5	Rd. 1	Rd. 2	Rd. 3
SC	87%	83%	100%	SC	20%	20%	40%	SC	84%	85%	94%
PC	4%	8%	0%	PC	20%	20%	60%	PC	8%	9%	6%
BC	9%	8%	0%	BC	40%	40%	0%	BC	8%	6%	0%
NC	0%	0%	0%	NC	20%	20%	0%	NC	0%	0%	0%
# Items	23	24	24	# Items	5	5	5	# Items	38	33	33
(#NA)	(0)	(0)	(0)	(#NA)	(0)	(0)	(0)	(#NA)	(0)	(0)	(0)

Time Adds				Access to Courts and Law Library				Access to Religious Programs			
8.6	Rd. 1	Rd. 2	Rd. 3	8.7	Rd. 1	Rd. 2	Rd. 3	8.8	Rd. 1	Rd. 2	Rd. 3
SC	44%	50%	64%	SC	27%	20%	90%	SC	100%	100%	100%
PC	0%	0%	36%	PC	18%	30%	10%	PC	0%	0%	0%
BC	37%	43%	0%	BC	9%	10%	0%	BC	0%	0%	0%
NC	19%	7%	0%	NC	45%	40%	0%	NC	0%	0%	0%
# Items	16	14	14	# Items	11	10	10	# Items	3	3	3
(#NA)	(0)	(0)	(0)	(#NA)	(0)	(0)	(0)	(#NA)	(0)	(0)	(0)

Physical Plant Improvements				Master Planning				Restricted Housing			
8.9	Rd. 1	Rd. 2	Rd. 3	8.10	Rd. 1	Rd. 2	Rd. 3	9.0	Rd. 1	Rd. 2	Rd. 3
SC	88%	87%	100%	SC	0%	0%	0%	SC	84%	85%	79%
PC	0%	0%	0%	PC	50%	50%	50%	PC	3%	4%	21%
BC	0%	0%	0%	BC	50%	50%	50%	BC	3%	4%	0%
NC	12%	13%	0%	NC	0%	0%	0%	NC	9%	8%	0%
# Items	17	15	16	# Items	2	2	2	# Items	32	26	24
(#NA)	(2)	(1)	(0)	(#NA)	(0)	(0)	(0)	(#NA)	(9)	(9)	(11)

Lockdowns			
10.0	Rd. 1	Rd. 2	Rd. 3
SC	100%	100%	80%
PC	0%	0%	20%
BC	0%	0%	0%
NC	0%	0%	0%
# Items	5	5	5
(#NA)	(0)	(0)	(0)

Of the twenty-two major areas covered in the standards and criteria, 17 show improvement and five show a small decline in compliance. Notable increases in compliance have occurred in

adding resources at the facility, research, laying a foundation for reform, orientation, positive incentives, and access to courts and a law library.³⁰ The five areas of decline include:

- Clarify Lines of Authority,
- Identify a Rehabilitative Model,
- Converting Facilities to a Rehabilitative Model,
- Lockdowns, and
- Restricted Housing

Clarify Lines of Authority, item 2.2, decreased from 40% to 33% substantial compliance, largely as a result of senior staff changes following the departure of the former Chief Deputy Secretary and the failure of DJJ to reflect some of the staff changes in the agency organizational chart.³¹ It is unclear why Dr. Krisberg shows a decline from 67% to 50% in the area of Identifying a Rehabilitative Model (item 4.0) because, during this period, agreement on the model was finally reached, a consultant was hired to facilitate the process and DJJ formed a team for development and implementation of the model.³² The Special Master believes that progress has been made on this action item. Decline in the rating for item 6.0, Converting Facilities to a Rehabilitative Model, follows the results of a DJJ internal audit that revealed problems and inconsistencies (between units and institutions) with Program Service Day implementation. The Program Service Day is a foundation for any rehabilitative model.³³ For the second time, the Safety and Welfare Expert rated four out of five elements under Lockdowns (item 10) in substantial compliance. However, he reduced the rating for the fifth element because of a perceived need to expand current policy to

³⁰ The areas noted for improvement all have at least a 40% increase in substantial compliance. It should be noted that these items vary significantly in their scope, importance and the baseline from which the percentage is derived. The areas of decline range from 6% to 20% decrease in substantial compliance.

³¹ See Central Office SW Audit Round Three Final, item 2.2.

³² Further discussion of the agreement on the Integrated Behavioral Treatment Model can be found in Section E. Identify a Rehabilitative Model.

³³ See item 6.2a of the Central Office SW Audit Round Three.

include limited programs on the living units.³⁴ Finally, restricted housing showed a decline of 6% because of the small decline in cleanliness and in the provision of mandated services at some facilities.³⁵ The Safety and Welfare Expert notes this area as one of DJJ's great successes. All Special Management Programs have been eliminated and the use of Temporary Detention (TD) units has dropped by more than 50 percent.³⁶ Not only has the number of youth placed on TD declined, but lengths of stay on TD have declined as well.³⁷

Overall, significant gains have been made this round as reflected in scores for several remedial plan audit items including Access to Courts and Law Library (70%), Research (50%), Laying the Foundation for Reform (62%), Adding Resources, Conflict Resolution Teams (47%), Positive Incentives (40%) and System Reform for Females (33%). Several of these issues, such as the use of Conflict Resolution Teams, Positive Incentives and Creating a Foundation for Treatment Reform and Research are directly related to the issue of reducing fear and violence discussed in Section C below.

B. Creating Capacity for Change

The elements of the remedial plan that speak to creating the capacity for change include:

- Insufficient management resources in the central office and at facilities,
- Lack of clarity and consistency in agency policies and procedures,
- An inadequate system for holding staff accountable at all levels,
- An inadequate management information system for providing managers with useful data,
- Inadequate training, particularly in regard to juvenile standards of care and practice.

³⁴ *Id.*, item 10.5

³⁵ See e-mail from Doug Ugarkovich, January 31, 2011. Specifically, S&W Item 9.2.3: TD rooms clean, well lighted, graffiti free. NA Chaderjian Youth Correctional Facility went from Substantial Compliance in Round 2 to Partial Compliance in Round 3. Also, SYCRCC went from Not Applicable in Round 2 to Partial Compliance in Round 3.

³⁶ Appendix B, p.11.

³⁷ *Id.* Dr. Krisberg provides an example here of thoughtful, evidence-based thinking. Data regarding reasons for placing youth in restricted housing were analyzed and then policy and training was adjusted to stop inappropriate placement of youth. DJJ should continue this process to ensure achievement of substantial compliance in this area.

Not all of these areas will be fully reviewed in this report, though a cursory review of these issues indicates that DJJ continues to build its capacity to support change.

Staff "right sizing" efforts at both the facilities and Central Office indicate that there are sufficient management resources in both settings.³⁸ The dramatic decline in DJJ's youth population has actually resulted in excessive management resources at DJJ Central Office.³⁹ The challenge before DJJ at this time is to ensure that the right sizing of Central Office results in the right quantity and quality of staff necessary to continue the reform efforts in the most cost-effective manner.

