Illinois Models for Change

Systems Reform in Juvenile Justice

Report on the Behavioral Health Program for Youth Committed to Illinois Department of Juvenile Justice

July 2010

Prepared in response to
a request for technical assistance from
Illinois Department of Juvenile Justice.

By Illinois Models for Change
Behavioral Health Assessment Team

Foreword

In response to a request for technical assistance from the Illinois Department of Juvenile Justice (DJJ), the Illinois *Models for Change* initiative assembled a team of mental health and corrections experts to evaluate the department's behavioral health policies, practices and programming. This assessment of DJJ's behavioral health program is based primarily on a series of site visits to the department's eight facilities. Given the geographic diversity of the facilities and the expedited timetable for completion of the assessment, this report would not have been possible without the full cooperation of DJJ's management team. The assessment team would also like to thank DJJ's staff members and the youth who agreed to be interviewed for the assessment. Their experiences and perspectives helped inform team members' understanding of DJJ's current behavioral health programming and areas of future need.

The Illinois *Models for Change* initiative and members of the assessment team hope that this study will offer valuable information to state policy makers and DJJ management and staff in their collective efforts to improve the provision of behavioral health services to youth in DJJ care. The ultimate beneficiaries of this effort will be the individual youth who receive these services and the communities to which these youth will return upon their release from state care.

Models for Change

Models for Change is an effort to create successful and replicable models of juvenile justice reform through targeted investments in key states, with core support from the John D. and Catherine T. MacArthur Foundation. Models for Change seeks to accelerate progress toward a more effective, fair, and developmentally sound juvenile justice system that holds young people accountable for their actions, provides for their rehabilitation, protects them from harm, increases their life chances, and manages the risk they pose to themselves and to the public. The initiative is underway in Illinois, Pennsylvania, Louisiana, and Washington, and through action networks focusing on key issues, in California, Colorado, Connecticut, Florida, Kansas, Maryland, Massachusetts, New Jersey, North Carolina, Ohio, Texas, and Wisconsin.

Contents

Foreword 3
Contents 4
I. Introduction and Executive Summary 5
II. Findings and Recommendations for System-wide Improvements 15
III. Methodology 20
IV. Site Visit Reports 23
IYC St. Charles 23
IYC Kewanee 36
IYC Harrisburg 41
IYC Murphysboro 48
IYC Joliet 56
IYC Chicago 65
IYC Warrenville 71
IYC Pere Marquette 79
V. Reintegration of Institutionalized Youth to the Community 85
VI. Facility-level Recommendations by Topic 92
Appendix A: DJJ Request 101
Appendix B: Description of Assessment 103
Appendix C: Post-Dispositional System 106
Appendix D: Recommendations from Previous Reports 107
Appendix E: Facility Profiles, Mental Health Services and Staffing 110
Appendix F: Institution Monthly Youth Profiles 120
Appendix G: Performance-based Standards Confinement Time Data 136
Appendix H: Profiles for Kewanee, Murphysboro and St. Charles 137
Appendix I: Murphysboro Transition Memo 139
Appendix J: Intake Procedures Survey 143

I. Introduction and Executive Summary

In September 2009, the Director of the Illinois Department of Juvenile Justice (DJJ) contacted the Illinois Models for Change initiative to request technical assistance to conduct a comprehensive evaluation and provide recommendations on the Department's policies, practices and programs for youth in DJJ care with mental health and substance abuse needs.[1] The Director's request came after two youth committed suicide in DJJ facilities within a 12-month period in September 2008 and September 2009. These tragic events highlighted the inadequacies of DJJ's efforts to respond effectively to the large number of DJJ-committed youth with mental health and substance abuse disorders.

The Illinois Models for Change initiative responded to the Director's request by assembling a Behavioral Health Assessment Team made up of national and local mental health and corrections experts to evaluate DJJ's behavioral health program and to make recommendations consistent with the evaluation's findings.[2] The Director and Models for Change agreed that the results of the study, together with its findings and recommendations, would be made public. The team was charged with evaluating and providing recommendations to DJJ in the following areas:

- Assessment of behavioral health needs of youth in the DJJ system;
- Adequacy of staffing levels;
- Adequacy of existing behavioral health services;
- Adequacy of training of DJJ behavioral health professionals;
- Adequacy of DJJ policies and directives regarding behavioral health care services;
- Adequacy of systems (screening, assessment and protocols) for identifying youth with behavioral health needs as they enter DJJ and as needs develop while in DJJ;
- Adequacy of systems for transitioning youth with behavioral health needs out of the Department; and
- Integration of Illinois' systems with responsibilities to meet youth behavioral health needs.

Overview of Illinois Department of Juvenile Justice

The Illinois Department of Juvenile Justice (DJJ) is a relatively young agency transitioning from an adult corrections model to a juvenile-centered services and rehabilitation model. Public Act 94-0696 established DJJ on June 1, 2006. This legislative action effectively separated the new agency from adult corrections in Illinois.

The newly created department's mission is to increase public safety and to provide treatment and services through a comprehensive continuum of educational, vocational, social, emotional, and basic life skills to enable youth to avoid delinquent futures and

[1] Please see Appendix A.
[2] Please see Appendix B.

become productive, fulfilled citizens. DJJ drafted a comprehensive strategic plan in 2007 that serves as its internal blueprint for the transition from an adult corrections model to a juvenile-centered services and rehabilitation model.

When DJJ was separated from the Department of Correction (DOC), it was not adequately staffed or resourced to function as an independent agency charged with the protection of the public and rehabilitation of young offenders committed to its care and custody. The new department was given responsibility for managing eight institutions that house about 1,200 youth on a given day and for supervising approximately 2,000 youth on parole in the community. DJJ was also charged with developing and auditing detention standards for Illinois' sixteen county-run detention facilities. The legislation creating DJJ provided that the following services were to be shared with DOC: Mental Health Services, Fiscal Services (budget, procurement and contract management), Personnel Services (hiring and payroll), Training, Medical Services, Parole and Management Information Systems. As a result of the shared services policy, these services were not included in DJJ's budget or personnel allocation.

Given its limited resources and the state's worsening financial situation, DJJ has sought additional administrative and programmatic support by seeking grants from public agencies and private philanthropy. DJJ received a multi-year grant from the Illinois Juvenile Justice Commission to support the positions of the clinical services director and the administrator of detention standards and audit services. In February 2009, the John D. and Catherine T. MacArthur Foundation's Models for Change Juvenile Justice Reform Initiative awarded DJJ a two-year, $400,000 grant to accelerate the agency's transition to a juvenile-centered services and rehabilitation model with a special emphasis on the improvement of behavioral health services.

Overview of Illinois' Youth Corrections System

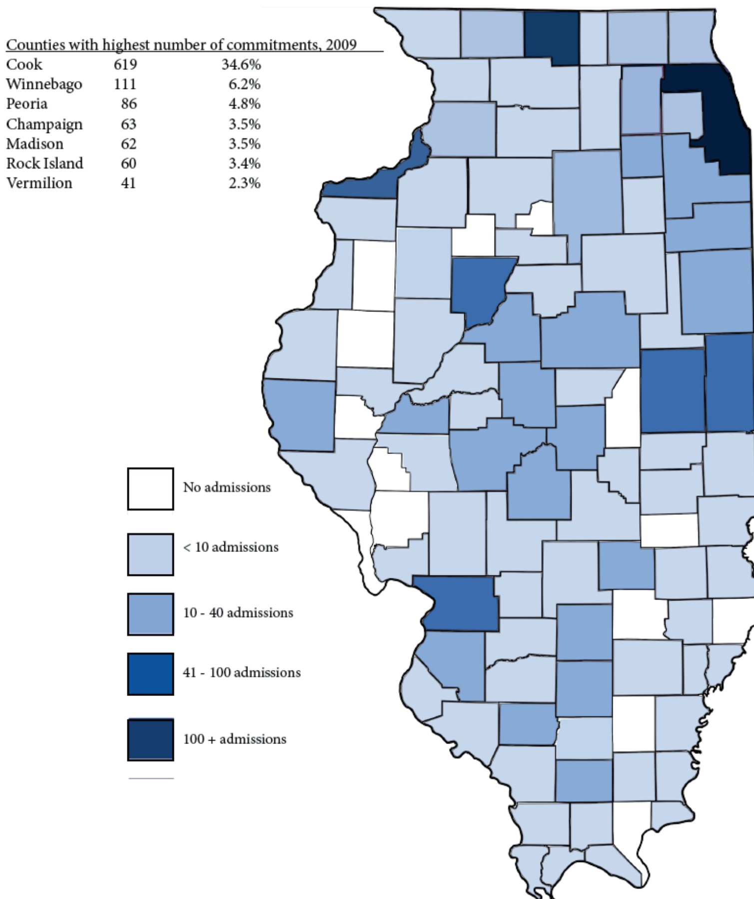
This report primarily focuses on youth committed to DJJ with an "indeterminate sentence" and placed in one of eight institutions operated by the department.[3] Six of the Illinois Youth Centers (IYC) house males: Harrisburg, Murphysboro, Joliet, Kewanee, St. Charles and Chicago. Two facilities house females: Warrenville and Pere Marquette. All youth committed to DJJ are initially placed in one of three Reception & Classification Centers (R&C) (located at IYC St. Charles, IYC Warrenville and IYC Harrisburg) for assessment, evaluation and placement determination in one of DJJ's eight facilities. Once a youth arrives at a long-term facility, he/she is assigned an Administrative Review Date (ARD) for an appointment to appear before the Prison Review Board (PRB). When a youth is determined by DJJ to be ready for possible release, he/she is presented to the PRB for a parole decision. If the youth is granted parole, he/she is paroled home or to a non-secure placement in the community. A youth may remain on parole up to the age of 21. If a youth is not following the conditions of release or is arrested on a new charge, the parole agent can violate the youth's parole. The PRB then conducts a Parole Revocation hearing. If the youth's parole is revoked, he/she may be returned to DJJ custody. If the youth returns to custody, the facility Program Assignment Committee, with approval from the Superintendent, establishes a new projected Administrative Review Date for the youth.

[3] Please see Appendix C for a fuller description of Illinois' post-dispositional system.

Overview of Youth in DJJ Care

In calendar year 2009, 2,281 youth were committed to DJJ by Illinois courts. Cook County juvenile courts committed 619 youth (35%) to DJJ. The next highest committing counties were Winnebago with 111 youth (6%), followed by Peoria with 86 youth (5%), and Champaign, Madison and Rock Island counties with 63, 62 and 60 youth respectively (about 3.5% each). Figure 1 shows admissions data by county for calendar year 2009.[4]

Figure 1



As reflected in the October 2009 Performance-based Standards data collection, the average length of stay in the three Reception & Classification (R&C) Centers was 14.6 days. The average length of stay in all DJJ institutions was 171 days; however, the average length of stay in Kewanee, the special program designed for youth with serious mental health problems, was 354 days. In 2009, 1,751 youth were paroled from a DJJ institution. In the same year, 939 youth returned to the R&C units for their parole

[4] Admissions data by county were not available for the 492 youth admitted to IYC St. Charles in July, August and September 2009. Percentages reflect proportion of the 1,789 youth (78 percent of 2,281 youth) for whom committing county data were available.

revocation hearing before the Prisoner Review Board and 85 parolees were convicted on new charges before returning to the R&C units as parole violators with new commitments. On average, more than 35 percent of youth released from DJJ return to juvenile or adult correctional facilities within 12 months.[5]

Overview of Mental Health Needs of DJJ Youth

Research has consistently confirmed that the prevalence of mental health and substance use disorders in justice-involved youth is significantly higher than that of the general population. Youth involved in the juvenile justice system in Illinois are no exception. In the nation's first, large scale, longitudinal study, the Northwestern University Juvenile Project found that youth entering the Cook County juvenile detention facility demonstrated "dire mental health needs and poor outcomes." This research, conducted at the detention stage of the juvenile justice system, reveals that nearly 75 percent of girls and 66 percent of boys met the criteria for at least one psychiatric disorder, rates up to four times that of the general population.[6] More than 56 percent of girls met the diagnostic criteria for more than one mental health and/or substance use disorder, while nearly 46 percent of boys presented multiple disorders.[7]

A recent study by Shufelt and Cocozza of the National Center for Mental Health and Juvenile Justice (NCMHJJ) found that 70.4 percent of youth in the juvenile justice system met the diagnostic criteria for one or more mental health disorders, a finding consistent with prevalence estimates produced by earlier studies.[8,9] It was suspected that because these youth were involved with the juvenile justice system, high rates of conduct disorder and substance use disorder were responsible for the high overall prevalence of mental disorders. However, removing conduct disorder from the analysis showed that "66.3 percent of youth still met criteria for a mental health disorder other than conduct disorder," and removing substance use disorders from the analysis showed that "61.8 percent of youth still met the criteria for a mental health disorder other than a substance use disorder." [10] Eliminating both conduct disorder and substance use disorders from the analysis showed that 45.5 percent of youth had some other type of mental health disorder.[11]

Data from the Illinois Department of Juvenile Justice (DJJ) indicate that two-thirds of youth committed to their custody have a "*diagnosed* psychiatric disorder and thus require mental health treatment while in custody" [12] (emphasis added). Nearly two-thirds of girls in

---

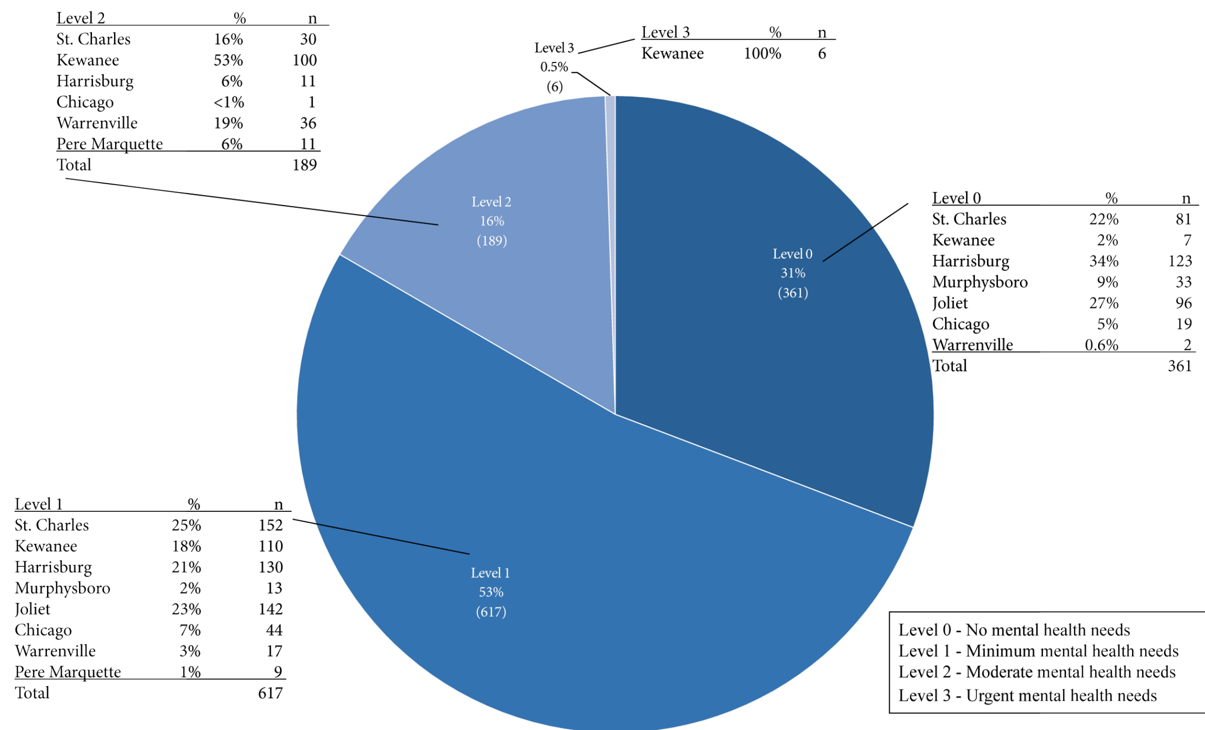
[5] DMJM Illinois | AECOM with Huskey & Associates. 2007. *Department of Juvenile Justice Comprehensive Master Plan.*
[6] Testimony of Dr. Linda Teplin, Professor of Psychiatry and Behavioral Sciences, Feinberg School of Medicine, Northwestern University before the Healthy Families and Communities Subcommittee, United States House of Representatives, March 2010.
[7] Ibid
[8] Wasserman, G., McReynolds, L., Lucas, C., Fisher, P., & Santos, L. (2002). The Voice DISC-IV with incarcerated male youths: Prevalence of disorder. *Journal of the American Academy of Child and Adolescent Psychiatry* 41(3): 314-321.
[9] Teplin, L, Abram, K., McClelland, Dulcan, M., Mericle, A. (2002). Psychiatric disorders in youth in juvenile detention. Archives of General Psychiatry, 59, 1133-1143.
[10] Shufelt, J. & Cocozza, J. (2006). Youth with Mental Health Disorders in the Juvenile Justice System: Results from a Multi-State Prevalence Study. *National Center for Mental Health and Juvenile Justice.* .
[11] Ibid
[12] DMJM Illinois | AECOM with Huskey & Associates. 2007. *Department of Juvenile Justice Comprehensive Master Plan.*

DJJ custody have experienced severe abuse, neglect or other traumatic experiences prior to their commitment.[13]

Figure 2 shows that on May 31, 2010, just under 70 percent (812 youth) of DJJ's institutional population (1,173 youth) were classified as having some type of mental health need, ranging from minimum to urgent, and just over 30 percent (361 youth) of the population had no mental health needs (Level 0).[14] Of the 812 youth with mental health needs, 617 were classified as having minimum needs (Level 1); 189 were classified as having moderate needs (Level 2); and six youth were classified as having urgent needs (Level 3).

St. Charles and Kewanee house the majority of male youth with more serious mental health needs and Warrenville houses the majority of females with more serious mental health needs. St. Charles housed 22 percent of all youth at Level 0; 25 percent of youth at Level 1; and 16 percent of youth at Level 2. Kewanee housed two percent of all youth at Level 0; 18 percent of all youth at Level 1; over 50 percent of youth at Level 2; and 100 percent of youth at Level 3. Warrenville, one of two female facilities, housed less than one percent of youth at Level 0; three percent of youth at Level 1; and 19 percent of youth at Level 2.

Figure 2 Mental Health Levels and Placements of DJJ's Institutional Population on May 31, 2010



Level 0	%	n
St. Charles	22%	81
Kewanee	2%	7
Harrisburg	34%	123
Murphysboro	9%	33
Joliet	27%	96
Chicago	5%	19
Warrenville	0.6%	2
Total		361

Level 1	%	n
St. Charles	25%	152
Kewanee	18%	110
Harrisburg	21%	130
Murphysboro	2%	13
Joliet	23%	142
Chicago	7%	44
Warrenville	3%	17
Pere Marquette	1%	9
Total		617

Level 2	%	n
St. Charles	16%	30
Kewanee	53%	100
Harrisburg	6%	11
Chicago	<1%	1
Warrenville	19%	36
Pere Marquette	6%	11
Total		189

Level 3	%	n
Kewanee	100%	6

[13] Ibid
[14] See Appendix F for Institution Monthly Youth Profiles.

Absent aggressive treatment intervention, the mental health, substance use and trauma-related needs of youth in DJJ predispose them to negative outcomes both while in institutional custody and upon release. The history of abuse, neglect and exposure to other adverse childhood experiences that is typical of the overwhelming majority of justice-involved youth, places them at increased risk for disrupted brain development, social, emotional and cognitive impairment, adoption of health risk behaviors and even early death.[15]

Summary of Assessment Process

In response to DJJ's request for technical assistance in evaluating its behavioral health program, the Illinois Models for Change initiative reached out to national and local mental health and juvenile justice experts asking them to volunteer their time to participate in the assessment process. (See page 20 for a list of assessment team members). Under the leadership of Edward "Ned" Loughran, Executive Director of the Council of Juvenile Correctional Administrators (CJCA), the team held an initial meeting to develop an assessment plan, including a uniform protocol to standardize the assessment process over the eight facilities. Team members also reviewed background information supplied by DJJ and facilities reports prepared by the John Howard Association, an independent organization that provides citizen oversight of Illinois' juvenile and adult corrections systems. [16] Between January and June 2010, team members spent at least one full day and sometimes more at each of DJJ's eight facilities. The members of each site team drafted summaries of each site visit and submitted them to CJCA. Ned Loughran and his CJCA colleagues then prepared a draft of the report, which was reviewed by assessment team members prior to its final adoption.

Summary of Findings and Recommendations

The assessment report makes two types of findings: system-wide and facility- specific. The system wide findings and corresponding recommendations are found in Section II. The facility-level recommendations by topic are set forth in Section VI. In addition, specific subject-matter findings and recommendations are included in each site visit report (Section IV).

SYSTEM-WIDE ASSESSMENT

In terms of DJJ's overall ability to respond effectively to youth with behavioral health needs, the assessment team noted some positive steps to move DJJ away from a corrections-focused and toward a developmentally-appropriate system of youth corrections. The team found, for example, that there has been reduction in the long-term use of confinement as the principal intervention for youth who manifest behavioral problems.[17] Another positive finding was the incremental transition to system-wide use of single beds and away from bunk beds that pose a serious risk for suicidal youth. The assessment findings also supported DJJ's ongoing collaboration with the

---

[15] Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *Am J Prev Med.* 1998;14:245-258.
[16] The John Howard Association DJJ reports on facilities and programming are available at http://www.thejha.org
17 See Appendix G for Performance-based Standards data on average duration of confinement.

Department of Mental Health through the Juvenile Justice/Mental Health Reentry Project and the Juvenile Forensic Trauma Project.

In general, however, the assessment findings point to serious deficiencies in DJJ's behavioral health programming. A recurrent theme throughout the assessment is the Department's failure to use validated mental health and risk-assessment screening and assessment instruments. This is especially problematic given the widespread availability of empirically-tested instruments for screening and assessing justice-involved youth for behavioral health issues, including suicide risk.[18]

The assessment team also found that DJJ does not have a comprehensive continuum of behavioral health services, nor has its adopted a process for aligning existing services with individual youth needs. According to the assessment team, existing behavioral health services are inadequate across multiple dimensions – the number of programs, the range of needed interventions, the failure to match individual needs with appropriate services, the lack of evidence-based treatment modalities, the absence of culturally-sensitive services, and an inattention to the needs of special populations.

A closely related concern is the critical shortage of behavioral health personnel and the corresponding high caseloads carried by existing professional staff in some facilities. Without adequate mental health staffing levels, the Department's ability to identify and address the behavioral health needs of the large number of DJJ youth who present with mental health and substance abuse issues is significantly compromised. The fact that the position occupied by the clinical services director is externally funded through grant resources is only emblematic of the serious shortage of mental health staff throughout the Department.

A theme repeated by DJJ staff members across facilities is the absence of adequate training on behavioral health issues. In most facilities, staff have received little or no training on emerging brain research, adolescent development, the impact of trauma, evidence-based behavioral health programming, de-escalation techniques, or other topics that are essential for understanding and responding to the mental health and substance abuse needs of youth in DJJ care. DJJ staff recognize the importance of such training and express concern that their ability to do their job effectively is hampered by a lack of ongoing professional development. The assessment team found that the absence of mental health and substance abuse training disserves youth and undermines the effort to transform the department into a rehabilitation- focused corrections model that improves recidivism rates and promotes positive youth development.

Another area of serious concern is the absence of appropriate aftercare planning and services for all youth, especially those with mental health and substance abuse problems.

---

[18] Numerous empirically-tested instruments are available for screening and assessing justice-involved youth. Examples of suicide screening tools include the Global Appraisal of Individual Needs-Short Screener (the GAIN-SS) and the Massachusetts Youth Screening Instrument-Second Version (MAYSI-2). Examples of substance use instruments include the Substance Abuse Subtle Screening Inventory-3 (SASSI-3) and the Practical Adolescent Dual Diagnosis Interview (PADDI). Examples of tools for assessment of needs for purposes of making placement and case management plans include Youth Level of Services/Case Management Inventory (YLS-CMI) and the Structured Assessment of Violence Risk for Youth (SAVRY). These tools are listed to provide examples of alternative instruments; the team is not recommending that these specific tools be adopted.

Aftercare refers to the services, support and supervision necessary to return a youth safely to the community. Under a best practices model of aftercare, planning for a youth's eventual release from state custody begins with effective screening and assessment at the time the youth enters custodial care, continues with an individualized case management plan based on the results of the screening and assessment, accelerates as a youth approaches his or her release date, and is implemented, monitored and evaluated for the duration of the youth's community supervision. In a well-functioning system of aftercare, at each stage of the process youth are matched with services designed to address their unique behavioral health needs and improve their potential for successful reintegration back into their families and communities. The assessment team found serious flaws in DJJ's aftercare system for youth with mental health and substance abuse disorders. Aftercare planning does not begin until a youth is approaching his or her Parole Review Board date, and unless a youth requires residential care there is no affirmative effort to link youth to services prior to release even if the Board has recommended or mandated such services. At best, youth are handed a list of community services available in their community during a Pre Parole Program.

Finally, assessment team members noted a system-wide lack of attention to issues of family engagement. Encouraging family involvement after a youth is committed to DJJ can provide valuable information about a child's medical and mental health history, reduce a youth's sense of isolation and despair, and facilitate his or her successful re-engagement with family members upon release, a critical factor in reducing recidivism and reintegrating youth successfully back into society. For these reasons, the assessment team strongly recommends that DJJ adopt policies and practices that actively support family involvement with youth in DJJ care.

Facility-specific Assessment

The assessment report contains detailed findings and recommendations with respect to each of DJJ's eight facilities. The site-specific information is organized around the following categories of inquiry: behavioral health services, staffing levels, training, policies, directives and philosophical change, transitioning youth, and family contact.

In terms of behavioral health services, the assessment team's most positive findings relate to the adoption and piloting of a Core Treatment Model at IYC Chicago. Elements of the Core Treatment Model include a range of cognitive behavior treatment interventions (*e.g.* Aggression Replacement Training, Cannabis Youth Treatment, etc.), as well as development of another evidence-based model, Family Integrated Transitions, which provides family treatment services to youth with co-occurring disorders. A final component, when in place, will create a comprehensive reentry structure, including partnering with youth-serving agencies, for DJJ youth in Cook, Lake and Will Counties. If successful, the Core Treatment Model will be diffused to other DJJ facilities.

In most DJJ facilities, however, the assessment team found an insufficient number and type of mental health and substance abuse services, together with concerns about how those services are being delivered. At IYC Kewanee, IYC Joliet and IYC Murphysboro, for example, the team noted the need for adoption of evidence-based practices rather than the widespread use of unproven screening, assessment and treatment approaches for youth in

residential care. The team called on other facilities, including Warrenville, Harrisburg and St. Charles, to develop and integrate individualized treatment plans.

The assessment team found critical behavioral health staffing shortages at several facilities, especially IYC St. Charles, IYC Harrisburg, and IYC Joliet. As a result, caseloads in these facilities are "unmanageable" and foreclose the opportunity for any meaningful treatment for youth.

Training was identified as a critical need at all DJJ facilities. This includes basic and advanced training in subjects such as adolescent development, trauma, mental health, substance abuse and medical disorders, evidence-based practices, screening, assessment and treatment options, and successful crisis intervention techniques. The assessment team suggested partnering with colleges and universities located near several of the sites to help support such training.

On the topic of "policies, directives, and philosophical change," there was widespread agreement that DJJ leadership and supervisory staff need to do a better job of communicating and supporting the Department's statutory mission across and within facilities. In addition, the assessment team found a need for a clearer adoption and articulation of uniform policies in critical areas such as the use of isolation, seclusion and restraint and aftercare planning and implementation.

Finally, the team found the need for greater involvement of families in the intake, treatment and re-entry process.

The Way Forward for DJJ Youth with Behavioral Health Needs

YOUTH COMMITTED TO DJJ

Research findings suggest that youthful offenders, even those facing serious mental health, substance use and trauma-related disorders are capable of positive change and growth.[19] As the birthplace of the juvenile court over a century ago, Illinois has long recognized in law, policy and practice that youth differ significantly from adults and that these differences should be reflected in how the juvenile justice system responds to their rehabilitative needs. Youth can benefit enormously from treatment, can learn constructive ways to survive histories of trauma and can transition safely to their communities and go on to lead successful productive lives. The findings in this assessment, together with the recent suicides of two youth in DJJ custody, clearly illustrate the need to prioritize identifying and meeting the behavioral health needs of all DJJ youth. Many youth in custody contemplate or attempt suicide, engage in self-injurious behavior, aggress against youth or staff, remain incarcerated longer than necessary, or return to custody due to a lack of institutional care, aftercare resources or community-based support. It is the state's irreducible obligation to rehabilitate, care for and treat youth while they are in state

[19] MacArthur Foundation Research Network on Adolescent Development and Juvenile Justice. Issue Brief 2: Creating Turning Points for Serious Adolescent Offenders: Research on Pathways to Desistance, available from http://www.adjj.org/downloads/7230issue_brief_2.pdf.

custody, and to maximize each youth's potential for change, treatment success and community reintegration.

ALTERNATIVES TO DJJ COMMITMENT

It is neither ideal nor effective for the juvenile corrections system to serve as a primary treatment provider for youth suffering from mental health, trauma or substance use disorders. Illinois has established regressive financial incentives for communities to send justice-involved youth with high needs to correctional facilities paid for and administered by the state rather than at the county level. A more progressive, best-practice approach would be to fund local, community-based services capable of meeting the behavioral health needs of justice-involved youth, while keeping them in their communities and maintaining public safety. Illinois took steps to accomplish this goal when it enacted Redeploy Illinois, a highly successful program that allows participating counties to respond to youthful offenders in their community rather than commit them to DJJ. Recently, however, funding for the state's network of community-based mental health and substance abuse providers has been decimated and faces even deeper cuts in State Fiscal Year 2011. This lack of funding for mental health, substance abuse, and other community-based alternatives to incarceration further reduces options for vulnerable youth, their families and the communities in which they reside.

Incarceration is expensive; averaging about $80,000 per DJJ youth per year.[20] Community based treatment approaches such as Functional Family Therapy (FFT) and Multisystemic Therapy (MST) are much less costly and they produce effective outcomes.[21] Investing in effective services for these youth now is not only fiscally responsible, it is statutorily required and offers the greatest opportunity for the success for youth, their families and communities across the state. Until these factors are addressed, far too many youth will continue to be inappropriately and unnecessarily committed to juvenile corrections due to unmet mental health, substance use and trauma-related needs. It remains the state's legal and moral responsibility to keep these youth safe, provide for their institutional care, offer appropriate treatment services and provide them with the skills and competencies necessary to return home safely and achieve the positive outcomes society wants for all youth.

---

[20] Auditor General Report on DJJ. *Compliance Examination for the Period Ending June 30, 2008, available from,* http://www.auditor.illinois.gov/Audit-Reports/Compliance-Agency-List/Corrections/DOJJ/FY08-DOJJ-Comp-full.pdf.

[21] Greenwood, P. (2008). Prevention and Intervention Programs for Juvenile Offenders. *The Future of Children*, 18 (2), 185-210.

II. Findings and Recommendations for System-wide Improvements

The Behavioral Health Assessment Team identified both facility-specific and system-wide trends, deficiencies and challenges. This summary provides the team's findings and recommendations for system-wide improvements. To achieve the recommendations listed below, DJJ must be given the resources and staffing to develop an administrative infrastructure to manage mental health services, training, parole/aftercare services, community-based programs and services, and management information systems.

FINDINGS AND RECOMMENDATIONS

1. Finding on Screening and Assessment

Effective initial screening and assessment is critical to identifying the acute, emergent and immediate mental health needs of DJJ youth. The three DJJ reception & classification (R&C) centers currently rely on screening and assessment measures not validated for use with youth in juvenile justice settings and fail to assess the short-term risk of aggression. Screening and assessment data are not routinely incorporated into the development of youth treatment plans and are not used to evaluate the effectiveness of interventions.

Recommendation:

Juvenile correctional reception and classification systems across the country have, for a number of years, been in the process of adopting systematic, validated ways to assess youths' behavioral health needs. All DJJ reception centers must adopt the use of standardized and validated screening and assessment instruments.

2. Finding on Staffing Levels

The current level of staffing of behavioral health personnel is insufficient to accurately, consistently and comprehensively identify and address the behavioral health needs of youth in DJJ's custody. In many facilities the current caseloads of Youth & Family Specialists and Mental Health Professionals are unmanageable and do not allow for meaningful monitoring, treatment or provision of vital case management functions.

Recommendation:

Critical shortages of behavioral health staff must be addressed. Resources should be allocated to allow for the hiring of necessary behavioral health staff to elevate

current behavioral health staffing levels to a level consistent with contemporary standards.

3. **Finding on Staff Training**

   Relevant, ongoing staff training is essential to ensuring that staff members have the necessary skills and competencies to perform their jobs effectively, efficiently and safely. Since separating from DOC in 2006, veteran DJJ staff members have had little or no training on the behavioral health needs of adolescents, brain development, adolescent development, trauma or de-escalation techniques. This leaves veteran staff unprepared and ill-equipped to meet the demands of the department's new vision.

   Recommendation:

   All staff must be provided with training on topics directly related to the department's new youth-focused orientation. These topics include, but are not limited to adolescent development, adolescent mental health issues, substance use disorders, adolescent development, brain development, trauma, de-escalation techniques and crisis intervention. Although the training curriculum for newly-hired staff is being revised to include more focus on these areas, this process should be accelerated, supported and reinforced for all DJJ staff. DJJ should also request support from other child-serving agencies (e.g. Department of Human Services (DHS) Division of Mental Health, DHS Community Health & Prevention, Department of Children & Family Services) to provide training in these areas. In-service training programs at each facility should be expanded beyond "cycle training" to include the topics mentioned above.

4. **Finding on Behavioral Health Programming**

   Current behavioral health services are inadequate with respect to their intensity, variety, individuality, cultural sensitivity and implementation of evidence-based practices. Youth are assigned a mental health "level" that dictates only the frequency of mental health services but not the type, modality or focus of the interventions. As a result, individual treatment is uncommon and superficial, and assignment to treatment groups is not based on assessed need. Some facilities base provision of mental health services on a measure that is not a mental health assessment (the Juvenile Assessment and Intervention System). This practice is fundamentally flawed, particularly in light of the number of well-researched, empirically validated instruments available for this purpose.

   Recommendation:

   DJJ facilities should use standardized and validated mental health assessment instruments to inform the creation of individualized and integrated treatment plans for youth in need of mental health services. Treatment services offered should include individual as well as group therapy and should be provided based on youths'

assessed needs. These services should incorporate appropriate evidence-based practices whenever possible. Treatment services for youth with co-occurring disorders (mental health and substance abuse) and youth with histories of trauma should be expanded. Currently, the Division of Mental Health provides evidence-informed trauma services to youth at two IYCs (Chicago and Warrenville). Based on the success of this treatment offering and the prevalence of trauma exposure among justice-involved youth, resources should be allocated to expand these services to all IYCs. All Mental Health Professionals and Youth & Family specialists should be provided with formal, ongoing clinical supervision.

5. **Finding on DJJ Mission and Culture Change**

Institutional culture change requires an unwavering commitment from leadership coupled with a concerted effort to obtain the support and collaboration of staff. Successful programming requires a clear understanding on the part of DJJ leadership and staff of how a rehabilitation-focused system of youth corrections operates and a strong commitment to adopting policies and practices that are consistent with such a model. The assessment team found, however, that within DJJ, the transition from an adult corrections model to a rehabilitative model has not reached many of the veteran staff members. As a result, many of these staff members express ambivalence about the transition and are unclear about their role in it.

Recommendation:

DJJ leadership needs to communicate clearly with staff members about the department's new mission and their role in it. Formal communication strategies such as monthly newsletters or quarterly all-staff meetings are useful in promoting and sustaining culture change. Staff should be encouraged and empowered to offer suggestions in support of the department's new mission. When feasible, these suggestions should be piloted and, if proven effective, formalized through written procedures and expanded to other facilities.

6. **Finding on the Use of Confinement**

All facilities have successfully reduced use of confinement (see Appendix G), particularly long-term confinement, but some facilities continue to place suicidal and self-injurious youth in confinement. Some facilities have implemented alternatives to confinement such as peer conflict resolution, mediation, role-playing and self-reflection exercises. Staff members at other facilities expressed frustration over the removal of deterrents without replacement with incentives and alternative interventions. As a result, staff reported that they feel ill-equipped to implement the new philosophy that many of them say they support.

Recommendation:

Policies regarding confinement should be updated to comply with accepted standards for juveniles. Staff needs training on, and resources to implement,

alternative behavior modification techniques and incentives to reduce the need for confinement. The practice of housing suicidal or self-injurious youth in confinement should be discontinued. Protocols should be developed for intervention with such youth using established techniques including 1:1, special and close observation, which are less punitive, more effective and provide a more rapid functional improvement.

7. **Finding on Aftercare**

Correctional research consistently indicates that effective reentry and aftercare planning begins when youth are incarcerated, not later, when a youth nears release. Effective aftercare planning is based on an individualized plan for meeting the youth's needs while incarcerated, readying the youth for reentry and accessing a range of community-based services which can ensure that the youth does not return to the justice system. Currently, aftercare planning begins only when a youth is deemed to be nearing release and is a function of a "shared service" unit with the adult corrections system. Aftercare planning does not sufficiently incorporate the youth, family or community perspective. Youth released from DJJ are currently supervised by parole officers assigned to DOC. Most officers oversee mixed caseloads of adults and juveniles and have no specialized training or support to assist in supervising youth effectively. Obstacles to accessing appropriate community-based services for youth on parole further hamper successful reentry and increase the likelihood youth will return to custody.