Efforts to create clear and consistent policies and procedures have continued throughout this round. Forty-four policies and procedures were written or re-written by DJJ compliance team staff and reviewed by experts and the Special Master's office staff.⁴⁰

The Special Master has not explored the issue of performance management for staff and therefore cannot comment on any progress or lack thereof during the round.

There has been consistent work throughout the round to improve management information systems. Instructions for the entry of data into the Performance Based Standards ("PbS") and "COMPSTAT" data bases continue to be updated and refined.⁴¹ Trend data exists for youth violence, batteries, physical alterations, group disturbances, serious disciplinary incidents, use of force, chemical use of force and staff assaults that provides measures for staff to analyze whether or

³⁸ See "Right Sizing DJJ Central Office Operations, CDCR, Division of Juvenile Justice, July 2010, a report by consultant Christopher Murray. Mr. Murray also did a similar right sizing report for institutional staffing. What is the site for that report?

³⁹ The Acting Deputy Secretary has discussed a proposal to reduce the Central Office staffing but no details of the proposal were available at the time of the writing of this report.

⁴⁰ See e-mail from Doug Ugarkovich, January 31, 2011.

⁴¹ The Use-of-Force Task Force has found the facilities each have different methods for capturing use-of-force data. Recommendations will be forthcoming to correct this.

not reform efforts are successful.⁴² Changes continue to be made that improve the data systems' accuracy.⁴³ Adequate trend data exist to analyze safety issues at all facilities. However, it is unclear to what extent such data have been used by DJJ's Central Office and facility administrators to reduce incidence of violence and force.

While these efforts are commendable and are critical to the reform effort, there remain many challenges in creating integrated information systems that allow staff to understand the behavior and needs of individual youth. Critical to achieving a safe and rehabilitative system is the sharing of information about a youth's treatment needs with all staff that work with the youth. DJJ is congratulated for working to implement a case plan that is tied to a valid and reliable risk/needs assessment such as the California-Youth Assessment Screening Instrument (CA-YASI). The goal of an integrated risk/needs and case plan is part of the Integrated Behavioral Treatment Model (IBTM) pilot.

At present, Case Managers are the only staff that currently have access to the CA-YASI assessment data and case plans.⁴⁴ This results in Case Managers completing two case plans, the Identified Treatment Issue (ITI) which is accessible by all unit staff and the CA-YASI, accessible

⁴² See DJJ Facilities Counting Rules (2). Trend data is drawn both from COMPSTAT and PbS databases. This allows for comparison within DJJ over time and to other juvenile correctional facilities over time.

⁴³ For example, changes are being made in how mechanical restraints are counted in the PbS system to make California data align better with the national data so more accurate comparisons can be made. Coaches are provided to ensure that if staff has questions regarding data entry for PbS or Compstat, they can contact someone for guidance.

⁴⁴ The initial CA-YASI is in the Word Information Network System but it appears few staff other than Case Managers know this and therefore do not access the information. This conclusion is drawn by the Special Master from conversations with staff on living units while touring institutions and from the comments of teachers at OH Cloce Youth Correctional Facility during IBTM training. See Proof of Practice (PoP) 780, p.2 of Memorandum from trainer, DaiNette Bowens to Tami McKee-Sani dated January 7, 2011.

only by the Case Managers. This duplication of efforts frustrates Case Managers who would like to put their time into other activities.

This parallel process is typical when implementing a new risk/needs tool and case plan. Recognizing that the implementation of such an assessment and case planning process takes time, interim efforts are under way to expedite the sharing of reliable risk/needs and treatment data to staff. DJJ is working to import information from the CA-YASI into the ITI. Early training efforts by the IBTM implementation team highlight the fact that staff are anxious to understand and to use the CA-YASI to better understand the needs of a given youth so they can interact successfully with the youth.⁴⁵ DJJ needs to prioritize the completion of tasks that will allow for the use of one case plan that can be shared by all unit staff.

Finally the capacity to create change relies on having staff trained in both the conceptual model of the desired change as well as the strategies and tactics to implement the model. There is no question that significant training of staff in several areas occurred during this round. DJJ is also beginning the critical step of explaining the conceptual model for rehabilitative change so that staff understand why the various changes in policy and practice are being requested.

Efforts to train staff in standards of care and practice have continued in this round. Training records reflect the following training during the round:

- 370 staff completed 3 day Motivational Interviewing.
- 21 staff were trained as trainers in Motivational Interviewing.
- 51 staff in case management I (ECWI).
- 51 staff in case management II (ECW2).
- 18 staff trained as trainers in ECW.
- 71 staff trained as coaches for ECW.
- 55 staff trained in Counterpoint a cognitive behavioral 5-day program.
- 12 staff trained as trainers in Counterpoint.

⁴⁵ See PoP 780 which describes the training of education staff by the IBTM implementation team. The educators indicate interest in accessing and using the CA-YASI.
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- 85 staff trained in the Cognitive Behavioral Primer.
- 14 staff trained in Safe Crisis Management.⁴⁶
- 123 staff trained as Master Trainers in Interactive Journaling.
- 308 staff trained in Interactive Journaling

Training in all of the areas listed above helps to build the type of skills needed by staff to transition from a culture of containment to a culture of rehabilitation. Motivational interviewing teaches staff to identify and respond effectively to youth needs and case-work training helps staff understand how to develop a cogent and effective plan for addressing rehabilitation issues. Cognitive behavioral programs help youth address criminogenic needs and safe crisis management helps staff learn how to safely and effectively defuse and contain crisis situations. While the numbers of staff trained during the round is impressive, DJJ faces the challenge of rapidly losing trained staff who are leaving the agency due to institution closures and fear that the agency will be closed altogether. For example, in the area of prevention and crisis management, of 368 staff trained only 225 remain at DJJ. Staff training is a key strategy in implementing the IBTM.⁴⁷ A stable vision of the future must be presented to stop the outflow of staff and thus ensure sufficient levels of staff are trained in key areas.

As discussed above, the next step is through the development of the IBTM to help staff understand why these strategies are needed and how they fit into a comprehensive model that will increase the physical and psychological safety and security of DJJ's youth. Feeling safe and secure is a prerequisite for rehabilitative efforts that can lead to changes in anti-social behavior.

C. Reducing Fear and Violence

⁴⁶ See PoP 785, p.1, #6, which is a request from the Special Master regarding a variety of issues. Re-certification is tentatively scheduled for April 11-15, 2011.

⁴⁷ See PoP 785, training records.

The remedial plan outlines many steps that DJJ will take to reduce the level of fear and violence in its facilities. Creating a safe environment remains one of the greatest challenges for any residential institution, particularly one with young people, most of whom have not developed the skills to self regulate their behavior. A safe environment is not something that can be dictated by policy, but rather is the product of changing the attitudes and beliefs of staff regarding their role. If staff believe safety is a product of using chemical restraints, they will attempt to use force to create a safe environment. On the other hand, if staff believe that safety is achieved by teaching youth how to regulate their emotions and behavior, they will want to learn how to help youth change their behavior and, in so doing, support the youth in creating a safe environment. In any case, staff cannot force safety to happen. It is a by-product of youth believing pro-social behavior has more benefits than anti-social behavior.