Recommendation:

Aftercare planning should be initiated upon intake and progress documented monthly in the treatment plan. Family engagement should be prioritized particularly as it relates to formulating a youth's re-entry plan. DJJ should be assigned parole authority through legislation. DJJ should establish regional/district offices to house Juvenile Aftercare Case Managers. Resources should be allocated to hire, train and supervise Juvenile Aftercare Case Managers. Juvenile Aftercare Case Managers should develop a relationship with the youth during his/her institutionalization that will continue once the youth is transitioned to the community. A youth's Juvenile Aftercare Case Manager should be assigned upon intake and should participate in development of the youth's treatment plan and case reviews during the youth's residential stay. DJJ should calculate the number of youth transitioning to the community annually; estimate the number that will require mental health residential programs and non-residential services; and request an allocation sufficient to purchase these programs and services.

8. **Finding on Promising Programs**

DJJ and the Division of Mental Health (DMH) participate in two formal collaborative programs, the Juvenile Justice/Mental Health Reentry Project and the Juvenile Forensic Trauma Project. For the Reentry Project, DMH funds two Juvenile Justice Reentry Liaisons to plan the transition process for youth who have been identified

by DJJ to have serious mental health issues. Each liaison carries a caseload of 60 youth beginning while the youth is still in an institution and continuing for six months after the youth's return to the community. The Juvenile Forensic Trauma Project provides evidence informed trauma services to youth in DJJ institutions. The program is conducted by two staff members and is offered at two of the eight DJJ institutions.

Recommendation:

Collaboration with DMH through the Juvenile Justice/Mental Health Reentry Project and the Juvenile Forensic Trauma Project should be expanded. Currently, there are two Juvenile Justice Reentry Liaisons for all eight facilities. The team strongly recommends that resources be allocated to assign two Juvenile Justice Mental Health Reentry Liaisons to each facility, increasing the number of liaisons by 14. The trauma backgrounds and needs of youth in DJJ institutions require two trauma specialists for each facility. The team recommends increasing the number of trauma specialists to 14.

III. Methodology

The Behavioral Health Assessment Team conducted site visits to each of DJJ's eight facilities between January and June 2010. The team assessed the range of behavioral health needs of youth in the DJJ system and the systems in place for identifying these youth; the adequacy of existing behavioral health policies, programming and staffing; the appropriateness of current approaches to transitioning youth with behavioral needs out of DJJ; and the level of collaboration between DJJ and other Illinois systems responsible for meeting the needs of youth with mental health and substance abuse issues.

Behavioral Health Assessment Team Members

Joseph J. Cocozza, Ph.D.
Director
National Center for Mental Health and Juvenile Justice
Delmar, NY

Debra Ferguson, Ph.D.
Associate Deputy Director of Forensics
Division of Mental Health, Illinois Department of Human Services
State of Illinois
Chicago, IL

Eugene Griffin, J.D., Ph.D.
Associate Director of the Mental Health and Services Policy Program
Northwestern University Feinberg School of Medicine
Clinical Director, Illinois Childhood Trauma Coalition
Chicago, IL

Thomas Grisso, Ph.D.
Professor and Director
National Youth Screening and Assessment Project
University of Massachusetts Medical School
Department of Psychiatry
Worcester, MA

Antoinette Kavanaugh, Ph.D.
Forensic Psychologist
Chicago, IL

Edward J. Loughran (Team Leader)
Executive Director
Council of Juvenile Correctional Administrators
Braintree, MA

Eric Trupin, Ph.D.

University of Washington
Public Behavioral Health and Justice Policy
Seattle, WA

The Behavioral Health Assessment Team utilized the following method to gather data for completion of this review:

1. Behavioral Health Assessment Team members were assigned to participate in site visits for each of the eight IYCs. Care was taken to ensure that all teams consisted of both clinical and policy experts at each of the site visits. Because of his extensive research and expertise in this area, Dr. Tom Grisso was specifically tasked with evaluating the screening and assessment procedures currently in place at the three Reception & Classification Centers. The dates of the facility site visits and the participating team members are listed below.

Location	Dates	Team Members
IYC Kewanee	Jan. 5, 2010	Joe Cocozza Ned Loughran Debra Ferguson Gene Griffin Antoinette Kavanaugh
IYC Harrisburg	Feb. 24	Debra Ferguson Ned Loughran Gene Griffin
IYC Murphysboro	Feb. 25	Gene Griffin Ned Loughran Debra Ferguson Tom Grisso
IYC Pere Marquette	Feb. 26	Ned Loughran Gene Griffin
IYC St. Charles	Mar. 11 June 7	Debra Ferguson Tom Grisso Antoinette Kavanaugh Ned Loughran Gene Griffin
IYC Warrenville	Mar. 12	Tom Grisso Debra Ferguson Gene Griffin
IYC Chicago	Mar. 26	Ned Loughran Gene Griffin

IYC Joliet	Apr. 6	Antoinette Kavanaugh Eric Trupin Ned Loughran

2. In general, each of the site visits was organized in a similar manner. The site visit team met with the Superintendent and members of the administrative leadership staff. The team then toured the facility, with special attention to Reception and Classification Units, Special Treatment Units and Confinement Units. The team also met with members of the Behavioral Health staff, direct care staff (e.g. Juvenile Justice Specialists, Youth & Family Specialists), members of the union and youth at the facility. When time permitted, staff also reviewed a small sample of Master Files.

3. A member of the Assessment Team conducted interviews with Department of Correction Parole Staff and Department of Correction Placement Resource Unit Managers.

4. A member of the Assessment Team conducted interviews with the Department of Human Services' Division of Mental Health.

5. Members of the Assessment Team conducted interviews with Directors of Provider Agencies and attempted to interview staff from the Department of Children and Family Services (DCFS). Staff from DCFS were unavailable and interviews could not be scheduled.

6. The site visit teams drafted individual reports for each facility as they were functioning at the time of the visit. The team as a whole then shared reports, compared observations, identified system-wide trends and concerns and then prepared recommendations for policy and practice improvements. This report was written by the team to inform immediate efforts to keep youth safe while in DJJ custody as well as to recommend long-term improvement of the law, policy, practice and treatment that directly impacts the opportunities for justice-involved youth to return to and remain safe in our communities.

IV. Site Visit Reports

This section includes detailed reports from site visits to each of DJJ's eight facilities. Youth entering Illinois DJJ are first oriented, evaluated and classified at one of three Reception and Classification Centers: IYC St. Charles and IYC Harrisburg for boys, and IYC Warrenville for girls. Their screening and assessment methods and procedures are described in detail within each facility's individual section. Site visit reports follow in the order listed below.

Facility	Description	Parole District, County
IYC St. Charles	Male; Reception & Classification; medium security; houses youth with serious mental health needs	District 2, Kane County
IYC Kewanee	Male; medium security; houses youth with serious mental health needs and juvenile sex offenders	District 2, Henry County
IYC Harrisburg	Male; Reception & Classification; multiple security	District 5, Saline County
IYC Murphysboro	Male; minimum and medium security for central and southern counties	District 5, Jackson County
IYC Joliet	Male; maximum security	District 1, Will County
IYC Chicago	Male; minimum security; Parole Readjustment Program- multiple-level	District 1, Cook County
IYC Warrenville	Female; Reception & Classification; multi-level security	District 2, DuPage County
IYC Pere Marquette	Female; Minimum and medium security	District 4, Jersey County

IYC St. Charles

Site visit overview

The initial site visit to IYC St. Charles was conducted on March 11, 2010. The IYC St. Charles site visit team consisted of: Debra Ferguson from the Division of Mental Health of the Illinois Department of Human Services, Antoinette Kavanaugh from Northwestern University, and Tom Grisso of the University of Massachusetts Medical School.

The site visit began at approximately 9:00 a.m. and lasted until approximately 4:00 p.m. At the beginning of the site visit, the team met with the Facility Superintendent and members of his Administrative Team including: the Assistant Superintendent of Programs, the Youth & Family Specialist Supervisor, the Health Care Administrator, School Principal and the Reception & Classification Unit Administrator. Over the course of the day, the team met with additional members of the facility staff including Mental Health Professionals, direct care staff, Youth & Family Specialists and members of the union. The team also met with 6 youth incarcerated at IYC St. Charles. The site visit team also toured the facility including visits to the Reception & Classification Unit, Special Treatment Units and the Confinement Unit.

In order to gather additional information on the provision of behavioral health services at IYC St. Charles an additional site visit was conducted on June 7, 2010. The site visit team consisted of Ned Loughran of the Council of Juvenile Correctional Administrators, Debra Ferguson of the Department of Human Services' Division of Mental Health and Gene Griffin of Northwestern University.

An initial meeting was held with facility administration including: the Superintendent, Assistant Superintendent of Programs and Chief of Security along with a facility social worker and a clinical psychologist from the Reception & Classification unit. DJJ's Behavioral Health Administrator was also present.

Facility description

Opened: December 1904
Capacity: 318
Level: Medium-Security Juvenile Male
Average Daily Population: 328
Average Age: 16[22]

IYC St. Charles is one of three Reception & Classification (R&C) units within the DJJ system. All youth committed to DJJ go through one of these three facilities in order to determine their security level, mental health needs and treatment needs. In addition to the R&C function, IYC St. Charles provides Special Treatment Units for mental health and substance abuse and medium security general population units for youth committed to DJJ. Youth identified during the R&C process as having Level 2 mental health needs or above are placed in one of the Special Treatment Units or are transferred to IYC Kewanee.

Youth Profile

IYC St. Charles is an all male facility. According to the Institutional Monthly Youth Profile for IYC St. Charles dated 5/31/2010, the population was 66 percent African-American, 16 percent Caucasian and 18 percent Hispanic. The average age was 16.5 years with 49 percent of the youth between the ages of 17 and 20 years old and 51 percent age 16 and younger. The majority of the youth had a medium security classification level (77 percent) and 22 percent were rated at the high security classification level.

The majority of the youth at IYC St. Charles (58 percent) were rated as having minimum mental health needs (Mental Health Level 1), 11 percent were rated as having moderate mental health needs (Level 2) and 31 percent were rated as having no mental health needs (Level 0). Staff reported that of the youth identified as having mental health needs in R&C at IYC St. Charles (Level 1 or 2), approximately 80 percent remain there and 20 percent are transferred to IYC Kewanee. Youth who remain at IYC St. Charles after completion of the R&C may be assigned to General Population based on

---

[22] http://www.DJJ.state.il.us/subsections/facilities/information.asp?instchoice= stc

their rated security and mental health level. Based on their security and mental health level, they may be assigned to one of the two Special Treatment Units for substance abuse or the mental health living units (two units though one was undergoing renovation).

Sixty to seventy percent of the facility is double bunked. However, the newly renovated special treatment unit has single beds and bunk beds are being replaced throughout the department. All facilities are expected to have the new single beds by September 2010. Though the elimination of the double bunks is considered to be a significant safety improvement, staff members have continued concerns about the risks associated with the sinks and toilets within the cells.

Staff report that the majority of youth entering the facility are parole violators. Additionally, they report that approximately 30 percent of the youth at IYC St. Charles are non-violent offenders and could be served in the community if appropriate services were available.

Reception & Classification

The R&C Unit has 119 beds. R&C accepts intakes five days per week and parole violations seven days per week. The complete R&C process takes approximately 14 days to complete. Staff report that approximately 1,800 youth undergo the intake process at IYC St. Charles annually. According to clinicians, many of these youth have failed in previous residential placements. They estimate that 5 percent of DJJ youth are DCFS wards. They describe serving four distinct youth populations: R&C, Special Treatment Units (Mental Health), Substance Abuse and General Population.

IYC St. Charles has an R&C Unit Administrator. Staff members include mental health professionals (psychologists), Juvenile Justice Youth and Family Specialists (YFS), and a Youth and Family Specialist Supervisor (YFSS). YFS were formerly called counselors and are bachelor's level case managers. Professionals (psychiatrists, licensed clinical psychologists or social workers) are available for follow-up assessments, and the Wells Center, a contracted provider of substance abuse services, performs screening and assessment functions related to substance abuse services.

Treatment Program

Both state and contractual (Health Professionals Limited (HPL)) employees provide behavioral health services at IYC St. Charles. A breakdown of the hours and unit assignments are listed in Appendix E of this report. The contractual staff includes two psychologists (one assigned to R&C) and one Licensed Clinical Social Worker who are employed by HPL. There are also two full-time psychologists who are State employees. Substance abuse services are provided through a contract with Wells Center. There are also six diagnostic interns from various schools throughout the state, and one social work intern. There are three psychiatrists who provide a total of 48 hours of psychiatric services per week.

The Director of the Treatment Program conducts a meeting of the clinical staff every morning with the clinical psychologists, social workers, shift supervisor, school

representative and youth and family specialists. These meetings are to review daily plans and any current crises. Treatment staff report they have little contact with the psychiatrists but the psychiatrists are available to clinicians for consultation.

The mental health services offered are individual therapy, group therapy and crisis intervention. There are six group therapy offerings (not EBPs) whose curricula were developed by mental health staff six years ago and have an accompanying pre- and post- test. There are currently 21 group therapy offerings for the entire facility. Enrollment in group is accomplished by a review of the Master Record file, staff referral or youth referral rather than by formal assessment. The therapist assigned to a youth completes a Clinical Needs Assessment Form which contains the initial treatment plan and schedule of groups to which the youth is assigned. The therapy groups usually have 8 youth and are conducted by 2 mental health staff. A youth is usually just in one group at a time (maximum 2). Inefficiencies of a large, spread-out geographical facility are a particular challenge for the clinical staff, as a great deal of time is required to gather the youth, transport them to the group therapy room and then return them to their living units. Staff members indicate in the worst case scenario that this entire process can take up to three hours for a single group offering. Groups are also held during school hours and lunch.

On the Special Treatment Units, youth receive individual therapy once or twice a week for 30 – 45 minutes and 1- 2 groups per week. Staff report that the majority of youth with mental health needs also have substance abuse treatment needs. Despite this fact, there is no integrated treatment offered for youth with co-occurring disorders at IYC St. Charles. Staff believe that IYC St. Charles needs a MISA program similar to the one at IYC Kewanee (the only one within the DJJ system). The Wells Center has a 6 month structured program for substance abuse consisting of 90 beds. However, youth can stay on the unit for up to a year in order to complete the program and may end up repeating parts. Wells Center staff determines when a youth has completed the program based on the youth's participation. There is also an Alcoholics Anonymous group conducted by a volunteer in the evenings.

IYC St. Charles utilizes a behaviorally-based level system. There are three levels: A (highest), B and C (lowest). Youth start on B and their level is adjusted based on points added or deducted. On Level A, they can spend more of their own money on commissary items and can purchase electronics. The school has a separate point system and youth can also purchase some items at school. However, this level system does not appear to be formally integrated into youth's treatment plan or part of an ongoing cognitive behavioral treatment approach. Such integration could strengthen the interventions and provide consistent feedback to youth about their progress. However, clinical staff report that due to a severe lack of resources, they do not have sufficient rewards available to reinforce positive behaviors.

The school uses Positive Behavior Intervention and Supports (PBIS), an evidence-based program for improving academic performance and behavior. PBIS is a data-driven system geared toward teaching social skills to youth to learn new positive behaviors to use (not just the cessation of negative behaviors). PBIS also utilizes a level system where youth can make purchases from the school store. However, with no data management system, all data are entered into Excel manually and they can only

generate quarterly reports. The school used to use a "Ready to Learn" (RTL) Room, where disruptive youth could go to during the school day. RTL staff would work with them and return them to class. Unfortunately, the RTL room was closed last year because of staff shortages. Staff report that since the closure of the RTL, in their opinion problem behaviors in the classroom and in the school have increased.

FINDINGS

Intake

Screening for various characteristics is done in the first hour after a youth enters the facility. Some of it is done by YFS personnel and other parts by a mental health professional. The following are the primary screening activities during intake.

Medical screening

The intake Youth & Family Specialist Supervisor completes a checklist of medical issues (on a form called "Medical Screening") based on observation and interview, e.g., youth reports whether he has allergies, asthma, heart issues, head injuries, medications, etc.

Substance abuse screening

A Certified Alcohol & Other Drug Counselor administers the Texas Christian University Drug Screen-II (TCUDS-II), a brief, standardized screen that identifies whether youth provide information indicating that they might have no, mild, moderate or severe drug problems. Very clear criteria have been developed for using answers on the TCUDS-II to determine level of severity and whether further assessment is needed.

Suicide risk screening

A mental health professional administers the Suicide Probability Scale (SPS). This is a 5-10 minute task during which the youth reads and answers 36 questions (with 4-point response format) contributing to four subscales: Hopelessness, Suicide Ideation, Negative Self-Evaluation, and Hostility. High scores indicate need to take initial suicide precautions per policy.

Mental health screening

Personnel engage in a semi-structured standardized interview with youth, providing interview notes on a "Diagnostic and Treatment Note Intake Screening" form. The interview asks about: past psychiatric hospitalizations and mental health diagnoses; past and current medications; past and current suicidal thoughts/threats/plans; recent stressors; residential placement; family mental health history; DCFS involvement; history of sexual offenses; history of substance use; and gang involvement. A checklist is provided to describe mood, affect, and thought symptoms. This screening information is used to determine level of mental health needs and thus need for mental health assessment.

RECOMMENDATIONS

The purpose of screening within the first hour upon admission is to determine whether youth have immediate (emergent) medical or mental health needs of which staff should

be aware, and to identify special considerations for the more extensive assessment that will follow in the next few hours and before a youth is assigned to a housing unit. Best practices in modern juvenile justice programs include the use of standardized and validated screening tools whenever possible. In addition, forms for collecting interview information should be written in a manner that minimizes differences across intake personnel in the types and quality of information they are collecting.

Medical screening

The medical screening form provides no structure for the interviewer. Interestingly, it does not even ask youth if they feel sick (e.g., cough, cold, feverish). It merely lists items (e.g., "Allergies," "Seizures") without indicating what it is that one wants to know about these items. For example, for "Medications" it is not clear what the interviewer is supposed to determine-- whether the youth has ever taken medications, has been taking them lately, or is taking them now—and for what purposes. It is not clear whether the "Head Injuries" item refers to current head injury or lifetime head injury. A nurse completes the youth's health history and conducts a medical assessment within hours of this initial screening. The youth remains in intake under direct supervision and is not placed in a housing unit until seen by a nurse within hours of the youth's admission.

Lack of standardization can contribute to unreliability and missed information. A better form could be developed by contracting with a pediatric physician to determine the essential medical conditions that could be reviewed with the youth without the need for medical expertise. In addition, several states' juvenile justice systems have developed medical screening intake forms (not requiring a medical practitioner) that focus on a limited number of important health questions appropriate for intake, identify specific questions to ask, and provide check boxes to record the youth's answers.

Substance abuse screening

The TCUDS-II has demonstrated some validity and utility in screening for drug problems in adult corrections. The criteria for assigning no, mild, moderate and severe categorization are clearly stated and do not require staff judgment. However, we could find no evidence that the instrument has been validated for use with juveniles, either at the intake stage of juvenile corrections or any other setting. A number of standardized and validated, 5-20 minute drug use screening tools exist for completing this task in an accurate and efficient manner at juvenile justice intake.

Suicide risk screening

The SPS was originally developed and validated primarily with adult samples and norms. A number of studies in the past 10 years have identified difficulties in the use of the SPS with adolescents. In one study, for example, the SPS identified less than one-half of youth who later manifested self-injurious behavior. Moreover, we have been able to locate no studies that have provided norms or evidence of validation for the SPS with youth at intake in juvenile justice programs. In contrast, there are a number of standardized and validated suicide screening tools for use with youth in juvenile justice settings. Moreover, unlike the SPS, some of the validated tools are free; the SPS requires the purchase of a carbon-copy form for each administration.

Mental health screening

The semi-structured interview used at St. Charles would be adequate for detecting possible need for further mental health assessment because it is administered and interpreted by a mental health professional (doctoral psychologist or psychiatrist). Supplementing this with a brief, standardized, scored and validated self-report mental health screening tool would have several benefits. It would provide considerable information to the mental health professional on a range of symptoms that are not included in the semi-structured mental health screening interview schedule. It would also provide cumulative numeric data on St. Charles' population regarding mental health needs. It would follow professional guidelines that support obtaining information on mental health issues from more than one method. Finally, it would reduce liability that could be associated with staff decisions that currently are based only on subjective judgment.

Other issues

Extended reception – Assessments

The primary reception and classification procedures beyond the initial intake include two types of extended assessment for those youth identified as having special needs during the intake screening.

Follow-up mental health assessment

Youth who screen at mental health severity Level 2 or higher are provided comprehensive mental health evaluation by psychologists. This evaluation is apparently individualized based on the clinician's initial impressions. A wide range of standardized psychological tools are available to the clinicians. Separate tracking for mental health assessment is employed for youth with mental health needs and youth who have committed sex offenses.

Follow-up drug use assessment

Youth scoring moderate or severe on the TCUDS-II at intake are evaluated by Wells Center staff (a contracted vendor) for more detailed substance use assessment. This includes the Global Appraisal of Individual Needs (GAIN).

Educational assessment

The educational assessment is not performed by the St. Charles Reception and Classification Unit, but instead is performed (with Terra Nova) after the 2-3 week Reception and Classification process, when the youth arrives at the parent facility where the youth will be spending his time in DJJ. Historically, the Juvenile Division of DOC conducted educational testing in the agency's three Reception & Classification Units prior to a youth's assignment to a facility. Additionally, vision and hearing testing was completed in Reception, prior to the youth's transfer from Reception. Special

Education services were also provided to youth while awaiting assignment to their treatment program at the assigned facility. All of these services ceased when staff resources were diminished in the late 1990s.

RECOMMENDATIONS

Follow-up mental health assessment

This review did not include a detailed examination of the evaluations performed by psychological and psychiatric professionals to whom youth are referred for further mental health assessment. In general, however, the assessment instruments used by St. Charles psychologists are adequate. The tools that they use are, by and large, well validated and widely used in juvenile justice and mental health services. It appears that the mental health professionals employ the tools selectively, based on youths' individual situations, rather than simply administering a standard battery of tests without consideration for their actual need. That is good policy and practice. We have no data, however, on the quality of their evaluations.

St. Charles has also been considering use of the V-DISC (Voice-Diagnostic Interview Schedule for Children) and VISA (Voice Index of Self-Injurious Actions), which are computer administered, provides probable psychiatric diagnoses for youth, and takes about 60-120 minutes. Staff members believe that it may be useful in defining their population of youth. Further consideration should weigh the added benefits, of which there may be several, against costs.

Follow-up drug use assessment

The Wells Center performs some range of methods when youth are referred for drug abuse assessment. It was noted that they use the GAIN, which is among the better validated tools for assessing drug problems in youth. IYC St. Charles professionals felt that it provided very helpful information. However, the Wells Center has difficulty with staff retention. The GAIN has a lengthy training period and staff turnover often occurs as staff become qualified to administer this instrument. Due to these issues, there may be a lapse in time whereby the GAIN will not be available. It appears that this would leave IYC St. Charles without a meaningful drug abuse assessment mechanism.

Other issues

We found no evidence that the IYC St. Charles reception and classification process included a validated instrument for **assessing risk of future violence for inclusion in their placement decisions**. We were told that a set of "factors" are considered. However, we were not provided with any materials that specifically enumerated those factors, indicated how the factors were defined and measured, or provided a manner for combining the factors to arrive at levels of risk. If such a set of factors exists, one would then want to know whether they have been subjected to any empirical test of their validity with youth in juvenile justice settings. If not, then they should be replaced with tools that have at least enough research to have been shown to be promising in this regard. Work is underway with the NCCD to develop and implement a research-based Juvenile Classification Instrument that incorporates demographic data of Illinois youth. This will assist the department in developing a standardized juvenile classification instrument subject to ongoing research and validation.

We found no evidence that IYC St. Charles has a systematic way to **assess youths' psychosocial needs** beyond mental health and substance use needs. Needs have been determined in the past by general interviews, but have not been systematically assessed. Without an individualized needs assessment, there is no prospect for systematically putting together individual intervention plans.

IYC St. Charles is anticipating the future use of the Juvenile Assessment and Intervention System (JAIS) for this purpose, but at the time of the visits there had been no introduction of it at this DJJ facility. The JAIS' potential rests with its intention to match youths' needs with four specific intervention strategies/programs. An initiative to use the JAIS in this way would require two things. First, all of DJJ would need to convert to intervention strategies or units that parallel the four intervention strategies that the JAIS identifies. Second, evidence would need to be collected to support the validity of the presumptions underlying the JAIS—that is, that matching youth to the four intervention strategies produces positive outcomes. In the absence of these conditions, the JAIS might still have a general positive value in learning about the individualized needs of youth so that they could be used in intervention planning, even without converting the system to these four intervention strategies. However, many other needs assessment tools developed for juvenile justice programs would also satisfy this objective, some of which have been validated in a manner that the JAIS has not yet achieved.

Existing mental health services

Current mental health offerings at IYC St. Charles are inadequate. There are insufficient programmatic offerings across all units at the facility. Treatment is not individualized and assignment to treatment group is not based on an assessment of individualized need. Staff report there is "nothing special" about Special Treatment Units and that they lack the resources to provide the services they believe the youth truly need.

RECOMMENDATIONS

Increase programming throughout the facility. There is not sufficient therapeutic activity occurring and there is not enough variety in what is offered. Create individualized treatment plans that address specific areas of need and build upon identified youth strengths. Consider a low cost re-configuration of living units to allow for therapy groups to be held on the units. This could increase the number of groups offered as well as the number of groups in which a youth could participate. Discontinue the practice of taking youth out of school for groups. The majority of DJJ youth have significant behavioral health and educational needs. Treatment and remediation should be available for both, rather than offering one at the expense of the other. The Information Technology system at IYC St. Charles (as with all DJJ facilities) is antiquated and unstable. Ideally, it would allow for the tracking of behavioral data on each youth and interface with the PBIS system for youth enrolled in school.

Staffing levels

Staff believes that no more than 24 youth should be housed on a living unit and there should be no double bunking. The management of 40 youth, most of them presenting complex treatment needs, is extremely difficult. The problem is compounded by such minimal staffing by Juvenile Justice Specialists (formerly called Correctional Officers) on the units. During a hiring freeze from 2001 to 2006, the number of filled positions at St. Charles dropped from 193 to 123. Currently, on each of the units the staffing ratio of Juvenile Justice Specialists to youth is 1:20 on day and evening shifts (6am – 2pm and 2pm to 10pm) and 1:40 on night shift (10pm to 6am). With larger, poorly staffed living units, the Juvenile Justice Specialists must prioritize limit setting and behavioral control rather than the therapeutic engagement of youth. The staffing levels for Mental Health Professionals are insufficient to provide the frequency and intensity of behavioral health services necessary for the youth. St. Charles just hired five new teachers but the ratio of teachers to youth is 1:15.

RECOMMENDATION

Address critical staffing shortages. The caseloads maintained by the Mental Health Staff are unmanageable and do not allow for any meaningful treatment to occur. Similarly, the caseloads of the Youth and Family Specialists are equally high and do not allow for them to perform the vital case management functions in a detailed and timely fashion.

Training

Staff receive annual training (Cycle Training) in Policies and Procedures, Administrative Directives and Life Safety Issues. There is no additional training offered, which facility management attributed to not having the funding to pay the overtime costs associated with staff training. All of the staff members the site visit team met with cited the lack of training as a major issue. The need for training came up repeatedly during both visits and with all groups of staff. Staff reported that since the transition from the adult corrections model, they have received no additional training on youth-centered interventions, adolescent development or the mental health needs of justice-involved youth. Training in de-escalation and aggression management were mentioned as specific needs. Youth De-escalation Training has been offered to some staff. However, this is offered through the Department of Corrections and therefore the curriculum was not available for the team to review.

RECOMMENDATIONS

Develop a program of in-service training for staff. Consider requesting mental health consultation and in-service training support from the Division of Mental Health and other child-serving agencies. For example, consultation and in-service training support could be provided by the nearby DMH Elgin Mental Health Center. Such a formal in-service training program would facilitate individual professional development and supplement internal training efforts.

Staff consistently mentioned lack of communication as a major problem. This was true for staff shift-to-shift on a living unit and across disciplines and across the facility.

There should be a regular, more structured and reliable process for documenting and communicating important, current clinical information about the youth.

Philosophical change

Staff describe the transition from the Department of Corrections (DOC) to DJJ as one in which youth are no longer held accountable for their behavior. Staff repeatedly describe the youth as "disrespectful" and report feelings of frustration and loss of control. The union in particular described their jobs as more stressful and more dangerous since the transition. The union stated that they were "sold a pipe dream and nothing has happened." They also report an increase in staff assaults (25 percent). However, Performance-based Standards (PbS) data show that in IYC-St. Charles' Reception there were zero assaults on staff in both the October 2009 and April 2010 data collection periods. Two injuries to staff[23] were reported in the April 2010 data collection, up from zero in October 2009. For IYC St. Charles' PbS Correction Site, one assault on staff and three injuries to staff were reported for April 2010.

Staff also believe that there is insufficient programming for the youth and that they need additional resources to adequately equip youth to successfully return to the community. They believe both staffing levels and programming has dramatically decreased since the transition. As a result they describe a overall lack of consistency that permits youth misconduct. They also cite lack of training as a major problem particularly in the area of mental health issues.

RECOMMENDATION

Prioritize staff training in the skills needed to address the rehabilitative needs of youth. The most critical of these seem to be mental health issues, substance use disorders, childhood trauma, adolescent development, brain development, de-escalation techniques, behavior management and crisis intervention.

Confinement/Restraint

Taylor is the confinement Unit at IYC St. Charles. Housed in confinement are those youth who require medical isolation, youth on suicide precautions, violent or aggressive youth received from the counties in Reception and youth on administrative hold. Like the other units, this unit is critically under-staffed, particularly considering the variety, complexity and severity of management needs of the youth. The physical layout of Taylor makes it difficult to maximally observe and monitor youth. On the day of the June site visit, the unit milieu was loud and chaotic despite a relatively low census.

Staff reported that when they first become aware that a youth is suicidal they follow facility protocol, which requires "eyes on" youth at all times, contacting the shift supervisor and the mental health professional regarding updates on critical information about youth. Youth are then placed on a watch status, which might be close

[23] Injuries, as defined by PbS, include any instance in which a staff member is hurt even if treatment is not provided. This includes minor injuries such as scratches or swellings, injuries from assaults/fights, accidental injuries from playing sports or other environmental hazards.

observation or suicide watch. Youth on close observation are checked every 5 minutes, even though that is not required by DJJ policy. On suicide watch, youth will be assigned a staff member who will be at the closed door observing through the window (though it was unclear if they maintain constant observation of the youth). Youth are stripped to their underwear, given a mattress and a specialized suicide blanket and smock. Staff report that therapeutic restraint has not been used in five years but could be used if needed. While on Taylor youth are seen by a Mental Health Staff and Youth and Family Specialist daily and undergo a daily mental status exam to see if they will contract for safety. Mental health staff determine when to take a youth off of special observation status. Administrative staff visit these youth daily in addition to the shift supervisor on every shift.

Staff believe PbS has been helpful in reducing the use of confinement. The change was difficult for some staff but the PbS data, showing improvement, encouraged staff and their positive efforts continue as reflected in their facility's data (See Appendix G). Now staff are more involved and talk with the youth more frequently. PbS youth climate survey responses and other data are shared with staff so they realize the impact of their efforts.

Transitioning Youth

The discharge/transition process begins when the youth are approaching their Administration Review Date (ARD) rather than upon admission. There is no formal, structured discharge planning process that engages the interdisciplinary team, the youth and his family. As a result, the process is rather haphazard and fragmented. The Mental Health Staff make recommendations for continued treatment however, staff are hampered by lack of services in the community. This may contribute to many of the youth returning to the facility on parole or technical violations. In the past, Juvenile Parole Officers visited youth before discharge but the practice does not occur with adult parole. Staff reports that adult parole officers are more likely to violate youth, even when the community or residential providers want to keep working with the youth. Juvenile parole officers were seen as more willing to work with the youth and more likely to offer assistance to youth to enable them to remain in the community.

There is only one Field Service Representative (a Youth & Family Specialist) for the entire facility who assists with transition planning for the youth (particularly the educational linkage), completes Support Services Requests that are submitted for the establishment of outpatient treatment, psychotropic medication continuance through psychiatric appointments, outpatient substance abuse treatment, medical follow up, parenting classes, outpatient juvenile sex offender treatment, etc.. The Field Services Representative calls the youth's family in preparation for the scheduled parole hearing or discharge date.

The Division of Mental Health supplies two Juvenile Justice Mental Health – Reentry (JJMH-R) Liaisons who screen and assess youth, with mental illnesses, transitioning from the facility and then linking them with necessary services in their own communities. These JJMH-R liaisons begin working with youth who are referred to them approximately 60 days prior to release and attend the youth's parole board hearing to present the treatment plan that has been developed. JJMH-R liaisons also

provide ongoing monitoring and case management for the youth, post-release, for a period of six months. However, there are only two JJMH-R liaisons for all eight IYC facilities and they maintain a caseload of approximately 60 youth. Staff identified the JJMH-R program offered by the Division of Mental Health as extremely helpful in assisting youth with mental illnesses transition successfully into the community.

Recommendations

Transition/Discharge Planning should begin in R&C with progress documented in the monthly staffing and reported on in the quarterly reviews. Parole officers should meet with youth and their family prior to release in order to establish rapport and identify potential challenges associated with community reintegration. Family involvement in transition planning is essential. Because youth and family involvement is associated with improved outcomes, a priority must be placed on engaging them in the process and developing a plan that reflects their unique needs.

Family

There was very little said about family involvement or family engagement. Family may visit on weekends and holidays or by appointment on other days, but there was no evidence that the staff worked to actively facilitate visits or to ensure that youth maintained close contact with family members. The staff did not seem to connect the importance of family contact with the success of the youth post-discharge. Clinicians may help a youth call his family. However, family visits are very rare. A few clinicians are available on the weekend to meet with families though this is a rarity. Very little in the way of family therapy or family involvement was noted.

Recommendations

Efforts should be made to engage family members and make it easier for them to visit and maintain connection with the youth.

Family input should be solicited in the development of the treatment plan and family participation in the treatment plan reviews, if only by phone, should be encouraged and supported. Additionally, clinical staff should be available on weekends to meet with youth and families during visitation. Adding family therapy to the behavioral health services offered would be of great benefit to the youth and their families.

IYC KEWANEE

Site visit overview

The IYC Kewanee site was visited on January 6, 2010 as part of the review of the Illinois Department of Juvenile Justice's Behavioral Health Program for Committed Youth.

The site visit team included the following individuals: Joseph J. Cocozza from the National Center for Mental Health and Juvenile Justice, Ned Loughran from the Council of Juvenile Correctional Administrators, Debra Ferguson from the Illinois Department of Human Services, Gene Griffin from Northwestern University and Antoinette Kavanaugh from Northwestern University.

The team met with individuals at the IYC Kewanee site from approximately 9 a.m.-4:30 p.m. A series of meetings and discussions were held beginning with the DJJ Behavioral Health Services Administrator, the Acting Superintendent, and, Alternative Behavior Treatment Centers Clinical Director (contractual) at IYC Kewanee. In addition, the team met with clinical and nursing staff, members of security, representatives from the school, direct care staff, representatives from the union and youth residing in the facility. The team also toured the facility and reviewed a small number of youth files.

Facility Description

Opened: November 2001
Capacity: 306
Level: Medium-Security Juvenile Male
Average Daily Population: 218
Average Age: 17[24]

As indicated in the previous section on IYC St. Charles, all youth committed to DJJ are processed through one of three Reception & Classification (R&C) Units. Youth identified as having significant mental health concerns are placed in one of two Special Treatment Units in the DJJ system. IYC Kewanee, with a capacity of 90 special treatment and 162 juvenile sex offender treatment beds, is the larger of these two programs.

Youth Profile

As shown in the attached tables (Appendix F) the youth at IYC Kewanee as of 5/31/2010 were 57 percent Caucasian, 37 percent African American and five percent Hispanic; and the majority of them were aged 17-20. Forty-nine percent of the youth had been assigned to a minimum mental health level, 45 percent had been assigned to a moderate mental health level classification and two percent were assigned no mental health level. Over two-thirds of the youth (66.8 percent) are experiencing both mental health and substance abuse problems (See Appendix H).

[24] http://www.DJJ.state.il.us/subsections/facilities/information.asp?instchoice= kew

Treatment Program

There are four primary treatment programs offered at IYC Kewanee. These are:

1. Kewanee Special Treatment Program-Youth with Acute Mental Health Issues-Capacity 54
2. Kewanee Special Treatment/Juvenile Sex Offender Program- Youth with Acute Mental Health Issues and Sexual Deviant Behaviors-Capacity 18
3. Juvenile Sex Offender Program-Youth with Sexual Deviant Behaviors-Capacity 162
4. Mentally Ill Substance Abuse Program- Youth with Substance Abuse and Mental Health Issues-Capacity 18

In general, the JSO and KST programs provide eight hours of groups each week and approximately 30-60 minutes of individual services per week. In both of these programs treatment is provided through a four-phase program intended to last approximately one year. The KST/MISA (Mentally Ill Substance Abuse) program lasts approximately six months. Fifteen groups are provided weekly with 30 minutes of individualized services.

FINDINGS

Existing mental health services

The Mental Health services are provided through a contract with a private firm, Alternative Behavior Treatment Center (ABTC). Reliance on ABTC seems to accomplish several goals. It provides the facility with a strong clinical presence for providing services and solves the difficulty of attempting to recruit trained clinical staff to the rural setting of IYC Kewanee. The only concern with ABTC raised during the visit were the Union representatives who we met with who were interested in unionizing staff from ABTC to insure consistency with other staff located at IYC Kewanee.

Effective September 1, 2010, ABTC will no longer have the contract to provide clinical services at Kewanee. The contract positions will be converted to state positions. The 24 positions on the ABTC contract that will convert to state general revenue fund effective September 1 include:

- (2) Psychologist III
- (2) Psychologist II
- (6) Psychologist I
- (7) Social Worker II
- (6) Youth and Family Specialist
- (1) Office Assistant.