Many of the violence reduction steps outlined in the remedial plan have been achieved. DJJ has achieved substantial compliance ratings in the areas of reducing living unit size, employing a classification system for living unit assignment, creating violence reduction committees and conflict resolution teams in the institutions and replacing restrictive units with Behavior Treatment Programs (öBTPö).⁴⁸ The development of an integrated behavior treatment model and integration strategies for gangs are both underway but have yet to be completed and have thus received partial compliance ratings by the Safety and Welfare Expert.⁴⁹ Table 2 shows the progress to date for those action items that are included in the reduction of fear and violence section of the standards and criteria. Action items in standard 3.0 include the development of an institutional classification system, revising the use-of-force policy, training staff in safe crisis management, developing

⁴⁸ See Central Office and facility audits for the round and Appendix B, p.4. The Safety and Welfare expert has indicated that while there is substantial compliance with the number of BTPs, currently a longer-term plan is still needed.

⁴⁹ *Id.*

databases to track violence and use-of-force rates, developing gang integration strategies, opening and maintaining sufficient BTP units, and developing climate surveys to measure staff and youth perceptions and experience regarding fear and violence. Many of these items are in substantial compliance and/or are making significant progress toward achieving substantial compliance.⁵⁰ Significant progress has been made in implementing the action steps identified in the remedial plan.

Table 2
Safety & Welfare Expert
Section 3.0: Reduce Violence and Fear
Historical Progress by Rounds of Audits

ROUND 1				ROUND 2				ROUND 3			
REMEDIAL PLAN:	Safety & Welfare			REMEDIAL PLAN:	Safety & Welfare			REMEDIAL PLAN:	Safety & Welfare		
AUDIT SITE:	Reduce Violence and Fear			AUDIT SITE:	Reduce Violence and Fear			AUDIT SITE:	Reduce Violence and Fear		
AUDIT DATE:	S&W Expert - Round 1			AUDIT DATE:	S&W Expert - Round 2			AUDIT DATE:	S&W Expert - Round 3		
# ITEMS IN SC:	33	Substantial Compliance	45%	# ITEMS IN SC:	37	Substantial Compliance	54%	# ITEMS IN SC:	46	Substantial Compliance	72%
# ITEMS IN PC:	29	Partial Compliance	40%	# ITEMS IN PC:	23	Partial Compliance	34%	# ITEMS IN PC:	15	Partial Compliance	23%
# ITEMS IN BC:	6	Beginning Compliance	8%	# ITEMS IN BC:	4	Beginning Compliance	6%	# ITEMS IN BC:	3	Beginning Compliance	5%
# ITEMS IN NC:	5	Non-compliance	7%	# ITEMS IN NC:	4	Non-compliance	6%	# ITEMS IN NC:	0	Non-compliance	0%
# OF ITEMS RATED:	73			# OF ITEMS RATED:	68			# OF ITEMS RATED:	64		

S&W Expert - Reduce Violence and Fear - Rd. 1

S&W Expert - Reduce Violence and Fear - Rd. 2

S&W Expert - Reduce Violence and Fear - Rd. 3

While progress is being made in implementing the remedial plan's prescribed action steps, it is unclear whether sufficient progress has been made to reduce fear and violence to tolerable levels. To accurately identify and measure what constitutes a safe environment is particularly challenging. Therefore, both qualitative and quantitative measures are included in the remedial plan.

As noted in the Safety and Welfare Expert's third round comprehensive report, there has been a definite decrease in the number of incidents of youth-on-youth violence, however, the rate of

⁵⁰ To see a roll up of the items in this area, see SW Expert Only Master Tracking Sheet-Round 3- as of 1/31/11-for the Office of Special Master .
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violence per 100 youth has not changed significantly.⁵¹ Table 3 compares the ratio of youth-on-youth violence per 100 youth days for calendar years 2008 through the first half of 2010.⁵² Ratios were dropping at the end of 2009 and spiked again in the first half of 2010. Currently the trend has again shifted downward.

Table 3
Youth-on-Youth Violence
Rate Per 100 Youth Days
All Facilities

Month	2008	2009	2010 (Two Quarters)
January	.50	.60	.47
February	.41	.53	.54
March	.37	.45	.58
April	.60	.39	.48
May	.59	.44	.43
June	.49	.40	.43
July	.50	.32	
August	.49	.46	
September	.45	.45	
October	.46	.36	
November	.57	.38	
December	.57	.36	

⁵¹ Appendix B, p.3. Dr. Krisberg is citing data from Compstat which is calculated using violence compared to average daily population (ADP). Caution is advised when comparing data from 2005 and 2010 because changes have been made to the data collection systems so it is likely these are not completely comparable measures.

⁵² The reason that these rates are different from Dr. Krisberg's is they are based on youth days and not ADP. This data is based on youth days, which is the rate that a youth is involved in violence over a twenty four-hour period and population. This rate or ratio of youth days is a more accurate representation because the rate using ADP results is a cumulative measure of incidents of violence across the period being measured compared to an average daily population. Youth days measures the incidents for a twenty-four hour period and compares them against the population during that twenty-four hour period. This accounts for Dr. Krisberg's rate being higher than the data provided by the Special Master.

One hypothesis explains the spike in violence as the result of integrating youth from Heman G. Stark Youth Correctional Facility (HGSYCF) into DJJ's remaining facilities.⁵³ This theory is supported by the timing of the increase in youth-on-youth violence as well as the timing of the increase and decrease in group disturbances. From July 2009 to December 2009 DJJ reported 14 group disturbances. In the first three months of 2010, the period during the movement of youth from HGSYCF to other facilities, the number of group disturbances rose to 22. From April to June 2010, DJJ reported a total of nine group disturbances.⁵⁴ Again, the spike in violence indicators directly coincides with the youth movement. HGSYCF was noted for having a culture that relied more on force and authoritarian control than the other remaining juvenile institutions. The integration of youth from HGSYCF into institutions that focus more on dialogue and problem solving has not been easy but there is clear evidence that effective integration is occurring.⁵⁵

⁵³ See Microsoft excel spreadsheet QSR Jul 9 to Jun 10 Charts land.xls. This is the Compstat data for facility safety indicators discussed in this section.

⁵⁴ *Id.*, The total number of group disturbances from July 09 to December 09 was 14 and from Jan 10 to June 10, 31. These numbers, while similar to what was reported by the Safety and Welfare Expert, differ slightly. The Safety and Welfare Expert's report indicates 20 and 31 respectively. It should also be noted that the expert characterizes these disturbances as having, "often led to restricted programs for the impacted living units for hours and sometimes days." While the Special Master agrees with the expert's conclusion that disturbances increase and exacerbate a climate of fear, the data regarding restricted programming does not indicate there were often extended limited program periods. There were no institution-wide lock downs for the period. Limited programs (where one or more living units have their normal program restricted) ranged from 13 at PYCF to none at SYCRCC from July 1, 2009 to June 30, 2010. NA Chaderjian Youth Correctional Facility had two, OH Close Youth Correctional Facility four and VYCF one. It should also be noted that not all of the youth in a unit must be on a restricted program for it to be classified as a limited program. In other words, sometimes only those youth who engage in problematic behavior are restricted and the data will not indicate the exact number of youth restricted.