While in the short site visit it was difficult to assess the overall quality of the mental health services provided by ABTC, there were a few issues that clearly need to be addressed. Consistent with the national picture and as reflected in the numbers provided earlier, most youth involved with the juvenile justice system and, therefore, many youth admitted into IYC Kewanee experience both mental health and substance abuse issues simultaneously. Despite this, the capacity of the Mental Illness Substance Abuse (MISA) program is only 18. It was reported that despite the small number of beds, there were over 135 referrals to IYC Kewanee's MISA program in 2008. In

addition, the treatment approach does not seem to adequately incorporate two other major trends occurring across the country-the growing reliance on evidence-based practices and the emphasis on understanding the impact of trauma on these youth. There was little evidence in the site visit that either of these two new important directions were being emphasized as part of the overall treatment approach currently provided at IYC Kewanee.

RECOMMENDATIONS

Clinical staff should explore and identify appropriate evidence-based practices (EBPs) appropriate for youth in residential care and these EBPs should be included as a significant part of the treatment approach used at IYC Kewanee.

The Mentally Ill Substance Abuse programs for youth with co-occurring mental health and substance abuse issues should be expanded to provide these services for youth who meet criteria for placement in this program.

Staffing levels

ABTC's clinical staff includes three psychologists, 13 masters' level therapists, six bachelors' level therapists and two activity therapists. In addition, a psychiatrist is available for 12 hours a week. The major issue with staffing seems to be the limited access to a psychiatrist. Previously, a psychiatrist was available to the program for 40 hours a week. The more restricted number of hours currently available does not seem to provide adequate time given the number of youth in the program with mental health needs and those on psychotropic medications (it was reported that 98 percent of the youth in the mental health program are on some psychotropic medication). Additionally, there was a real shortage of counselors. Some were carrying caseloads of 1:36, double what the facility established as optimal. Shortages of mental health staff and Youth & Family Specialists result in almost no family therapy and little family contact or visitation.

RECOMMENDATIONS

Increase the number of mental health staff and Youth & Family Specialists. The number of psychiatric hours available to support the clinical program should also be increased to 40 hours weekly.

Training

One of the most frequently noted needs identified during the site visit was for training. The movement from the correctional system to a juvenile justice agency has not been accompanied by the training needed to support the transition to a juvenile rehabilitative approach. Training on adolescent development, adolescent mental health issues and trauma is insufficient. In addition, for training to be effective within the IYC Kewanee setting, it should extend not only to clinical but to custodial staff as well.

RECOMMENDATION
Training of all staff at IYC Kewanee in the program's new juvenile orientation, adolescent development, youth mental health disorders, trauma and other such issues should be significantly expanded and strengthened.

Philosophical Change
Raised throughout the various meetings held during the site visit were issues surrounding the shift from DOC to DJJ. While the structural change has occurred, a number of concerns and barriers associated with this move continue to exist. On the one hand, it was clear from the discussions that a shift from the more custodial approach used with adults within corrections to a more rehabilitative one reflecting the needs of youth has begun to occur. This change was reflected not only in discussions with administrators and staff members but also with the residents themselves. Several of the youth interviewed who had been in IYC Kewanee for a number of years reported sensing a clear shift within the facility. On the other hand, it was also clear that this shift is far from complete, as reflected in the differing philosophies, approaches to care for the youth and beliefs with regard to most effective methods for dealing with the residents. While some of this can be attributed to the mix of old and new staff within the facility, as described later, the lack of adequate training appears to also be a major contributing factor. Several staff members who had been with the facility for a period of time talked about the shift depriving them of some of their usual ways of dealing with youth without providing them with new tools and strategies for responding to youth.

RECOMMENDATION
Training of all staff at IYC Kewanee in the program's new juvenile orientation, adolescent development, youth mental health disorders, trauma and other such issues should be significantly expanded and strengthened.

Confinement/Restraint
The use of isolation, solitary confinement and restraints appear to continue to reflect a correctional approach. While overuse of these options is in general something to be avoided, the situation is even of greater concern for those youth who have a mental health problem. Under IYC Kewanee's policy, a youth can be held in solitary confinement for up to 30 days, although the acting superintendent is attempting to cap the use of such confinement to a maximum of three days (See Appendix G for PbS confinement time data).

RECOMMENDATION
Policies regarding isolation, seclusion and restraint should be reviewed in light of generally accepted standards for juveniles with a particular emphasis on juveniles with mental health issues.

Transitioning Youth
The Division of Mental Health (DMH) provides liaisons to assist IYC Kewanee and other DJJ facilities in discharge planning and re-entry. DMH liaisons serve 72 youth assigned to the Special Treatment Unit. Parole services at this time within Illinois remain under adult corrections. Parole staff working with juveniles released from IYC Kewanee do not appear to have received any special training regarding youth. This appears to be true even in Cook County where, because of the volume, specialized juvenile parole programs have been established.

RECOMMENDATION
Aftercare and Re-entry services provided by IYC Kewanee and DJJ should be enhanced in support of the work being done in this area by DMH.

Family
In general, the policies and practices in place at IYC Kewanee do not seem to encourage or support family contact and involvement with youth residing there. Many of the youth's families are located far distances from IYC Kewanee and they have difficulty visiting their sons. One youth interviewed during the site visit who has been at IYC Kewanee for over a year indicated that he has never had a visit from his family during the entire period.

RECOMMENDATION
Strategies for facilitating family contact with youth such as providing outreach and transportation, should be examined and implemented.

IYC HARRISBURG

Site visit overview

The IYC Harrisburg site visit was conducted on February 24, 2010. The IYC Harrisburg site visit team consisted of: Debra Ferguson from the Division of Mental Health of the Illinois Department of Human Services, Gene Griffin from Northwestern University and Ned Loughran of the Council of Juvenile Correctional Administrators.

The site visit began at approximately 9:00 a.m. and lasted until approximately 4:00 p.m. At the beginning of the site visit, the team met with the Facility Superintendent and members of his Administrative Team. Throughout the day, the team met with additional members of the facility staff including mental health staff, juvenile justice specialists and members of the union. Members of the team also met with youth incarcerated at IYC Harrisburg and reviewed a small sample of Master Files. The site visit team also toured the facility including visits to the Reception & Classification unit and the Maximum Security unit.

Facility Description

Opened: July 1983
Capacity: 276
Level: Multiple-Security Juvenile Male
Average Daily Population: 316
Average Age: 17[25]

IYC Harrisburg is one of three Reception & Classification (R&C) units within the DJJ system (IYC St. Charles and IYC Warrenville are the others). IYC Harrisburg and IYC St. Charles are male R&C facilities and IYC Warrenville is the female R&C facility. All youth committed to DJJ go through one of these three facilities in order to determine their security level and mental health needs. In addition to the R&C function, IYC Harrisburg is a multi-level security institution for youth committed to DJJ. Youth identified during the R&C process as having serious mental health needs are transferred to the Special Treatment Units at either IYC Kewanee or IYC St. Charles.

On the day of the site visit, the census at IYC Harrisburg was 269 youth. The facility has the capacity to house 496 youth (if double bunked) and has 276 single bunk rooms. On the day of the visit there were 29 youth at IYC Harrisburg past their Administrative Review Date (ARD), the date the youth is eligible to be presented to the parole board. One youth was there 1,000 days past his ARD date.

IYC Harrisburg currently operates 10 living units. There is one R&C unit (capacity 34), one maximum security unit (capacity 25) and eight general population units. Of the eight general population units (typically 32 youth per unit), two are substance abuse treatment units and one is a pre-release unit (capacity 28).

[25] http://www.DJJ.state.il.us/subsections/facilities/information.asp?instchoice= hrb

Youth Profile

IYC Harrisburg is an all male facility. According to the Institutional Monthly Youth Profile for IYC Harrisburg dated 5/31/2010 the population was 64 percent African-American, 33 percent Caucasian and two percent Hispanic. The average age was 17.1 years with 62 percent of the youth between the ages of 17 and 20 years old and 38 percent age 16 and younger. The majority of the youth have a high security classification level (64 percent) and 36 percent are rated at the medium security classification level.

Youth who are transferred to general population from the R&C process are rated as having few or no mental health needs. In fact, according to the Institutional Monthly Youth Profile for IYC Harrisburg, 42 percent of the youth were rated as having no mental health needs, 56 percent were rated as having minimum mental health needs and two percent were rated as having moderate mental health needs. Youth in general population are rated as having minimal mental health needs. Staff report that 80 percent of the youth there have been diagnosed with Conduct Disorder. IYC Harrisburg also has a high percentage of youth with substance use disorders and co-occurring disorders. Bipolar Disorder and Attention Deficit Hyperactivity Disorder are common diagnoses. They report "some" youth with PTSD or trauma-related disorders. At the time of the site visit, there were 50 youth on psychotropic medication.

Treatment Program

All behavioral health services offered at IYC Harrisburg are provided by contract employees. Wexford provides the mental health services (these employees are also in the American Federation of State, County and Municipal Employees (AFSCME), a labor union) and CiviGenics provides the substance abuse services (non-union). Wexford provides 115 service hours per week offered by a licensed clinical professional (either a licensed social worker or psychologist). There are also two full-time licensed clinical social workers. There rest of the Mental Health Staff is comprised of Licensed Social Workers (LSW) and Licensed Clinical Professional Counselors (LCPC). Two new positions have recently been added to the staffing ratios at IYC-Harrisburg. Two full time assessors will administer the JAIS, V DISC, VISA, and TCU. The ratio of mental health staff to youth is 1:35.

Most of the youth at IYC Harrisburg are rated as having Level 1 mental health needs. There are some youth with Level 2 mental health needs at IYC Harrisburg though this is rare. All youth with a mental health level above zero have a treatment plan. This plan can be altered or revised by the Youth and Family Specialist. Monthly staff meetings are held to review the treatment plans. There is a psychiatrist at the facility for 10 hours per week. Youth must be seen by a psychiatrist prior to being transferred to either of the Special Treatment Units at IYC St. Charles or IYC Kewanee.

A mental health therapist has one individual session with each youth assigned to his or her caseload every week. These sessions are necessarily brief and mainly focus on crisis intervention and problem-solving. Youth on Level 2 also receive group therapy once per week. Youth on Level 1 receive biweekly group therapy. Groups are offered in the areas of anger management, coping skills and problem-solving. Youth in maximum security have group once per week. Youth on the pre-release unit have

group daily. Youth report that there is more programming on the substance abuse units. They have daily groups including life skills groups.

FINDINGS

Reception and Classification

R&C has 34 beds and is typically at census. There are 10 single rooms that are used for youth committed for a sex offense. For those who require close observation there are two observation rooms. However, those deemed to require formal watch status are placed in confinement rooms. The complete R&C process takes three weeks though the staff believes that a two week process would be ideal. A mental health screening is administered within the first hour after a youth arrives at the facility. The screening consists of a Suicide Probability Scale, TCU substance abuse screen and a DJJ Intake Form. Based on the results of the screening, the mental health professional makes a recommendation regarding level of mental health treatment needs. A Level 0 indicates a youth with no mental health needs, Level 1 is mild mental health needs, Level 2 is moderate mental health needs and Level 3 represents serious mental health needs. A youth's assigned mental health level determines the intensity of services he receives. The recommended mental health level is reviewed by the psychiatrist and other mental health staff and a final determination is made.   While in R&C, each youth has one individual therapy session and one group therapy session each week. R&C does not have a licensed psychologist and lacks complete psychological assessment materials.

While in R&C, youth are fingerprinted by the Bureau of Identification.   Youth also receive a hearing and vision screening. A health care screen is also completed. They are seen by a physician within seven days and by a dentist within 10 days. Educational testing does not take place until the youth has been in general population for seven days. Youth are also evaluated for single or double bunking.   The Youth and Family Specialist makes the recommendation for the security level (low, medium, high, extreme) using a point system in the juvenile tracking system that takes into account factors like age, offense, previous criminal history and mental health needs. A computer-generated report is produced with a recommended security level, but allows for a staff override.   The security level classification is usually completed within the first week. Once the security level and mental health level are determined, a recommendation is made for the youth's DJJ facility placement.

IYC Harrisburg's R&C personnel completed a survey instrument that provides the basics of its screening and assessment procedures.   It indicates procedures, screening tools, forms, and assessment procedures that are similar in many respects to those reported by IYC St. Charles, but with some important exceptions.

First, IYC Harrisburg's survey responses do not indicate any use of follow-up assessment of youth who score high on the TCUDS-II at initial intake.   In addition, they do not indicate use of validated tools for individualized assessment of youth who may be identified as having mental health problems at the initial screening.   Second, IYC Harrisburg's survey response claimed that an "Initial Classification Instrument," the JTS, is used to assess youths' needs and level of risk of aggression. It is our understanding, though, that the JTS does not use validated instruments for those purposes.

RECOMMENDATIONS

R&C process needs to be revised to better identify youth's mental health and substance use needs. Based on the results of an initial behavioral health screening, youth should undergo a comprehensive assessment to identify needs, strengths and level of functional impairment. Results of these assessments should inform the treatment planning process and identify specific programmatic needs.

The practice of administering the SPS should be replaced with an alternative measure such as a standardized interview or a screening tool that has been validated for use with youth in juvenile justice settings.

Existing mental health services

Current mental health offerings at IYC Harrisburg are inadequate. The screening offered is not effective in identifying the specific behavioral health needs of the youth and the lack of a psychologist or adequate testing materials makes further assessment impossible. The staff seemed to minimize the impact of childhood trauma. Youth are essentially triaged into one of three treatment categories and what varies is the intensity of services, not the services offered. This lack of individualized treatment planning is a significant weakness that further impedes an already incomplete discharge process. The ratio of mental health staff to youth is unmanageable (1:35) and does not allow for anything more in depth that crisis intervention and weekly check-ins. The problem of insufficient mental health staff is further exacerbated by the fact that they are often detailed from their duties to perform administrative tasks (like facility audits). There is no clinical supervision or in-service training program. Though there are monthly staff meetings, there is no real interdisciplinary team approach to the youth. There is little use of de-escalation techniques to avoid crises before they occur. However, the school does use Positive Behavior Intervention and Supports (PBIS), an evidence-based program improving academic performance and behavior.

The Mental Health Staff designed and proposed a behavior management unit (termed a Youth Intervention Unit) that could be used as an alternative to maximum security. The unit would focus on mental health and behavior management issues and ideally reduce the need for confinement or maximum security. The Mental Health Staff report that the Youth Intervention Unit was not approved by Administration.

RECOMMENDATIONS

Increase programming throughout the facility. There is not sufficient therapeutic activity occurring and there is not enough variety in what is offered. Create individualized treatment plans that address specific areas of need and build upon identified youth strengths.

Review the Mental Health Staff's proposal for a Behavior Management Unit and consider piloting it for a 90 day time period. Collect data on how this pilot affects the use of confinement, restraints and the number of tickets written.

Staffing levels

IYC Harrisburg is critically understaffed in specific areas that impact its capacity to meet the behavioral health needs of youth. For example, the position of Assistant Superintendent for Programs has been vacant for 2.5 years. There is no Reception Unit Administrator and no psychologist in R&C. There is no licensed clinical psychologist at the facility at all, though the facility is engaged in active recruitment for one. There used to be six Leisure Time Activity Specialists at the facility and there is now only one. There is essentially no recreational programming for the youth. There are five Youth and Family Specialists (Counselors) at the facility with a staff to youth ratio of 1:52. The facility is simply not staffed at a level and with the appropriate types of personnel that would enable the proper identification and treatment of youth with behavioral health issues. The Juvenile Justice Staff are also rotated throughout the facility in a manner that does not allow for them to get to know the youth and establish rapport.

RECOMMENDATIONS

Address critical staffing shortages. The most critical of these are the Assistant Superintendent for Programs, a Licensed Clinical Psychologist for Reception & Classification, Reception Unit Administrator, and Leisure Time Activity Specialists. In addition, the caseloads maintained by the Mental Health Staff are unmanageable and are a barrier for meaningful treatment to occur. Similarly, the caseloads of the Youth and Family Specialists are equally high and do not allow them to perform the vital case management functions in a detailed and timely fashion. Youth and Family Specialist Supervisors are also required in Reception and in programming.

Training

Staff receive annual training (Cycle Training) in Policies and Procedures, Administrative Directives and Life Safety Issues. There is no additional training offered which is attributed to funding issues. All of the staff the site visit team met with cited the lack of training as a major issue. Of particular concern is the lack of training on mental health issues, adolescent development, brain development and trauma. This training is particularly necessary among those Juvenile Justice Staff who transitioned from DOC and spend the most time with the youth.

RECOMMENDATIONS

Develop a program of in-service training for staff. The Mental Health Staff is extremely dedicated and can offer training to Juvenile Justice Specialists, Youth and Family Specialists and other key staff.

Consider requesting mental health consultation and in-service training support from the Division of Mental Health and other child-serving agencies. For example, Clyde C. Choate Mental Health & Developmental Disabilities Center is nearby and could potentially provide consultation and training either in person or via videoconference.

At the time of the site visit, 68 percent of the youth populations at IYC Harrisburg were either African-American or Hispanic. Aggressive training efforts should be implemented to ensure cultural sensitivity and cultural competency in all services rendered to youth.

Philosophical Change
Staff describes the transition from the Department of Corrections (DOC) to DJJ as a superficial rather than substantive one. They report that because they have not had the training, staff or funding to implement a rehabilitative approach, that little has changed and in fact, some things have worsened. The staff report they were told there would be more programming and more incentives, though none of that has materialized. Staff also believe the deterrents removed in the transition were not replaced with incentives and interventions. As a result, staff feel ill-equipped to implement the new philosophy that many of them say they support. They observe that there are few programs, few incentives and no deterrents. Therefore, many believe that the facility still operates under a punishment, rather than a rehabilitative model. Staff write hundreds of tickets per day for a variety of infractions but this is ineffective and not taken seriously by the youth or Administration.

The transition has been hardest for the correctional officers (now called Juvenile Justice Specialists), many of whom saw the change in title and uniform as a loss of status and authority. The lack of training, for the Juvenile Justice Specialists in particular, contributes significantly to poor transition. The union feared that the transition was the first step toward privatization and this might have contributed to their ambivalence about the transition. Not surprisingly, the union does not believe that the transition has been successful.

RECOMMENDATIONS
Prioritize staff training in the skills needed to address the rehabilitative needs of youth. The most critical of these seem to be mental health issues, substance use disorders, childhood trauma, adolescent development, brain development, de-escalation techniques, behavior management and crisis intervention.

Confinement/Restraint
IYC Harrisburg has one confinement unit. On the day of the site visit, there were 13 youth on the unit. Youth can spend a maximum of 10 days on the confinement unit although there is an ongoing effort by administration to decrease the use of confinement (See Appendix G for PbS confinement time data). Youth can be in confinement for either behavioral problems (fighting) or because they require close observation (suicidal or self-injurious youth). While in confinement, youth are seen daily by both a Youth and Family Specialist a Mental Health Professional, and administrative staff. Youth in confinement are on 10 minute checks, 24/7. There is no programming or activities for youth in confinement. They are released from their rooms for a maximum of two hours a day to a cage on the confinement unit.