⁵⁵ Most notable is the ability of the institutions to get rival gang members to engage in programs together. The Special Master saw examples of youth from rival gangs together in programs at PYCF while on a site visit in July 2010. Notably, the youth from Heman G. Stark Youth Correctional Facility had never done this while at Heman G. Stark Youth Correctional Facility but were successfully doing so at PYCF.

Incident reports are another measure of violence. The rate per youth days for serious incidents, Level 3 Disciplinary Decision Making System (öDDMSö), from July 1, 2009 to Dec. 31st 2009 was 10.7. The rate increased to 12.2 from January 1, 2010 to June 30, 2010. The greatest number of serious incidents (i.e. group disturbances and staff assaults) occurred at VYCF. Since November 2009, VYCF has consistently had a higher rate of serious incidents than other facilities. This data indicates that VYCF continues to struggle with the nature and size of its new population. The other institutions appear to have adjusted better to the influx of youth from HGSYCF.

Despite DJJ's significant success in implementing the standards and criteria action items, the Safety and Welfare Expert notes that the rate of violence does not seem to have changed much since 2006.⁵⁶ The Plaintiff and Safety and Welfare Expert have focused their concerns about the increase in violence on VYCF, which has seen notable culture change in the doubling of its population and the transition from an all female to a co-ed facility. There is no question that the greatest fluctuations in youth violence toward the end of 2009 and early 2010 (the middle of the round) have been at VYCF, NA Chaderjian Youth Correctional Facility (öNACYCFö) and PYCF, but the increase in youth-on-youth violence at O.H. Close Youth Correctional Facility (öOHACYCFö) was the primary factor for the rate increase in from July 2009 to June 2010.⁵⁷ From July 2009 through December 2009, OHACYCF's rate ranged from .17 to .25. From January 2010 through June 2010, the rate ranged from .60 to .66.

This highlights the need for all parties to use existing data as well as interviews and tours to identify possible causes of changes in violence patterns. It is also a reminder that assessing what

⁵⁶ Appendix B, p.4.

⁵⁷ See e-mail from Alex Mora which compares fluctuations in rates of violence. NACYCF went from a low 0.07 to a high 0.52 to reflect a 643% increase. PYCF went from a low 0.31 to a high 1.06 to reflect a 242% increase. OH Close went from a low 0.23 to a high 0.66 to reflect a 187% increase. This date shows that the largest fluctuations were not at NACYCF. The fluctuations may capture attention because they stand out.

constitutes safety is not an easy task. What is not being analyzed in these reports is any changes in the risk and needs of the population. Certainly risk is addressed with the integration of the HGSYCF youth but safety is much dependent on risk and need. DJJ's youth population declined from 2,068 as of December 31, 2007 to 1,278 by December 31, 2009.⁵⁸ As noted by the Safety and Welfare Expert, the considerable changes to the DJJ population has resulted in a smaller but higher risk and need population that creates new management issues and makes it difficult to have confidence in trend data over time.⁵⁹

Currently, all institutions are showing a decline in violence as the integration process progresses. PYCF has seen a decrease of 58% since February, SYCRCC a 61% decrease since March and VYCF's ratio of violence had decreased by almost 50% since the second half of 2009.⁶⁰ The institutions are making significant progress in integrating the HGSYCF youth into their programs. What remains unclear is if the rate of violence is too high for this population. Further study and comparisons with similar populations should be conducted.⁶¹

It appears that there has been some benefit to implementing action items that the remedial plan prescribes to reduce youth violence, however, it remains unclear exactly which action items are responsible for progress achieved to date. While it is impossible to completely understand the impact of reduced living unit size and better unit assignment, the creation of violence reduction committees and conflict resolution teams, and replacing restrictive units with behavior treatment

⁵⁸ See Population Overview of Research and Statistics in DJJ Website

⁵⁹ Appendix B, p.4.

⁶⁰ See QSR Jul 09 ó Jun 10 Charts Land (2).xls

⁶¹ The PbS data system is still undergoing some refinement but overall is well implemented with clear rules and practices. This system allows for comparisons between different juvenile systems and DJJ's rates in general compare favorably against the average rates of all participating jurisdictions. If there is a way to control of age, risk and need, this type of comparison would be invaluable.

programs, the Special Master and Safety and Welfare Expert agree that assessment of the efficacy of these strategies is needed.

For example, violence reduction committees are an excellent concept. Staff coming together and discussing ideas and methods for reducing violence may result in changes that reduce violence. However, the Special Master previously reported that the committees neither employ sound operational practices nor are strategic in their methods to prevent violence.⁶² The committees appear to lack focus, direction and their work is not coordinated with the use-of-force review committees.⁶³ The committees are tasked with reviewing and evaluating incidents of violence each quarter and using the information to develop violence reduction plans, measure and report the impact of violence reduction efforts and share best practices. There is evidence that the committees meet each month, but there is little evidence of a clear strategy for how to achieve their purpose. For example, the Crisis Prevention and Management Policy requires each violence reduction committee to, on a quarterly basis, review violence indicators from COMPSTAT and PbS reports, identify violence patterns, and develop and submit a draft violence reduction plan to the Superintendent. Instead, the violence reduction plans in general are “embedded” within the violence reduction committee’s monthly meeting minutes.⁶⁴ Review of meeting minutes reveals little evidence of thorough and meaningful data analysis to achieve violence reduction.

Having different committee structures at institutions makes sense, but without clear objectives and measures to evaluate outcomes, there is no way to understand if they reduce violence in any way. The only measure of activity is meeting minutes and there is little evidence that the meetings themselves result in changes in policy or practice that could be evaluated to reveal the

⁶² See OSM 13, p.6.

⁶³ These assertions are a product of the interviews with staff by the OSM team while touring institutions and the review of systems during the work done by the Use of Force Taskforce.

⁶⁴ See Email, dated February 3, 2010 from Major Jeff Plunkett to Deputy Special Master John Chen.

committees' impact on violence, if at all.⁶⁵ Similar concerns exist regarding the conflict resolution teams.

DJJ should consider assessing the role, objectives and outcome measures of both the violence reduction committees and the conflict resolution teams. If the agency believes these functions support violence reduction, clear goals and objectives should be developed as well as activity and outcome assessment processes. The effort to understand the impact of violence reduction measures should continue. The question remains what data exists for the various strategies to support this supposition.

Another measure that cannot be overlooked is the level of activity in a facility. The Safety and Welfare Expert and the Special Master agree that the increased number of youth that are out of their rooms and participating in activities, the number of youth able to share day room time (especially those from rival gangs), improved staff-youth interaction and the number of youth moving up through the incentive level system all are indicators of a safer environment than existed years ago. The variety of incentives for youth continues to include movies, pizza nights, sporting events, gardening, family events, beauty shops, religious celebrations, decorating contests and is continually expanding.⁶⁶ The SYCRCC 'Peace and Unity Campaign' continues to reward youth for demonstrating non-violent behavior. In March 2010, the fourth celebration for Peace and Unity took place. Youth honored for their commitment ranged from six months to three years.⁶⁷

The challenge today is to determine how to reduce the existing rates of violence. The Special Master believes that the key to violence reduction is the successful implementation of the

⁶⁵ See examples of meeting minutes for PYCF (held on January 13, 2011), VYCF (held on January 19, 2011) and SYCRCC (held on July 8, 2010).

⁶⁶ See PoP 785 for an example of level activities from VYCF throughout the year.

⁶⁷ The celebration programs show which youth are honored for their commitment to non-violence and the period of time for which they have remained non-violent. The numbers range from 29 to 66 youth that were non-violent for periods of time ranging from six months to three years.

Integrated Behavior Treatment Model, a cognitive behavioral approach to assessing, understanding and treating youth problem behaviors. If implemented correctly, a cognitive behavioral approach based on actuarial risk and need provides the social learning needed for youth to change problem behaviors. In so doing, youth learn skills other than violence for problem solving and staff learn to engage more in proactive preventive activities by developing a continuum of responses to problem behaviors.

D. Use of Force

As aptly noted by the Safety and Welfare Expert, use of force is in part a reflection of the level of violence in a facility but it is also a reflection of what the staff believes is the most effective way to respond to youths' anti-social behavior.⁶⁸ DJJ has worked to provide training in safe crisis management to its staff, revised its use-of-force policy and review process in an effort to ensure staff focus on a continuum of prevention, intervention and force when responding to anti-social youth behavior.⁶⁹ Despite these efforts, use of force rates remain fairly constant.

As with incidents of violence, the total number of uses of force has decreased dramatically as the youth population has declined but the decrease in use of force rates is small.⁷⁰ From July 1, 2009 to December 31, 2009, the rate per youth day of force was .28. The rate of force climbed to

⁶⁸ Appendix B, p.7.

⁶⁹ All staff required to have safe crisis management training do not. Changes to the Use-of-Force policy are documented in PoP 785.

⁷⁰ The rate based on Average Daily Population has fluctuated from 71 in 2005 to a low of 54 in 2009 and is now at 68 for the first two quarters of each year. See OSM 13, p.21 and *see* Krisberg Comprehensive Report Round 3, p.6. The Special Master wishes to clarify the statement of the Safety and Welfare Expert that the data is not reliable, underreports and needs substantial improvement. The use of force study group found underreporting occurred for the cases reported by the Division Force Review Committee, as the committee staff did not reconcile data reported in WIN to the number of force incident packages submitted by the facilities. Evidence suggests one of the facilities did not submit a substantial portion of its force incident packages. For COMPSTAT data, the study group found each of the facilities employs a different process for collecting force data for submission to COMPSTAT and there is no audit trail to provide assurance that the data are accurate, complete, and reliable.

.37 from January 1, 2010 to June 31, 2010 for an average of .33 for the fiscal year. Uses-of-force rates were lowest at OHCYCF and highest at NACYCF and VYCF.⁷¹ The Special Master believes that the prospect of substantive reduction in DJJ's overall use-of-force rate is remote without fundamental changes in its current youth treatment model and its use-of-force review processes to prioritize prevention over compliance with policy and procedures.

The Mental Health, Safety and Welfare and Disabilities Experts have shared their concern about what they perceive to be higher than necessary use of force rates, in particular, excessive use of chemical agents with disabled and mentally ill youth.⁷² In response to these concerns, DJJ initiated a comprehensive study by a multi-disciplinary team to assess not just use-of-force rates but the specific circumstances that led to uses of force and efforts made to prevent the incidents in all DJJ facilities. At DJJ's request, the Special Master's Office is participating in the study. The Safety and Welfare and Wards With Disabilities Experts also participated in some of the team's deliberations and offered their insight and perspectives. In addition, to ensure accountability and transparency, the Office of the Inspector General (OIG) was invited to participate in the study and to serve as an independent observer. The OIG also provided valuable technical and computer support to the project.

The study is comprised of four components. The first component consists of quantitative analysis of 300 cases randomly generated through a computerized program maintained by the OIG. A matrix was developed to capture as much relevant data as possible from the force incident packages. Examples of the data captured include the name of the youth, date and time of the incident, mental health status, disability status, the type of force incident, and the type of force

⁷¹ See Microsoft excel spreadsheet QSR Jul 9 to Jun 10 Charts land.xls.

⁷² See OSM 13, p. 22 which describes the request by Plaintiff's counsel to have the experts examine the use of force for this population. Turn over of *Farrell* Mental Health Experts and methodology problems led to the development of an expanded strategy to review this issue.

applied. The study group analyzed the data in the matrix to identify trends and patterns regarding use of force at the DJJ facilities. The data is highly useful to support the observations and recommendations of the study group by placing them into proper context.

The study also consisted of a qualitative review of 100 use-of-force cases. The qualitative review process entails each member of the multi-disciplinary team independently reviewing the entire force incident package and then meeting as a group to frankly discuss each team member's view and perspective with respect to the case. The results of the qualitative review, supplemented by the quantitative review data, are used as the basis for formulating observations and recommendations in the report being prepared by the team.

An outside expert, Mike Gennaco, has been retained to observe the process employed by DJJ to review the force incidents at the facility level and at the division level and provide other comments and suggestions as he deems appropriate. As the Director of the Los Angeles Sheriff Office's Office of Independent of Review, Mr. Gennaco is a use-of-force expert and is uniquely qualified to comment on DJJ's current use-of-force practices.

In addition, the team will interview a sample of youth, most of whom have been involved in use-of-force incidents in the past, to gain insight from the youths' perspective. The team anticipates releasing a draft report in February 2011 with the final report to be released in March 2011.

Building on the combined expertise of DJJ outside experts and the OIG, hopefully agreement will be reached on the nature and type of any problems with DJJ's use-of-force practices as well as the strategies that should be employed to address them. The Special Master agrees with the Safety and Welfare Expert who indicates that the IBTM may help to reduce use of force. Ultimately, use of force is reduced by providing staff with the skills to appropriately use force when needed but, more importantly, providing staff with the skills and systems to prevent the need for use

of force. Several of the systems and skill sets needed for further reduction of use of force are tied to the development of an effective rehabilitative model.

E. Identify a Rehabilitative Model

Research regarding the effectiveness of treatment models in community and institutional settings provides some broad guidelines for the type of principles, if adhered to, help reduce anti-social behavior and therefore violence.⁷³ In short, we know that cognitive behavioral therapies work best and as, social learning models, it is imperative that staff understand that all activities are an opportunity to support treatment goals. We also know that the best results are achieved when the design of any cognitive behavioral program is strictly adhered to. Creating a treatment process that truly integrates assessment, case planning, programs, and transition strategies is a challenging process that typically takes years to fully implement.

The idea of replicating a program from another jurisdiction has not proven to be an effective approach to creating effective treatment models.⁷⁴ The adherence to the principles of evidence-based practice that support effective interventions has resulted in better outcomes. Wisely, the parties have not agreed to a model but to use evidence-based principles to guide the development of the best program for the unique needs of the DJJ youth population.⁷⁵

⁷³ See Lipsey MW, Landenberger NA, Wilson SJ. Effects of cognitive-behavioral programs for criminal offenders. *Campbell Systematic Reviews* 2007:6 and Garrido V, Morales LA. Serious (violent or chronic) juvenile offenders: A systematic review of treatment effectiveness in secure corrections. *Campbell Systematic Reviews* 2007:7 for examples of meta analyses of the research on this issue

⁷⁴ Decades of model replication have resulted in notorious failures. Many jurisdictions have implemented the tools and models used by other jurisdictions only to discover that they do not work when applied to their jurisdiction.