RECOMMENDATIONS
Discontinue the use of confinement for suicidal and self-injurious youth. Develop a protocol for intervention with such youth using established techniques including 1:1, special and close observation that are less punitive, more effective and provide a more rapid functional improvement.

Transitioning Youth

IYC Harrisburg has a pre-release unit consisting of 28 beds. The pre-release program is six weeks. Some of the most intense programming at the facility occurs on this unit. The Youth and Family Specialists make a recommendation for youth to go before the parole board. Discharge/transition process begins when the youth is approaching their ARD date rather than upon admission. There is no formal, structured discharge planning process that engages the interdisciplinary team, the youth and his family. As a result, the process is rather haphazard and fragmented.

The Mental Health Staff make recommendations for continued treatment however, staff are hampered by lack of services in the community. This may contribute to many of the youth returning to the facility on parole or technical violations. There is only one Field Service Representative for the entire facility who assists with transition planning for the youth (particularly the educational linkage). The Division of Mental Health supplies two Juvenile Justice Mental Health – Reentry (JJMH-R) Liaisons who screen and assess youth with mental illnesses transitioning from the facility and then link them with necessary services in their own communities. These JJMH-R liaisons begin working with youth who are referred to them approximately 60 days prior to release and attend the youth's parole board to present the treatment plan that has been developed. JJMH-R liaisons also provide ongoing monitoring and case management for the youth, post-release, for a period of six months. However, there are only two JJMH-R liaisons for all eight IYC facilities and they maintain a caseload of approximately 60 youth.

RECOMMENDATION

Transition/discharge planning should begin in R&C with progress documented in the monthly staff meetings and reported on in the quarterly reviews.

Family

When a youth first arrives at the facility, staff in R&C contacts the family to obtain the necessary consents for mental health, health and medication information; explain the visiting, writing & phone information; answer questions and discuss parole placement options. The youth is also allowed to talk with his family. However, there is little in the way of an effort to actively engage family members or facilitate their visitation and there is no family therapy. Youth are provided one 15-minute phone call home per month (if the family does not accept collect calls). Very few families visit (approximately 20 visits for the entire facility per weekend) and it does not appear that the facility actively promotes or enables this.

RECOMMENDATION

Efforts should be made to engage family members and make it easier for them to visit and maintain connections with the youth.

OTHER RECOMMENDATIONS

Maintain college courses offered through a contract with Southeastern Illinois Community College. IYC Harrisburg is the only DJJ facility that offers college courses. The contract with Southeastern Illinois Community College has been renewed for FY11.

IYC MURPHYSBORO

Site visit overview

On February 25, 2010 the site team visited IYC Murphysboro. The site visit team included the following individuals: Ned Loughran from the Council of Juvenile Correctional Administrators, Debra Ferguson from the Illinois Department of Human Services, and Gene Griffin from Northwestern University.

The team met with staff at the IYC Murphysboro site from approximately 9 a.m. - 3:30 p.m. The team held an initial discussion with DJJ's Behavioral Services Administrator, and IYC Murphysboro administrators, including the Acting Superintendent, Clinical Services Supervisor, and the School Principal. In addition, the team met with clinical and nursing staff, members of security, direct care staff, representatives from the union and youth residing in the facility. The team also toured the facility and reviewed a small number of youth files.

Facility Description

Opened: April 1997
Capacity: 156
Level: Medium/Minimum-Security Juvenile Male
Average Daily Population: 75
Average Age: 17[26]

IYC Murphysboro is a medium security facility for males. Facility capacity is 156 youth but on the day of the visit the census was 52. Youth stay, on average, for five months. The physical layout of IYC Murphysboro living units is dormitory style rather than individual rooms. There are currently 17 – 18 youth per dormitory though the capacity is 26. One former dorm space is now used for reward time.

Until about 18 months ago, the facility followed a strict boot camp model. The youth (referred to as "cadets") wear military fatigues, march and stand at attention. However, for the last year and a half, the facility has begun to discontinue the boot camp model though the replacement model remains unclear and undefined. As a result, staff describe the facility as having "an identity crisis," being in "a quagmire" and leaving the staff and youth "in limbo." Please refer to the letter from the Acting Superintendent of IYC Murphysboro to Director Friedenauer confirming the completed conversion of Murphysboro from a boot camp model to a treatment program (Appendix I). The Executive and Administrative Teams have been providing direction and leadership to implement current juvenile justice practices into the facility.

Youth Profile

According to the DJJ IYC Murphysboro profile on 5/31/2010, 54 percent of the youth were 16 years old or younger. Seventy-six percent of the youth were African American, 17 percent were Caucasian and seven percent were Hispanic. Most IYC

[26] http://www.idjj.state.il.us/subsections/facilities/information.asp?instchoice= mpb

Murphysboro youth were committed to DJJ based on non-violent, class one or two delinquency charges. No sex offenders or adult felons are admitted to IYC Murphysboro. Almost all of the youth were considered low run risk. An earlier report indicated that for two thirds of the IYC Murphysboro population this was their first commitment to DJJ.

The majority of youth at IYC Murphysboro have a substance use disorder but do not have major mental health needs. IYC Murphysboro staff explained that because youth are pre-screened at R&C centers no youth with serious mental health needs are admitted. In May 2010, 72 percent of the population was Mental Health Level 0 and 28 percent was Mental Health Level 1. The facility can admit youth with Mental Health Level 2 treatment needs if they are stable, but staff report that they have not had a Mental Health Level 2 in years. The facility does not admit youth with developmental disabilities.

An internal study indicated that about 50 percent of the IYC Murphysboro youth come from Cook, Lake or Will County. About two youth a month are transferred to IYC Harrisburg for acting out behaviors.

Treatment Program

The program model consists of three phases and youth are assigned to a dormitory based on their program phase. The three phases are: Orientation (on Unit 1), Substance Abuse Treatment (on Unit 2 or 3) and Discharge Planning (on Unit 4). Typically, a youth is on the orientation unit for one to two weeks and moves to unit four when the youth is within thirty days of his Administrative Review Date (ARD).

During Orientation, youth receive the Suicide Probability Scale, clinical interviews, a health screen and an education screen. While on Unit 1, youth are administered a pre-test on substance use education. On Unit 4, they are administered a post-test. Comparison of the pre-test and post-test data indicates that youth's knowledge about substance use increases over the course of the programming.

The Wells Center, a private, contractual group, provides substance abuse treatment. The Wells Center program uses evidence-based curriculums and youth receive drug education. Those youth who were assessed as having substance abuse treatment needs receive therapy as well. There is substance abuse programming seven days a week. Monday through Friday there is one hour of drug education and 1.5 hours of therapy. On weekends therapy is for two hours in addition to a group on substance abuse triggers and cravings. Unit 1 currently receives seven hours of substance abuse services per week; units 2 and 3 have 15 hours per week; unit 4 has five hours per week. Groups usually begin immediately after the six hour school day.

Substance abuse services are all provided in a group therapy format. There is no individual substance abuse treatment. All therapy groups use a standardized curriculum. Substance education group runs for 13 weeks then repeats. Youth can join anytime and continue to repeat the group as long as they are on the unit.

There is no regular, ongoing mental health treatment, though a psychologist reported doing some work with individual youth on the discharge unit. Very few youth are on psychotropic medication. At the time of the visit, there were four youth on medications, most for ADHD. One youth was on an antipsychotic for anger, according to the nurse. The use of anti-psychotics for behavioral control is considered "chemical restraint" and in children and adolescents in particular, is a practice that should be discontinued.

With respect to discharge, the substance abuse counselors make treatment recommendations and have youth complete a recovery plan. The counselor gives this information to the field services representative, who develops parole recommendations. The field services representative might make community contact to schedule appointments. A clinician conducts an anger management group for four weeks on the discharge unit. There is also some group discussion regarding life skills and self-esteem. In the past, there was a formal boot camp graduation ceremony, however, this was discontinued in the last year.

A clinician acknowledged that many youth have had adverse experiences and histories of trauma in their lives but did not view this as a significant factor or relate it to the youth's presentation or behaviors. The substance abuse counselors indicated they were aware of some of the current brain research and reported that their provider was offering trauma services at a women's prison but that there were no trauma services offered at IYC Murphysboro. The group therapists indicated that they did not "want to get too gut-wrenching" with the youth because the therapists do not have the opportunity to process with the youth individually.

FINDINGS

Existing mental health services

The Mental Health services are largely nonexistent at IYC Murphysboro. Clinical staff noted the need for standardized assessment tools across institutions. Little information is received from sources outside of DJJ. Social histories are poor and clinical records from schools or community providers are rarely available. Crisis intervention is used infrequently, as is psychotropic medication. There is no individual treatment.

Group treatment focuses on substance abuse with some youth receiving additional anger management treatment just prior to discharge. The substance abuse group treatments follow standardized curriculums, which is positive. Staff from the private provider appeared competent to deliver substance abuse services. However, the substance education groups are run by one counselor with the entire unit in the group, which does not allow for much participation and staff point out that the counselors spend most of the group session setting limits. Further, the same group formats repeat continually so that some youth go through parts of a group twice in a stay or upon recommitment. Youth report being bored by the same groups and requested other topics be covered.

Some clinical staff recognized the importance of trauma in the lives of the youth but acknowledged that the treatment programs do not address this. These clinicians correctly point out that uncovering psychotherapeutic approaches are contraindicated

given the lack of resources to supplement with individual treatment. Other clinical staff denied that a youth's past would have much impact on the youth's behavior, which is inconsistent with the research and current understanding of the prevalence and impact of trauma on justice-involved youth. This demonstrates the need for ongoing training of the department's staff.

Clinical staff also noted that current youth are not as high functioning as many of the youth in the past. Staff reported that the youth do not learn as quickly and do not benefit as much from cognitive/talking therapy. Staff also reported that youth have more learning disabilities and need to receive immediate reinforcements or consequences in order to learn. Line staff acknowledge that the youth might respond well to positive reinforcements but very few positive reinforcements are available for the staff to use. Thus, control is maintained more by punishments, time outs and the inconsistent application of rules. Similar to the other DJJ facilities, the Performance-based Standards reports indicate that the use of confinement has been reduced in this facility (See Appendix G).

Staff also pointed out that youth do not get adequate exercise or time outdoors. Youth move directly from a full school day to substance abuse groups on the units. Staff cited PbS standards requiring youth to receive 1 hour of large muscle activity a day during the week and 2 hours on weekends. However, staff acknowledged that youth do not get outside during the week based on the schedules and only rarely on weekends because of behavior problems. Youth may get inside gym time if they have enough points. The facility stopped using the obstacle course when the boot camp was eliminated.

There are no family services provided outside of weekly telephone calls that are initiated by the Youth and Family Specialists. There are no follow-up clinical assessments to measure whether a youth has actually improved as a result of any treatment offered.

In sum, though the need for mental health services at IYC Murphysboro is low, current assessment and treatment programming is inadequate.

RECOMMENDATIONS

The Orientation Unit should conduct standardized, functional assessments of both the needs and strengths of youth, including mental health, developmental disabilities, substance abuse, and trauma needs.

These same assessments should be repeated in order to determine whether youth are improving and as part of the Discharge planning.

Treatment should include individual as well as group modalities and should include appropriate evidence-based practices. Treatment should also include family therapy. Therapists should receive appropriate clinical supervision.

Youth should participate in outdoor recreational activities (weather permitting) daily after school prior to beginning therapy groups.

Staffing levels

In addition to the Wells Center Substance Abuse staff, IYC Murphysboro clinical staff include a part time psychiatrist (through another private provider- Health Professionals, Ltd.), a Clinical Services Supervisor, a Psychologist, a Juvenile Justice Youth and Family Supervisor and four Juvenile Justice Youth and Family Specialists. Additionally, the Leisure Time Activity Department has three staff members.

Employees did not express major concerns about current staffing levels. There is a staff vacancy issue. They would like 10 more staff members, including a Chief of Security, an Assistant Superintendent of Operations, one more mental health staff, four clerical staff and some educators. The bigger issue is that five specialists and a supervisor are currently out on injury.

RECOMMENDATIONS

Though not as major a problem as at some other youth centers, the department should address the staff vacancies. It should also review the history of injuries to see whether any training (such as de-escalation) or program changes might reduce the number of staff injuries. Further, if the youth center adds treatment programs, as recommended above, additional treatment staff will be required.

Training

As noted in the IYC Kewanee report, "movement from the correctional system to a juvenile justice agency has not been accompanied by the training needed to support the transition to a juvenile rehabilitative approach. Training on adolescent development, adolescent mental health issues and trauma is insufficient."

Staff reported being interested in more training, though union representatives emphasized that it should be offered based on seniority. Previously, training included behavior management training by a psychologist however this was recently discontinued. All staff have received training on de-escalation and on hostage negotiation.

There is some peer review for clinicians but no clinical supervision.

RECOMMENDATIONS

IYC Murphysboro should train all staff in the program and DJJ's new orientation, adolescent development, youth mental health disorders, trauma and how these relate to the substance abuse work already being done.

Policies and Directives

Two issues are relevant: the transition from DOC to DJJ and the move away from the boot camp model. Regarding the move from DOC to DJJ, some staff indicated that they were fearful in anticipation of change from DOC to DJJ but the change was unremarkable. They commented that changes were slow in coming. Some staff were more receptive to the philosophical changes than others. The biggest difference noted

is the change in the use of confinement, with heavy use seven years ago and much less use for shorter periods now.

Staff are much more concerned about the move away from being a boot camp without a clear designation of what the current program should be. This was true across job levels and was echoed by some of the youth. The label of "identity crisis" seems accurate. Rules are not clear and are not enforced consistently from shift to shift or even from staff to staff. It is not clear when a youth is to receive confinement or consequences or positive reinforcements. Staff state that they are open to change but they need to know what the change is. Some staff report that they have submitted suggestions to the administration regarding programming for youth, including getting youth out into the local community more, but these plans have either been rejected or were never responded to. Staff report feeling frustrated and some fear that the facility will be closed. All appear to be waiting for clarification and direction from DJJ administration.

RECOMMENDATIONS

IYC Murphysboro needs to determine the general rules of conduct, consequences for infractions and positive responses for the youth. All staff should receive training on appropriate interventions and be provided with appropriate resources to support such a behaviorally-based program approach.

Confinement/Restraint

PbS has resulted in the reduction of restraints and confinement. Staff report that three years ago there were 260 events. Now there are 20 in a year. There is almost no use of confinement (See Appendix G). Confinement has been established to last 59 minutes. A counselor and shift supervisor visit during this time. With permission, staff can go beyond 59 minutes. Fighting with another youth might get 2 -3 hours in confinement.

There are still crisis beds or medical beds. A youth deemed at risk for self-harm would be placed on high risk/crisis status. If a youth is on a high risk status he will be observed while in confinement every 10 minutes. Only a few youth have been on high risk/crisis status in the past 60 days.

Not all staff support the change from the strict boot camp to the more rehabilitative model. Some staff feel that the program no longer holds youth accountable for their negative behaviors and allows them to show off in front of their peers and disrespect staff. Staff still issue disciplinary reports, also referred to as tickets, for youth misbehavior, which could extend their parole hearing date. For example, recently, staff issued 525 tickets for 50 youth in one month. Youth report that some staff will still push them around or make them stand all day. Youth commented that some staff are still more punitive when administrators are not around and will push and shove youth when they are outside of camera range. Assaulting a staff will result in the youth being sent to a more secure facility.

Recommendations
Administration should review the use of tickets, the inconsistent use of discipline and possible abuse of discipline by staff.

Transitioning Youth
IYC Murphysboro is to be credited for having a discharge unit and for doing some preparation for the youth who are leaving. Substance abuse staff work with youth on a possible recovery plan, though there is no requirement that parole officers actually follow through on these plans. A liaison from the Southern Illinois University Credit Union speaks to the youth on the discharge unit regarding handling of money. In the past, there were also college classes, cooking and job skills classes. All of these were discontinued due to budget limitations.

Youth report that when they return to the community they do not get re-enrolled in school. Some finish their high school work while in IYC Murphysboro or obtain their GED but college classes are no longer available in the facility. When possible, some educators work with youth on applying to colleges and some local community colleges have accepted youth from IYC Murphysboro.

As was true at other facilities, there is almost a total lack of aftercare. The youth are supposed to have intensive parole services but do not get them. Parole officers used to visit the facility to meet the youth and then the family- but not anymore. There are few DJJ community alternatives that are currently funded. IYC Murphysboro staff recognize that youth need help to transition to parole but lament that there are no aftercare services which results in higher recidivism.

Recommendations
Vocational training should be restored and enhanced, including reconnecting with local colleges and volunteers.

Parole officers should visit with youth prior to discharge and participate in the discharge planning. Appropriate, available, affordable community services need to be identified with linkage provided by the parole officer after discharge. The same assessment tools should be used to continue to measure the youth's progress.

Family
Very few youth receive visitors. Staff feel it is too far for most families to travel. Youth do get mail and Youth and Family Specialists ensure each youth receives a weekly phone call. The Education Department has parent-teacher conferences by telephone if parents are unable to attend the conference personally. Families used to be invited to the boot camp graduation ceremonies but those ceremonies have discontinued with the elimination of the boot camp. However, families are invited to attend educational graduation ceremonies. Staff initiate contact with the youth's family for parole planning purposes. Some parents do attempt to make arrangements to attend their son's parole hearing before the PRB. The facility, like other facilities, has

one Youth and Family Specialist who is assigned Field Service Representative responsibilities.

RECOMMENDATION

Counselors should engage families as resources both during the initial orientation and during the discharge planning.

IYC JOLIET

Site visit overview

The IYC Joliet site visit was conducted on April 6, 2010 by Antoinette Kavanaugh from Northwestern University, Eric Trupin from the University of Washington and Ned Loughran from the Council of Juvenile Correctional Administrators.

Facility Description

Opened: April 1959
Capacity: 344
Level: Maximum-Security/Medium-Security Parole Readjustment Program Juvenile Male
Average Daily Population: 230
Average Age: 17[27]

IYC Joliet is an all male maximum security facility that also has a medium-security Parole Readjustment Program.

IYC Joliet has six housing units: one staff (Juvenile Justice Specialist) in the control area and one staff on each wing. Usually a housing unit has 2-3 wings with 12-20 youth per wing. According to a Juvenile Justice Specialist, room doors are not opened after 10 p.m. After midnight, there are no wing staff, instead, just one staff member in the control area and one movement officer for every two buildings. On a regular basis, the movement officer comes to the unit, goes into the control area and the officer who was in the control area checks the unit.

A new class of 18 Juvenile Justice Specialists who have been hired at Joliet will be graduating from the training academy on June 21. The new hires will remedy the staffing shortage described above. During the 10:00 p.m. – 6:00 a.m. shift, there will be one JJS in each building. The 6:00 A.M. – 2:00 P.M. shift will have four JJS in each unit. Each wing on all living units will have an assigned JJS.

Youth Profile

According to the Institutional Monthly Youth Profile for IYC Joliet dated 5/31/2010, the population was 81 percent African American, three percent white and 16 percent Hispanic. The average age of youth at IYC Joliet was 17.5 years with 76 percent of the youth between the ages of 17 and 20 years old and 24 percent age 16 or younger. As of 5/31/2010, 96 youth (40 percent) were on Mental Health Level 0 and 142 youth were on Level 1 (60 percent). In June, 95 youth were on Level 0, 138 were on Level 1 and four youth were on Level 2.

Treatment Program

IYC Joliet does not have a special mental health unit. The Wells Center operates a 30 bed substance abuse treatment program at IYC Joliet. The program utilizes the New

[27] http://www.idjj.state.il.us/subsections/facilities/information.asp?instchoice=joe

Directions Curriculum that provides cognitive behavioral treatment over a six-month period.[28]

FINDINGS

Existing mental health services and other programming

As mentioned above, there is no special mental health unit at Joliet. There is one Residential Treatment Unit for substance abuse treatment operated by the Wells Center.

IYC Joliet mental health staff members include a Treatment Unit Administrator, two licensed clinical psychologists and a social worker. Previously IYC Joliet had 11 mental health staff when they had a special mental health unit (this unit became IYC Kewanee). IYC Joliet also has a psychiatrist, employed by HPL, who works eight hours per week.

The two licensed psychologists are not state employees, therefore cannot be supervised by the Mental Health Administrator, a state employee; their supervisor is offsite. At times this is a problem, but the Mental Health Director gives indirect supervision and tries to coordinate things with their supervisor. The psychologists have worked in their current roles at Joliet for 10 years. The caseload is 15-20 youth per mental health worker. The MHP who does the intake assessment decides if the youth needs mental health services and reviews the file and previously assigned mental health level. If appropriate, the youth is assigned a mental health level and added to the mental health caseload.

Staff estimated that a quarter of the population is on the mental health caseload. The Treatment Unit Administrator repeatedly defined these youth as "severely behaviorally disordered," and indicated that this is not the same as having a mental health issue. It was reported that most (95 percent) of the youth on the mental health caseload receive once a week individual sessions and weekly group treatment.

The group treatment provided at IYC Joliet is not evidence-based. Each group, "has a core component of anger management and criminal thinking;" each psychologist runs two groups per week; and the group leader determines the focus of the group.

Volunteers from Guardian Angels Community Services, a community-based organization, run anger management groups one or two nights per week. The volunteers may or may not be mental health professionals. The curriculum used does not require degreed personnel to implement. Occasionally the DJJ Mental Health Administrator sits in on the group sessions.

IYC Joliet does not use any standardized method of assessing if the mental health or psychotropic interventions provided are effective.

School is scheduled from 8:30-3:30, but because of staffing issues (five teachers are out) not all youth who are eligible for school are scheduled to attend school. Those

[28] https://www.wellscenter.org/Patient-Programs/

youth who do not attend school due to these staffing issues are typically older, do not have their GEDs, have not graduated from high school, are going to be paroled soon or will be going to the adult system. Instead of attending school, these youth have independent studies. They get an education packet on Monday, on Wednesday they meet with a teacher and on Friday they turn the packet in. The teacher grades the packet and the process begins again.

Over one third of the youth have IEPs. IYC Joliet does not have enough special education teachers to meet the need. The school administrator is concerned that they are shaping IEPs to meet the situation (lack of staff and resources), instead of the needs of the youth. IYC Joliet has one school psychologist who is shared with IYC Chicago.

It is clear that the youth at IYC Joliet who have earned their GEDs have very little to do during the day. IYC Joliet operates small engine and automotive vocational programs, but it is not clear how many youth participate in these programs and they are not certificate programs.

Programming and activities for the youth are lacking – no arts, journalism or music. Staff indicated they would like more incentives for the youth and would like to have more Leisure Time Activity Specialists. A point system impacts privileges (whether or not a youth can attend movie night, what they can purchase at commissary assuming they have the money on the books, and how many phone calls they can have). If a youth has the required level but does not have money on the books, he can get a state loan television, radio or walkman.
There are some jobs at the facility that youth can have to earn money for commissary. The youth say that the staff show favoritism regarding who does a job. They explained a youth may be assigned to a job but staff may allow another youth to do the job and get the money.

RECOMMENDATIONS
Increase programming throughout the facility. There is not sufficient therapeutic activity occurring and there is not enough variety in what is offered. Create individualized treatment plans that address specific areas of need and build upon identified youth strengths.

IYC Joliet staff should conduct standardized assessments of both the needs and strengths of youth and repeat these assessments in order to determine whether or not the interventions being provided are working.

Include EBP (evidenced based programs) such as Aggression Replacement Training (ART).

Increase educational staff and vocational programming to give the youth opportunity for meaningful work once they return to the community. Provide educational and vocational opportunities for those youth who have obtained their GED or are awaiting a case in adult court.

Staffing

Inadequate staffing levels were a recurrent theme throughout the site visit. IYC Joliet relies heavily on volunteers and staff indicated that there are not enough volunteers. With the exception of the school, it is not clear how many vacancies IYC Joliet has in each department; even the superintendent indicated that the vacancy list is not meaningful. In part, this seems to be a byproduct of the separation from DOC. In a follow-up conversation with the superintendent, a list of vacancies of authorized positions was requested. A list was received that identified the following vacancies:

- Assistant Superintendent for Operations
- Administrative Assistant I
- Account Technician I
- Corrections Supply Supervisor I
- Corrections Supply Supervisor II
- Carpenter
- Painter
- Stationary Fireman
- Corrections Food Service Supervisor I/II (2)
- Office Associate (3)
- JJ Youth & Family Supervisor
- JJ Youth & Family Specialist (5)
- Social Worker II
- Corrections Leisure Activity Specialist I/II
- Dental Assistant
- Chaplain II
- JJ Specialists/Intern (-25)
- JJ Supervisor (5)

The lack of clerical workers for the different departments (educational, mental health and JJYFS) was mentioned.

Decreases in YFS staff has contributed to an increase in caseload, which subsequently results in less face to face contact with juveniles and more paperwork. The team was told that the average caseload has been 62-66 for the past three years and prior to 2004 it was 28-37.

When caseloads were lower, contact with youth was weekly. Staff reported that contact with youth is now "every other week at the most." A YFS indicated that seeing a youth in line and saying hello, which she called a "walk by," counts as contact. The YFS said administration has instructed them to "be creative" with what constitutes a contact.

YFS staff members complete counseling summaries and other paperwork by hand. This is untimely and inefficient.

Lack of computer infrastructure is another problem that affects staff at IYC Joliet. Neither the staff nor the youth have reliable access to the internet. The administration has limited access to the internet. Staff and administration indicated that they look things up at home; print them out and make copies as needed at work.

Coordination between school and mental health staff is limited and communication between Juvenile Justice Specialists (security staff) on a unit and staff (mental health, education or YFS) is inconsistent, verbal, and appears to be based on relationships.

Union issues do not appear as problematic at IYC Joliet as they are at other facilities. However, union staff said they do not feel like they have a seat at the table when changes are being considered and policy developed.

IYC Joliet, like all DJJ facilities, participates in the Council of Juvenile Correctional Administrators' Performance-based Standards (PbS) initiative. Early on, staff struggled with implementation of PbS. Response rates for the staff climate surveys were too low to identify trends and patterns in the data. According to the superintendent, the most recent data collection showed significant improvements in response and completion rates for the staff climate surveys.

RECOMMENDATIONS
Address critical staffing shortages. Fill key vacancies including the Assistant Superintendent for Operations position. The caseloads of YFS staff and mental health staff are unmanageable and do not allow for meaningful treatment or provision of vital case management functions in a detailed or timely manner.

Address lack of computer infrastructure.

Ensure communication and coordination among staff members increases when vacancies are addressed.

Training
As mentioned above, the need for training about adolescent development and appropriate intervention with juveniles was brought up throughout the site visit to IYC Joliet. Staff acknowledged that the new class of JJS that came into the facility as part of the transition from DOC received such training. The veteran staff have not received the extensive training. In the Cycle Training, the Mental Health Administrator has included a module on adolescent growth and development but not the full 18 hours that the new juvenile justice specialists receive in the academy.

The crisis team members (Juvenile Justice Supervisors and health care staff) receive quarterly training in areas such as suicide prevention, signs of depression and bi-polar disorder. There is also a special training for health care and clinical staff involved in the intake process.

The YFS supervisor explained that YFS are/should be caseworkers; "they want us to be the counselors, but we haven't been trained on how to be counselors."

RECOMMENDATION
Prioritize staff training for all staff, including those who have been there since DOC, in the skills needed to address the rehabilitative needs of youth.

Policies and Directives
A recurrent theme throughout the site visit was the need for education about adolescent development and appropriate intervention with juveniles in order to shift from the philosophy of DOC to the youth-focused mission of DJJ. One Juvenile Justice and Youth Specialist said, "People throw around terms like cognitive behavioral but I don't know what they are talking about."

Repeatedly people indicated that they liked the concept of DJJ and the individualization mentioned in the mission statement but the facility does not have the resources, staff or funds to make this a reality.

RECOMMENDATION
Training of all staff at Joliet in the agency's new juvenile orientation, adolescent development, appropriate intervention with juveniles and other such issues should be significantly expanded and strengthened.

Confinement
The confinement unit at IYC Joliet has two 16- bed wings. If a youth is there for a youth on youth fight, the mental health staff will see them as part of the confinement rounds. However, if the fight is youth on staff, the youth is seen immediately.

Youth in the confinement unit spend two hours out of the room per day and the average time in confinement for the past two months (April and May) is 2.8 days (See Appendix G for PbS data on confinement time).

IYC Joliet has four crisis/observation rooms in the confinement unit for youth with mental health needs who need 1:1 observing. These youth can be on any mental health level but are in need of crisis watch. The site visit team was told that there are special mattresses in observation and confinement unit, but furniture is the same as in the other units.

Staff indicated that they feel a sign of the change to DJJ is that writing tickets is discouraged. Use of other de-escalation techniques are to be employed first. They discussed how behavior that used to warrant a ticket disciplinary report and a set number of days in confinement, such as cursing at staff, no longer results in the same number of days in confinement; so "they [the youth] don't care and do what they want." However, youth privileges may be reduced due to their behavioral level, i.e., commissary purchases, movie night, etc.

RECOMMENDATIONS
Policies regarding confinement should be reviewed in light of generally accepted standards for juveniles. Staff need training on other behavior modification techniques so that they can use various methods of behavioral interventions rather than rely on confinement.

Transitioning Youth

There is no contact with parole agents while a youth is at Joliet; youth have no contact with parole agents until they are back in the community. A parole school is conducted for youth who have a date with the parole board coming up. Staff go over with the youth what will be expected of them when they return to the community. Groups focus on how to handle situations post release such as how to communicate with people in authority and how to obtain and keep a job.

For youth who are returning to the Chicago area, Chicago Public Schools (CPS) works with Alternative Learning Opportunities Programs (ALOPs) and Local Area Networks (LANs) to help link the youth to educational and social services when they return to the community. A full time teacher helps with this; this is another resource issue because it involves a lot of paperwork.

RECOMMENDATION

Transition/Discharge Planning should begin at intake with progress documented in the monthly staff meetings and reported on in the quarterly reviews.

Family

Staff indicated that lack of family services and family involvement is a problem at IYC Joliet. Identified obstacles include transportation, childcare and things occurring during the day.

YFS staff indicated that there is no policy regarding how often they are required to contact parents.

Opportunities for parent participation in education programming are parent-teacher (PT) conferences, graduation and IEPs. PT conferences started last year and IYC Joliet has had four of them. One parent of 198 attended the first one; of the other three, the greatest parent participation was 67 parents. Nineteen parents attended the most recent PT conference.

If a parent cannot attend an IEP, a state parent surrogate is utilized. The percent of parents who participate in IEPs in person or by phone is unknown.

Transportation and economics are issues that prevent parents from attending IEPs and conferences. Most youth housed at IYC Joliet are from Cook County. A casino bus leaves the south side of Chicago to take people to a Casino close to the facility. Staff indicated that they would like to figure out a way to use this existing bus service to bring parents to the facility or think about other creative ways of getting parents to the facility.

RECOMMENDATIONS

The level of family engagement and obstacles should be identified and efforts should be made to engage family members and make it easier for them to visit and maintain connections with the youth.

Family members should be engaged at all levels such as school, mental health services and aftercare. A family advisory board of youth who are no longer in the facility should be considered to assist with this issue.

Other issues

Cook County jail (adult) is under a consent decree and is trying to limit its census. Consequently, if a youth is paroled from DJJ then commits an offense that lands him in adult court, he is sent back to DJJ (for a parole violation) while his adult case is being heard. These youth are 17-20 years old, typically. The staff and administration at Joliet refer to these youth as "Consent decree youth." They are housed separately (in Dorm 8) from the other youth and have a separate movement and gym schedule to limit their interaction with the other youth. On the day of the site visit 63 youth were housed in Dorm 8. Staff and administration made it clear that they view these youth as a management issue.

The site visit team talked to Dorm 8 youth- they complained that they do not know their levels daily. They indicated that they were initially told they would have to be in Dorm 8 for three months while staff determined if they should be on another unit, but many of them stated that they have been there for a longer period. The youth described their daily schedule- if you do not have school you are in your room most of the day with an hour out. They indicated that they used to get two hours out of their room. The youth and staff indicated that the rooms in Dorm 8 do not have electrical sockets. This means the youth, who have reached the appropriate level, cannot have TVs in their rooms and only walkmans. Dorm 8 was originally constructed for youth now housed at Kewanee; rooms had no electrical outlets by design.

The youth talked about having no contact with the superintendent; the poor food in the facility and wanting better food in the visiting room. One indicated that the visiting room in St. Charles has better food. One youth indicated that he takes Trazadone (an antidepressant) "because it pretty much knocks me out."

Since the site visit, the "Consent Decree Youth" have been moved to Dorm 2, a dorm that has electrical outlets. Youth 18 and over are housed separately from younger "Consent Decree Youth." GED preparation has been offered to these youth. "Consent Decree Youth" under 18 are now housed in the general population and attend school with other youth. There is a separate special education class for "Consent Decree Youth" who have an IEP.

Dorm 8 now houses medium security youth who are participating in the parole readjustment program. They mix with the general population, attend school and participate in other activities on campus. They do not spend much of their waking hours on Dorm 8

Joliet also receives youth categorized as "juvenile felons" who have been convicted as adults. These youth reside at Joliet until their 21st birthday when they are transferred to the Department of Corrections. While at Joliet, they are in the general population.

Approximately half of the youth at Joliet are young adult offenders, either "Consent Decree Youth" or convicted juvenile felons awaiting transfer to DOC.

RECOMMENDATION

Housing "Consent Decree" youth (17 and older, charged as an adult and facing trial in adult court) is not consistent with DJJ's mission. DJJ should pursue a legislative remedy to resolve this situation.

IYC CHICAGO

Site visit overview

The IYC Chicago site visit was conducted on March 26, 2010 by Ned Loughran from the Council of Juvenile Correctional Administrators and Gene Griffin from Northwestern University.

Facility Description

Opened: July 1999
Capacity: 130
Level: Minimum-Security Juvenile Male
Average Daily Population: 104
Average Age: 16[29]

IYC Chicago is the pilot site for the two year, $400,000 grant from the MacArthur Foundations' Models for Change Initiative. DJJ has adapted a Core Treatment Model from Washington Juvenile Rehabilitation Administration that is being introduced into IYC Chicago and ultimately will be replicated in all DJJ facilities.

Youth Profile

According to the Institutional Monthly Youth Profile for IYC Chicago dated 5/31/2010, the population was 75 percent African American, 11 percent Caucasian and 14 percent Hispanic. The average age of youth at IYC Chicago was 16.0 years with 72 percent of the youth age 16 or younger and 28 percent between the ages of 17 and 20 years old. Thirty percent of the youth at IYC Chicago were classified as having no mental health needs (Level 0), 69 percent of the youth were classified as having minimum mental health needs (Level 1) and two percent were classified as having moderate mental health needs (Level 2).

Treatment Program

There are 130 beds at IYC Chicago. Two wings of General Population (50 and 38 beds); 20 substance abuse beds (not MISA); 22 beds for Half-Way Back wing (parolees that are struggling and are placed progressively for 14, 22 or 30 day periods). Forty hours of mental health services are provided weekly. If a youth begins to exhibit severe mental health symptoms the youth is referred to IYC St. Charles. Youth assigned to IYC Chicago have minimal mental health issues.

IYC Chicago also serves as a District 1 Writ Service. Youth who have court related matters are moved to IYC Chicago for transportation to the appointment. These youth wear orange t-shirts and stay at the facility for approximately one week.

---

[29] http://www.idjj.state.il.us/subsections/facilities/information.asp?instchoice= chi

Core Treatment Model

As mentioned above, DJJ selected IYC Chicago to pilot a Core Treatment Model based on the Integrated Treatment Model developed at the Washington State Juvenile Rehabilitation Administration (JRA). Components of the Core Treatment Model include, Dialectical Behavior Therapy (DBT), Aggression Replacement Training (ART), Illinois Behavior Motivational Systems (IBMS), and Cannabis Youth Treatment (CYT), also called Motivational Enhancement Therapy (MET)/Cognitive Behavioral Therapy (CBT). Staff will be trained in these skill-based approaches by a Ph.D. clinical psychologist who was the former director of Clinical Services at Washington State JRA. The long-term goal of the Core Treatment Model is to have a staff skilled in the use of evidence-based treatment approaches within the facility that will help reduce disciplinary infractions and promote positive behaviors and ultimately, reduce recidivism.

In addition to the cognitive behavior interventions in the treatment program, IYC Chicago will also develop Family Integrated Transitions (FIT), also a model pioneered at Washington State JRA. This program will provide systemic family treatment services to juveniles with co-occurring disorders. The services will begin while the youth is confined and continue after the youth returns to the community. FIT emphasizes family and community involvement.

Finally, as part of the Core Treatment Model, the *Illinois Second Chance Mentoring Initiative* proposes to create a comprehensive reentry infrastructure for juveniles targeting male youth who are in delinquent status and who are being released, or paroled from DJJ facilities in Cook, Lake and Will counties. A partnership between Youth Outreach Services (YOS), DJJ, and the Youth Network Council provides youth with a life plan that addresses interests and needs and establishes a team of mentors from their respective communities

DJJ plans to roll out these services to all facilities after implementation at IYC Chicago.

FINDINGS

Existing mental health services

Each youth entering IYC Chicago receives an intake screening within an hour of admission. They receive a mental health intake and are given the Suicide Probability Scale (SPS). The mental health intake is completed by a psychologist, if available, or else by a crisis team leader (with the psychologist on call).

Presently, Mental Health Professionals do a standardized interview, non MHP staff are required to use SPS. Youth fill out the SPS form so often that the staff question its utility. Staff indicated that they would prefer a standardized interview instead.

Psychologists at IYC Chicago do not perform assessment batteries; rather, a packet is received from IYC St. Charles.

The substance abuse unit (Wells Center) uses the TCU-II and the GAIN (both administered at IYC St. Charles), a file review and an interview to select youth for the substance abuse program.