⁷⁵ The remedial plan sends contradictory messages on this issue. At times, it suggests modification of the Washington State Juvenile Rehabilitation Agency (JRA) model and, at other times, strict adherence to it. The attempt to apply the JRA model resulted in lengthy periods of debate and court action. The Special Master believes the parties were wise to move to a principle-based model that demands consistency with current research but also the flexibility to create a system that builds on Seventeenth Report of the Special Master

DJJ has demonstrated a clear understanding of the principles of an evidence-based treatment model. The development of an actuarial risk and needs assessment and training for staff to understand cognitive behavioral programs, to increase responsiveness by staff, and to facilitate cognitive behavioral programs as well as effective case planning are all strategies that build capacity for evidence-based programs. These efforts are the first steps in creating an evidence-based rehabilitative treatment system. Some of the next steps include:

- Completing training of staff for general and specific skill areas,
- Providing coaching and learning strategies to ensure staff can demonstrate skills learned in on-the-job training,
- Ensuring treatment plans are readily accessible and understood by all staff,
- Creating a valid assignment process for youth to treatment programs,
- Determining treatment dosage for different type of youth,
- Helping staff understand that actions like how and when force is used are part of social learning and thus, impact a youth's development of pro-social behaviors,
- Using existing (and creating other needed) quality assurance data and measures to determine if desired treatment outcomes are being achieved and
- Revising performance management systems to reward adherence to the social learning model.

It is a significant challenge to create a truly multi-disciplinary team the members of whom all understand what a youth's problems are and what the best response to his or behavior should be. It is also difficult to learn how to deliver therapeutic interventions exactly as prescribed. It requires ready access to easily understood treatment plans and the retraining of many staff ranging from psychologists to custody staff. Staff from all disciplines--education, mental health, custody, administration and extra-curricular--must understand that their individual actions with a youth must align with the collectively agreed upon treatment plan. A key element of social learning is modeling. Some staff will have to learn new responses to youth behavior.

Now that DJJ has identified the parameters of the IBTM, it has created an IBTM implementation team consisting of five subcommittees responsible for administration, assessment and case planning, treatment scheduling, quality assurance and behavior management. DJJ staff has been working to complete the deliverables for the first six months of the plan.⁷⁶ The subcommittees are involved in activities that introduce the program to youth, families and facility staff, define the treatment teams, evaluate youth for placement in the pilot units, ensure the training for staff is completed, revise the program service day, and determine which non evidence-based groups or interventions should be eliminated.⁷⁷

DJJ has contracted with Dr. Ed Latessa, Center for Criminal Justice Research, School of Criminal Justice, University of Cincinnati. Dr. Latessa is a nationally renowned expert in the implementation of evidence-based programs in community settings and institutions for juveniles. This contract ensures that DJJ will have guidance and coaching in the implementation process. Dr. Latessa's team will work with staff to ensure fidelity to program models, interventions are targeted for those youth who can most benefit and the amount of treatment provided adheres to current research.

Two units at OHCYCF will be the initial sites for refinement of the IBTM. While DJJ has created a relatively detailed plan, only with actual implementation can the model be modified to best align with the capacity of the physical setting and staff resources. Regular reports will be provided from the consultants to the parties and the Special Master regarding implementation progress and challenges. While learning is occurring at the two initial sites, broader training efforts and changes will continue throughout DJJ institutions to better align them with the philosophy and

⁷⁶ See the most current activity report, IBTM Implementation Plan 12 14 10.doc

⁷⁷ This list provides examples and is not intended to be comprehensive.

principles of the IBTM. The OHCYCF units will serve as learning laboratories where staff from other units and institutions can visit and see the process in action.

The concept of social learning and how it influences the growth and development of youth while in DJJ custody is likely understood by all staff at some level. Most people understand that in a two-parent family, if parents want a child to adhere to a rule or behavior, both parents need to reinforce the desired behavior through modeling both in word and deed. The likelihood of rule or behavior adherence increases if significant others besides the parents also model and support the desired behavior.

The challenge in an institutional environment is that multiple caregivers have ample opportunities to send conflicting messages. Understanding the impact of social learning is not difficult, but convincing groups of staff who have different beliefs and understanding about what actions support the development of pro-social behavior is extremely difficult. Helping staff recognize their own thinking errors regarding what helps anti-social young people change their attitudes and behaviors takes time. It requires consistency in leadership at the first-line supervisor and mid-management levels. It also requires a performance management process that rewards team work and adherence to principles of social learning and to treatment plans and protocols.

Key to the success of the model is communicating with all staff who interact with a youth, the treatment and behavior management needs and plan for that youth. All staff interactions must support the individualized intervention plan for a youth which defines the youth's potential for self harm, aggression, escape, behaviors that interfere with treatment, motivation for change, risk for recidivating and treatment risk, needs and goals and, finally, the current targets for intervention and change in the youth's behavior. Creating a shared understanding of what works to develop pro-social behavior in youth and having shared information and a common language to work with youth

are the best ways to reduce fear, violence and use of force. DJJ has put in place (or is in the process of putting in place) the foundation for this integrated treatment and behavioral management system. Helping staff to see how treatment impacts custodial practice and vice versa is the current challenge for DJJ. Now having the parameters of the IBTM, DJJ has created the IBTM implementation plan.

F. Gang Strategy

Clearly the issue of how to manage gang behavior in DJJ facilities is essential to the safety and security of the youth. DJJ staff is commended for some remarkable results they are achieving at integrating members of rival gangs into programs.⁷⁸ This work should continue to be explored in the IBTM.

The DJJ committee tasked with developing an agency-wide gang strategy has contracted with a national gang expert to assess the DJJ gang issue and to recommend potential strategies. The committee has proposed a draft policy which was reviewed with the Safety and Welfare Expert and the Special Master. It was agreed that the policy will be put on hold until the gang consultant report is received.⁷⁹

G. Gender Appropriate Services

The Safety and Welfare Remedial Plan and the Mental Health Remedial Plan require that DJJ provide for its young women "Gender Responsive Programming" that meets the unique needs of the population.⁸⁰ Specifically, the plans call for a comprehensive approach to address their needs

⁷⁸ The Special Master has talked with rival gang members at PYCF who were working together in program activities. PYCF staff managed to successfully integrate rival gang members in small numbers. For some youth this was the first time in their incarceration that this had happened. Senior leadership at OHCF has had rival gang members from PYCF meet with youth from their rival gang prior to transfer.

⁷⁹ See PoP 744. DJJ Gang Task Force, compliance team members, the Safety and Welfare Expert and the Special Master had a conference call on December 13, 2010 where this agreement was reached.

⁸⁰ Safety and Welfare Remedial Plan, p. 5, 58-59 and Mental Health Remedial Plan.
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and foster positive relationships with one another, staff, their families and their communities in a safe, trusting, supportive and gender-responsive environment.⁸¹ All of DJJ's young women remain housed at VYCF, though there are ongoing discussions of removing the young women to another location that DJJ would identify as better equipped to meet their needs. The Safety and Welfare Expert recommends, and the Special Master agrees, that efforts should continue to find a more suitable location for the female population, ideally one that is closer to a major urban center.

With the influx of young men to the facility following the HGSYCF closure in February 2010, there was great concern that the young women were not receiving the same quality of care that they received prior to the young men's arrival.⁸² Initially, the staffing shortage and the spike in violence impacted all of VYCF's youth. However, VYCF administrators made significant efforts to ensure the young women's safety and have attempted to quickly restore services in emergency situations, including those that originate from within the young women's units.

The Safety and Welfare Remedial Plan requires the hiring or assignment of a Program Administrator for Female Programs.⁸³ The position was originally contemplated as a Central Office assignment to include such duties as contracting with local vendors to provide services to DJJ's young women. To date, young women's services have not been contracted out and the primary administrator in contact with DJJ's young women is VYCF's Assistant Superintendent. In addition to tending to her countless other duties, the Assistant Superintendent is particularly knowledgeable about the young women, visits the unit daily, knows each of the young women by name as well as their individual backgrounds and daily concerns. The Assistant Superintendent takes her assignment to the young women's programs seriously and personally. However, she and VYCF

⁸¹ *Id.*, at p. 5.

⁸² See Memorandum, Cathleen Beltz, "Ventura Program for Young Women," October 1, 2010. This is the source for the remainder of the section.

⁸³ Safety and Welfare Remedial Plan, pp. 21 and 58.

staff and administrators agree that the young women need an advocate dedicated solely to them.

The Program Administrator for Female Programs position is crucial to DJJ's provision of gender responsive programming and treatment, however, the position should be relocated to VYCF where the population resides. In addition to contracting duties, the Administrator is also responsible for quality assurance oversight of young women's programs and for ensuring that young women receive services that are equal to the young men's.⁸⁴ Relocating the position would both further DJJ's goal to provide effective gender responsive programming as well as relieve pressure on facility administrators who must compensate for the position's absence.

As an interim measure, the Central Office Program Administrator should immediately engage in frequent and consistent communication and visits with the facility administrators, the young women and their loved ones and should systematically review incident reports, including disciplinary and force documentation, in order to come to know the youth.

In efforts to meet the needs of DJJ's young women, DJJ has implemented, "Girls Moving On," a cognitive behavioral curriculum that, while new, appears promising. Additional gender responsive programming must be developed, however, and DJJ has thus far failed to contract for assessment and the development of protocol to improve the program's overall quality. Despite some efforts to meet this remedial plan requirement, DJJ must do more to meet the needs of its female population. Budget constraints and lack of funding are not adequate reasons for failure to provide the necessary and required programming for young women as outlined in the remedial plan.

H. Facilities

The parties are in agreement that the DJJ facilities should be designed to facilitate treatment. Facilities with smaller living units and different types of units that support the incentive system,

⁸⁴ *Ibid.*

ample group and individual counseling space as well as space for extracurricular activities align better with treatment strategies. The design of several DJJ facilities is one better suited for adult prisoners. Where the design is better for juveniles, the facilities are old and difficult to maintain.

Significant efforts were undertaken to design a prototype for a facility that would support treatment efforts.⁸⁵ In addition, a committee established in 2005 assessed space needs for all DJJ facilities and developed estimates of renovation costs where needed, and the purchase of modular units.⁸⁶ A total of \$9,725,000 (funded from federal block grant dollars and 2006/2007 general fund dollars) was spent on modular construction for five DJJ facilities. The last modulars were completed at OHCYCF in November of 2010. These units will provide counseling and classroom space for the IBTM and the Sexual Behavior Treatment Program (öSBTPö). Fortunately, most of the modular classroom and treatment units were built in facilities still used by DJJ.⁸⁷ Funds for capital expenditures of \$1.9 million were allocated in 2005/2006 and 3.5 million in the 2007/2008 fiscal year. These funds were used to build a variety of treatment, recreation and medical spaces.

In the present fiscal crisis and with the effort to eliminate DJJ, there has been little willingness to invest money into the current facilities or to request funds for new facilities. Funding designated for the building of modular units to provide needed treatment space was defunded in the last fiscal year. DJJ has worked tirelessly to craft a creative solution to acquiring additional treatment space. DJJ has successfully negotiated the lease of surplus modulars from the public schools. The Department of General Services, DJJ and Prison Industries (öPIAö) have negotiated

⁸⁵ The prototype and an operational master plan were completed. See OSM 13, p.32. A facilities master plan was completed and sent to the Safety and Welfare Expert. Given the dramatic change in the size of the youth population and the staffing model, the plan is likely of little value at this point. That said, DJJ should not be penalized for changes beyond its control. Credit should be given for the work completed.

⁸⁶ See PoP 758. This history of the effort to assess space needs and to find solutions for space needs was created by the Program Administrator in charge of space planning for the Special Master.

⁸⁷ *Id.* at p.2.

for the purchase of 18 modular units to be placed at VYCF, SYCRCC and NCYCC.⁸⁸ Twelve of the units will be placed at VYCF which has the greatest need for additional education and treatment space.

As noted by the Safety and Welfare Expert, DJJ continues to do a good job of coordinating and recording the need for repairs and making routine repairs as needed. Small renovations such as adding counseling space to units, painting and repair projects continue on an as needed basis. DJJ staff continue to demonstrate creativity in their efforts to solve maintenance problems, including having youth help with projects.⁸⁹

IV. TRANSITION PLANNING FOR CLOSURE OF PRESTON YOUTH CORRECTIONAL FACILITY

The Special Master has previously reported on the history of DJJ's population reduction and facility closures as well as multiple issues that DJJ has faced in the closure process.⁹⁰ DJJ Central Office and facility staff possess the requisite expertise and certainly the desire to complete successful problem-free closures and other related transitions. Indeed, some of the problems reported in the wake of HGSYCF's closure might have been significantly worse but for the tremendous efforts of DJJ staff to quickly integrate previously segregated youth, acquire and acclimate receiving facility staff and to restore the provision of interrupted services. The experts and Special Master also agree, however, that with sufficient advance planning, even in the face of the relentless fiscal crisis and resulting budgetary constraints and staffing issues, DJJ staff can reduce or prevent the types of problems that have emerged in the past.

⁸⁸ See PoP 740. The total number of modulars has been reduced due to the closure of PYCF.

⁸⁹ The Special Master notes that in a recent tour of SYCRCC, that the former county unit which was in dreadful repair has been vastly improved. Fresh paint and newly renovated counseling space were among changes. Youth were also assisting in renovation and repair projects at the institution.

⁹⁰ *Id.* at pp. 8-10 and Fifteenth Report of the Special Master, July 2010, pp. 5-10.

On October 21, 2010, DJJ announced system wide its plans to close PYCF by June 30, 2011.⁹¹ PYCF's closure will reduce to four the number of operational state juvenile facilities from 11 in 2003.⁹² The *Farrell* Experts and Special Master, the parties and DJJ staff have expressed concerns about DJJ's ability to effect a safe and successful transition. DJJ administration and staff have developed a thoughtful PYCF closure plan and have begun its methodical implementation. If DJJ follows its proposed plan and if planning efforts are not again thwarted by a drastically reduced closure timeframe or other unanticipated obstacles, DJJ should expect to accomplish a successful transition.

DJJ has communicated closure plan details with the OSM/expert team and incorporated the OSM/expert team's recommendations into its transition planning. Immediately following the closure announcement in October, DJJ requested input and recommendations from the *Farrell* Experts and the Special Master to incorporate into their closure plans in progress. The experts and the Special Master provided DJJ with their recommendations on November 12, 2010.⁹³ DJJ then requested a follow-up call with the experts and proposed a five-month, 24-step timeline for the PYCF closure that incorporates several of the experts' recommendations and addresses concerns expressed.⁹⁴ The timeline was provided to the parties and experts on December 13, 2010 and a follow-up conference call with the experts was held on December 15, 2010. DJJ also requested that the closure be placed on the agenda for and the issue was again discussed at the parties meeting held on January 20, 2011. Finally, the DJJ Central Office administrator assigned to oversee the PYCF

⁹¹ Memorandum from Rachel Rios to all DJJ staff, October 21, 2010

⁹² See Sixteenth Report of the Special Master, November 2010, p. 8. DJJ closed three facilities in 2003 and 2004, and has since closed three more, including DeWitt Nelson, El Paso de Robles and most recently in Heman G. Stark Youth Correctional Facility.

⁹³ Email, Special Master to the parties re: "Family Closure Meetings at Preston," November 12, 2010.

⁹⁴ DJJ, "Proposed Transition Timeline, Preston Youth Correctional Facility," November 2010. Seventeenth Report of the Special Master
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closure and transition provided the OSM with a progress update via teleconference on January 27, 2011 and faxed to the OSM the following day additional documentation requested during the call.

Among the most serious concerns and the OSM/expert team's related recommendations for a safe and successful facility closure are two sets of challenges that have impacted closures in the past: (1) ensuring the safety of all DJJ youth and staff and (2) sufficient preparation at the receiving facilities so that youth do not suffer interruptions to the provision of services.

A. Safety

Information and documentation provided by DJJ indicate that youth and staff safety remains DJJ's fundamental goal as it prepares for the upcoming closure. In addition to the proposed transition timeline, on January 4, 2011, DJJ's Director of Juvenile Facilities prepared a memorandum outlining the Director's vision for an organized transition with emphases on safety and violence prevention.⁹⁵ The memo describes a six-step process for "Moving Preston Youth," the first four steps of which focuses on pre-transfer communication between DJJ Central Office, facility staff and the youth who are being transferred. For example, Step 4 requires that PYCF Gang Information Coordinators and Case Managers begin to dialogue with identified active gang members and to develop "peace agreements" between rivals to be carried from PYCF to receiving facilities. As of this filing, several such agreements are reported to have been reached.⁹⁶

The plan also requires that prior to the youths' movement, DJJ Central Office and facility staff analyze available bed space and balance it against needs of individual youth in making facility and unit assignments. The fifth step in the plan calls for the slow and steady transfer of youth

⁹⁵ Memorandum, "Moving Preston Youth," Sandra Youngen, January 4, 2011. This is the source for the next two sentences.

⁹⁶ Statements of facility administrators to the Special Master and Deputy Special Master, Cathleen Beltz, February 2, 2011. PYCF and OH Close staff have worked together to attain peace agreements between youth from rival "Bulldogs" and "Norteros" gangs that are scheduled for transfer from PYCF to OHCYCF.

between institutions and the assembling of additional staff in teams to assist with the moves.⁹⁷ Step six addresses the process of orienting youth transferees to their receiving facilities, including the provision of a free phone call, the facility orientation packet, meetings with the youths' treatment teams and other facility staff and school enrollment for eligible youth within 72 hours of the youths' arrival. In the event that violence prevention plans are unsuccessful and interventions are necessary, the memo describes a "Disturbance Control Plan" to achieve quick recovery in a way that minimizes injury to youth and staff.

B. Provision of Services

DJJ's transition plans also ensure sufficient preparation at receiving facilities so that youth do not see extended breaks in the provision of required services. Key to ensuring that DJJ youth continue to receive services is ensuring that receiving facilities have sufficient staff in place *prior* to the youths' transfer. Lack of sufficient staffing at VYCF prior to HGSYCF's closure is cited by experts as the cause for substantial breaks in the provision of mandated medical, education and mental health services following the youths' transfer.⁹⁸ DJJ plans include the transfer of sufficient staff to the receiving facilities to ensure continued provision of required services.

DJJ has taken the following measures to ensure that receiving facilities are properly staffed:⁹⁹

- All intake unit and clinic staff are being temporarily redirected to receiving facilities.
- Labor unions were sent a 30-day notice that DJJ will move PYCF's intake clinic to Stockton by a date specified in the notice. DJJ plans to stop youth intake to the clinic one week prior to the date specified in order to allow for the transfer of clinic staff prior to the youths' arrival.
- Meetings with the California Correctional Peace Officers' Association have been scheduled to discuss the temporary redirection of necessary staff.

⁹⁷ Memorandum, "Moving Preston Youth," Sandra Youngen, January 4, 2011.

⁹⁸ Appendix A and Fifteenth Report of the Special Master, pp. 16-23.

⁹⁹ Statements of Bob Moore to Cathleen Beltz, January 27, 2011.

- NACYCF Education and Medical staff are currently developing written intake and clinical plans.
- California Department of Corrections and Rehabilitation's Seniority and Placement Unit that will identify for staff their placement options following the PYCF closure and removal of positions have a scheduled visit with PYCF staff.

DJJ's Central Office Administrator assigned to oversee the closure process reports that staffing issues are among the most troublesome. The fiscal crisis, the population reduction and subsequent facility closures coupled with uncertainty for DJJ's future have resulted in high rates of staff transfer to the adult division and has impacted morale of remaining DJJ staff.

Whether DJJ staff will have sufficient time and necessary resources to follow the transition plan as scheduled remains to be seen. The Special Master will provide an update to the closure plan's implementation in her next quarterly report and will again report on the plan's success following the closure.

V. CONCLUSION

Significant progress has been made by DJJ in implementing both the Health Care Services and Safety and Welfare remedial plans. The Medical and Safety and Welfare Experts have provided explanations of their compliance ratings with clear suggestions for what must be done to increase the ratings. The Special Master suggests that, given progress in each remedial area, the *Farrell* experts begin identifying those items or areas that have achieved substantial compliance for two or more rounds and that they believe DJJ is capable of monitoring. Plans for training the DJJ staff should be developed and implemented for the transfer of the monitoring of any items or areas.

Because the use-of-force issue is directly related to IBTM implementation, a use-of-force discussion by DJJ's Use-of-Force Task Force will be included in the next quarterly report. Similarly, DJJ's Use-of-Force Task Force will report its results in March of 2011 and the Special Master will provide a more detailed overview of its process, outcomes and recommendations.

The Special Master respectfully submits this report.

Dated:

Nancy M. Campbell
Special Master