Psychologists manage mental health services and provide group treatment including a social skills group, Conduct Change in Thinking group, Aggression Replacement Training groups, Washington Aggression Interruption Training (WAIT), Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), an evidence-informed group therapy for youth with exposure to trauma, Cannabis Youth Treatment, and Motivational Enhancement Therapy. SPARCS groups have been conducted by staff from the Department of Mental Health.

There is no mental health treatment for youth in the Half-way Back program. Crisis intervention services for youth in the Half-Way Back Program is always available.

IYC Chicago has the following mental health staff: two part-time (40 hours total weekly) psychologists and one psychiatrist (5 hours per week). The Wells Center operates the substance abuse treatment unit and has a clinical supervisor, two Masters level staff members and two externs from the Chicago School of Psychology.

The decision to place a youth in the Wells Center is made at IYC Chicago even though the screening is done at St. Charles. The Wells Center is a 120-day program. If a youth has a 90-day placement and is placed in the Wells Center for substance abuse treatment, the youth's stay will be extended so he can complete the program. IYC Chicago administration has an ongoing conversation with the Wells Center administration about developing a 90-day program to coincide with the 90-day LOS at the facility.

If a youth is not in the Wells Center program he does not receive substance abuse treatment. The JAIS will identify a high number of youth in IYC Chicago who need substance abuse treatment but do not receive it.

RECOMMENDATIONS

The SPS is overused and has questionable utility with this population. Instead of completing the SPS form every time a youth returns to the facility from a trip outside when an MHP is not available, staff should administer a standardized interview.

All youth who have been identified as in need of substance abuse treatment should receive such treatment.

The administration should continue to work with the Wells Center to develop a 90-day program to coincide with the 90-day LOS at the facility.

Staffing

At this time there is no Mental Health Administrator (MHA) position. There are two half time contractual positions (through HPL) for psychologists who share the duties of the MHA. These staff report to the superintendent. There is no clinical supervision.

IYC Chicago has vacancies for their Chief of Security, Assistant Superintendent – Director of Operations, Assistant Superintendent of Programs, Youth & Family Specialist Supervisor and one teacher position.

As mentioned above, IYC Chicago has externs from the Chicago School of Professional Psychology. These students are in the second year of their Masters program. They have 1-3 youth on their caseloads. The externs are supervised by someone in the substance abuse program because the HPL contract does not allow clinicians to supervise interns. The externs co-facilitate groups, are involved with youth in idle time activities, are able to observe psychologists, participate in crisis intervention, make rounds and conduct file reviews.

IYC Chicago has 130 volunteers and several volunteer programs, which virtually eliminates idle time in this facility.

There is good communication among the various departments at the facility, e.g. clinical, direct care, education, recreation, food services. The superintendent is accessible to the youth and staff and will always work with staff regarding a youth.

The staff to youth ratio is 1:20 on the wings; when possible, the superintendent sets up a 1:10 ratio.

RECOMMENDATION
Key vacancies listed above should be filled.

Training
All staff have received training in JAIS Strategy and Intervention, a training that identifies different interventions for different youth and the agency's Master Plan training.

Staff receive annual training (Cycle Training).

All staff will be trained in Aggression Replacement Training (ART) as soon as the request for approval of the ART trainer's contract has been approved.

Staff will receive training in the Core Treatment Model

RECOMMENDATIONS
All staff should receive training in ART.

All staff should receive training in the Core Treatment model.

Philosophical change
Regarding the correction/rehabilitation split that has been evident in other facilities since DJJ was broken away from adult corrections, training of staff at IYC Chicago has reduced the split between the two opposing philosophies. The transition from adult corrections to DJJ was relatively easy at IYC Chicago because the facility was much more rehabilitation-oriented before the split; there was less reliance on isolation here than in other facilities.

Staff reported that the transition from DOC to DJJ went well. There were few changes at IYC Chicago. Staff view the facility as very different from adult corrections, such as Stateville. At IYC Chicago staff work more with the youth and use relationships to achieve goals rather than punishments.

RECOMMENDATIONS

IYC Chicago administration should continue to support staff in adopting the Core Treatment Model through communication of goals and benefits of the model and training in implementation of the model.

Behavior Management

There is no use of lengthy confinement at IYC Chicago (See Appendix G). A youth may go for an hour or two. More likely, they will be given a cooling off period (15 minutes) where they will be removed but will remain with staff. A youth is never kept overnight on the confinement wing; a youth is brought back from confinement after the unit has shut down for the night.

Staff utilize conflict resolution to handle issues of conflict between residents as they arise. The psychologist and another staff member meet with the disputing youth together or one youth at a time depending on the conflict and circumstance. This is one of the many benefits of operating a small facility.

If a youth has a chronic behavior problem, he is put in the "Blue Jumpsuit Program." In this program, youth attend programs but lose free time and are not allowed to participate in the following: card playing, video games, team sports activity, but can participate in individual large muscle activities, i.e. walking, sit-ups, pushups, etc. The maximum time a youth can be on jumpsuit restriction is seven days and the average length of time is three days.

Transitioning Youth

Some youth participate in a nearby vocational education program in automotive repair, but staff want more vocational training and trade skills. There are some food service skills learned for youth who get jobs at IYC Chicago, but there is no "culinary arts" training. Youth can get a Food Service Safety and Sanitation License.

Staff want more vocational training and trade skills. Also, some youth are fathers and there is no program offered to teach parenting skills.

IYC Chicago has a baseball team supported by the Lost Boy's Foundation that allows for youth to play in the community.

"Reach" and "One Child One Family" are volunteer programs at IYC Chicago that can continue into the community. Volunteers from Northwestern School of Business teach a program on how to handle money.

Staff reported that there is no aftercare program, which results in recidivism. Youth reported that going on "house arrest" when they leave just sets them up to fail.

Staff proposed using day passes for youth with family and providing more family education. Staff reported that there is no structure to visitation and some parents could use training.

Family

IYC Chicago is in the process of revising the youth handbook to reflect changes in regulations, including more frequent visiting hours. The facility is trying to make visiting more family friendly; administration has added an information board to the visiting room with information posted for parents. Parents are invited to activities where youths' accomplishments are recognized, such as school graduation or completion of the substance abuse program. IYC Chicago is also considering starting family support groups.

COMMENTS AND RECOMMENDATIONS

IYC Chicago has an advantage because it is the pilot site for the 2-year, $400,000 Models for Change grant. The facility has made great progress in developing and implementing the core treatment program, and should continue its current course of developing a prototype to be replicated throughout the department.

NOTE

In the late afternoon of June 18, a major storm with high velocity winds destroyed a section of the IYC Chicago roof. DJJ followed its emergency evacuation plan by transporting residents to IYC St. Charles and Joliet. The state leases the building from a private owner. DJJ has been informed that the repairs could take up to six months before the building would be habitable again. In the interim, DJJ has temporarily discontinued the "Half-way Back" program, which was temporarily transferred to Joliet because the program was especially designed for youth from Metropolitan Chicago. Currently, the majority of displaced youth are being housed at IYC St. Charles and the remainder at IYC Murphysboro.

IYC WARRENVILLE

Site visit overview

The IYC Warrenville site visit was conducted on March 12, 2010. The site visit team included Tom Grisso from the University of Massachusetts Medical School, Debra Ferguson from the Illinois Department of Human Services and Gene Griffin from Northwestern University.

Facility Description

Opened: January 1973
Capacity: 86
Level: Multi-level-Security Juvenile Female
Average Daily Population: 78
Average Age: 16[30]

IYC Warrenville is one of three Reception & Classification (R&C) units within the DJJ system (IYC St. Charles and IYC Harrisburg are the others). IYC St. Charles and IYC Harrisburg are male R&C facilities and IYC Warrenville is the female R&C facility. All youth committed to DJJ go through one of these three facilities in order to determine their security level and mental health needs.

In addition to the R&C function, IYC Warrenville provides housing units for mental health and substance abuse and maximum security general population units for youth committed to DJJ. After completing the R&C process at Warrenville, youth may be sent to IYC Pere Marquette if they are from central and southern Illinois and have a Mental Health Level of 0, 1 or a stable 2.

Youth Profile

According to the Institutional Monthly Youth Profile for IYC Warrenville dated 5/31/2010, the population was 56 percent African American, 35 percent Caucasian and nine percent Hispanic. The average age of youth at IYC Warrenville was 16.9 years with 58 percent of the youth between the ages of 17 and 20 years old and 40 percent age 16 or younger. Four percent of the youth at IYC Warrenville were classified as having no mental health needs, 31 percent were classified as having minimum mental health needs and 65 percent were classified as having moderate mental health needs.

Treatment Program

IYC Warrenville has five housing units plus a confinement unit.

1. Intake unit;
2. The Focus Program for youth who are pregnant or have young children (girls can cross units to participate in this program);
3. The Wright One for youth with mental health needs;
4. The Wells Center for youth with substance abuse issues; and
5. An older youth unit.

[30] http://www.idjj.state.il.us/subsections/facilities/information.asp?instchoice=wrv

IYC Warrenville is using the "Girl Matters" curriculum from the National Council on Crime and Delinquency (NCCD), which is gender specific programming that focuses on identity, communications and emotions.

FINDINGS

Intake

Screening of various kinds is completed within the first hour after a youth enters the facility. Most of it is done by YFS personnel, although apparently a mental health professional performs one piece of the screening. The following are the primary screening activities during intake.

Medical risk screening

The intake YFS completes a checklist of medical issues (on a form called "Medical Screening") based on observation and interview. E.g., youth reports whether she has allergies, asthma, heart issues, head injuries, medications, etc.

Substance abuse screening

An MHP completes a checklist based on youth's answers to interview questions about drugs used, age started, and prior SA treatments. A Wells Center representative also gives the TCU Drug Screen-II (TCUDS-II), a brief, standardized screen that identifies whether youth provide information indicating that they might have no, mild, moderate or severe drug problems. Very clear criteria have been developed by the Wells Center for using answers on the TCUDS-II to determine level of severity.

Suicide risk screening

YFS administers the Suicide Probability Scale (SPS: Western Psychological Services). This is a 5-10 minute task during which the youth reads and answers (4-point response format) 36 questions contributing to four subscales: Hopelessness, Suicide Ideation, Negative Self-Evaluation, and Hostility. High scores indicate need to take initial suicide precautions per policy.

Mental health screening

Personnel engage in a non-standardized interview with youth and complete a checklist to show presence of certain outward manifestations of what might be emotional difficulties: e.g., "Appears confused," "Unable to express rational, coherent thoughts," etc. It was not clear who performs this screen. It was reported that it is performed by a mental health professional. However, the form indicates that if one or more items are checked, "contact on call MHP," which suggests that MHPs do not always do this screen (or the form's instructions are inaccurate/obsolete).

RECOMMENDATIONS

The purpose of screening in the first hour after admission is to determine whether youth have immediate (emergent) medical or mental health needs. This screening also identifies special considerations for the more extensive assessment that will follow. Best practices in modern juvenile justice programs include the use of standardized and validated screening tools whenever possible. In addition, forms for collecting interview

information should be written in a manner that minimizes differences across intake personnel in the types and quality of information they are collecting.

Medical risk screening
The medical screening form that was provided is the same form that is used at St. Charles and described in that review. The medical screening form provides no structure for the interviewer. Indeed, it does not even ask youth if they feel sick (e.g., cough, cold, feverish). It merely lists items (e.g., "Allergies," "Seizures") without indicating what it is that one wants to know about these items. For example, for "Medications" it is not clear what the interviewer is supposed to determine-- whether the youth has ever taken medications, has been taking them lately, or is taking them now—and for what purposes. It is not clear whether the "Head Injuries" item refers to current head injury or lifetime head injury. Lack of standardization can contribute to unreliability and missed information. It should be noted that all youth are seen by a nurse for a medical history and assessment on the day of admission and before being assigned to a housing unit.

Substance abuse screening
The initial checklist tool appears to be a form developed in Illinois DOC. It relies solely on three types of information: types of drugs used, earliest age used, and number and location of prior drug abuse treatments. Modern drug abuse screening tools rely on different observations than these for making decisions about emergent problems (e.g., possible detox issues) and decisions about the need for further drug abuse assessment. Moreover, the form offers no structured way to interview the youth about drug use; thus the information obtained is vague in its meaning. For example, one part says, "Check any drugs used by inmate," with a checklist for about 20 drugs. It is not clear whether this means "ever used" or "used recently."

The TCUDS-II has demonstrated some validity and utility in screening for drug problems in adult corrections. The criteria for assigning no, mild, moderate and severe categorization are clearly stated and do not require staff judgment. However, we could find no evidence that the instrument has been validated for use with juveniles in general or with adolescent girls in particular, either at the intake stage of juvenile corrections or any other setting. A number of standardized and validated, 5-20 minute, drug use screening tools exist for completing this task in an accurate and efficient manner at juvenile justice intake.

Suicide risk screening
The SPS was originally developed and validated primarily with adult samples and norms. A number of studies in the past 10 years have identified difficulties in the use of the SPS with adolescents. In one study, for example, the SPS identified only about one-half of youth who later engaged in self-harm behavior. Moreover, we have been able to locate no studies that have provided norms or validity indicators for the SPS with youth or with adolescent girls at intake in juvenile justice programs. In contrast, there are a number of standardized and validated suicide screening tools for use with youth in juvenile justice settings. Moreover, unlike the SPS, some of the validated tools are free; the SPS requires the purchase of a carbon-copy form for each administration.

Mental health screening
The mental health screening form simply indicates whether the YFS (or MHP) believes the youth is confused, crying, has fresh scars, is scared, is speaking strangely, expresses thoughts of harm (self or others), and sounds or acts angry. It is unclear why these particular items were selected, and why others were not (e.g., sad, withdrawn, hyperactive, etc.). The lack of standardized interview guides and of ways to identify degrees of severity of the above characteristics offers poor prospects for reliable identification of mental health risks and symptoms, and there is no evidence for this method's validity. In contrast, several standardized and validated tools for mental health screening, taking no more than 5-10 minutes and requiring no special clinical expertise, have been developed specifically for juvenile justice intake. They provide numeric scores with cut-offs to aid intake staff in making decisions about the need for immediate mental health consultation or specialized assessment.

Other issues
There appears to be little attention at intake regarding **potential for harm to others**. This is important in terms of resident and staff protection during the early days of admission when little is known about the youth. Several tools are available for assessing aggression risk in adolescents.

Extended reception – Assessments
The primary reception and classification procedures beyond the initial intake include two types of assessment for all youth and two types for those youth identified as having special needs during the intake screening.

Needs assessment for intervention planning
Apparently youth' psychosocial needs (beyond mental health and substance use needs) have been determined in the past by general interviews, but have not been systematically assessed. Warrenville recently implemented the Juvenile Assessment and Intervention System (JAIS). It has been administered for a few months, but has not yet been used for intervention planning. The facility expected that it would be fully implemented sometime within the year.

Educational assessment
All youth are assessed with the Terra Nova package, which places youth in grade levels according to various formal educational abilities.

Follow-up mental health assessment
Youth who screen at mental health severity Level 2 or higher are referred to psychologists/psychiatrists for a more comprehensive evaluation of their mental health needs. This evaluation is apparently individualized based on the clinician's initial impressions. A wide range of standardized psychological tools are available to the clinicians. Warrenville will be initiating use of the V-DISC (Voice-Diagnostic Interview Schedule for Children), and VISA (Voiced Index of Self Injurious Actions).

Follow-up drug use assessment

Youth scoring moderate or severe on the TCUDS-II at intake are referred to the Wells Center staff for more detailed substance use assessment. This includes the Global Appraisal of Individual Needs (GAIN).

RECOMMENDATIONS

Needs assessment

All juvenile corrections reception and classification programs should have a systematic, standardized method of determining youths' needs in several psychosocial domains. This is necessary for meaningful placement and intervention planning. Warrenville currently does not meet this objective, because it does not use a systematic tool for doing so. The GAIN has that capability, but it is used only with youth who require drug use assessment. The JAIS has that potential as well, but it is currently being used only experimentally, not as a formal part of intervention planning.

The JAIS' potential rests with its intention to match youths' needs with four specific intervention strategies/programs. An initiative to use the JAIS in this way would require two things. First, IYC Warrenville and IYC Pere Marquette would need to convert to intervention units that parallel the four intervention strategies that the JAIS identifies. Second, evidence would need to be collected to support the validity of the presumptions underlying the JAIS—that is, that matching youth to the four intervention strategies produces positive outcomes. In the absence of these conditions, the JAIS might still have a general positive value in learning about the individualized needs of youth so that they could be used in intervention planning, even without converting the system to these four intervention strategies. However, many other needs assessment tools developed for juvenile justice programs would also satisfy this objective, some of which have been validated in a manner that the JAIS has not yet achieved.

Educational assessment

The present consultants are not expert in educational assessment, but the Terra Nova assessment program is used widely in juvenile justice and presumably satisfies their need for educational placement of youth while in juvenile justice custody.

Follow-up mental health assessment

This review did not include a detailed examination of the evaluations performed by psychological and psychiatric professionals to whom youth are referred for further mental health assessment. In general, however, the assessment instruments used by Warrenville psychological and psychiatric consultants appear to be adequate. The tools that they use are, by and large, well validated and widely used in juvenile justice and mental health services. It appears that the mental health professionals employ the tools selectively, based on youths' individual situations, rather than simply administering a standard battery of tests without consideration for their actual need. We have no data, however, on the quality of their evaluations.

In exploring the V-DISC, Warrenville has had some concern that it requires online administration (since girls are not allowed to operate a terminal that is online with external networks). This issue can probably be resolved. However, it is important to recognize that the V-DISC is not a substitute for clinical diagnostic expertise. It will be

of value only if the psychologists or psychiatrists who perform Warrenville's follow-up mental health assessments find it to be of value and use it together with their own diagnostic information about youth.

Follow-up drug use assessment

The Wells Center performs some range of methods when youth are referred for drug abuse assessment. It was noted that they use the GAIN, which is among the better validated tools for assessing drug problems in youth.

Existing mental health services

There was a significant discrepancy in the reports of how long the R&C process takes to complete. Youth reported it usually takes between 2.5 and three weeks while staff reported it was completed within 10 days. In the future the JAIS will be used to inform what programming each girl receives. Each youth has a number of plans (IEP, JAIS, MTP) without being integrated into a single, overarching, coordinated treatment plan. Weekly clinical supervision is provided to all clinical staff by an on-site psychologist. A total of 14 different groups are offered to youth at Warrenville, including Seeking Safety, Victory Program and substance abuse groups. The SPARCS Program (an evidence-informed practice to treat youth with histories of trauma) is organized and provided by staff from the Division of Mental Health, Illinois Department of Human Services.

Although treatment groups are mixed across cottages, the cottage meetings are not mixed. No MISA program exists at Warrenville. When a youth is received at the facility and has been identified with both serious mental health issues and substance abuse issues, treatment recommendations would first address the mental health concerns. Once these have been stabilized, a youth could be referred to the substance abuse program.

Recommendations

Treatment planning is neither integrated nor individualized. In addition, the plan to base the provision of mental health services on a measure that is not a mental health assessment (the JAIS) is fundamentally flawed, particularly in light of the number of well-researched, empirically validated instruments available for this purpose.

Staffing levels

Facility administration no longer sees IYC Warrenville as understaffed (they were previously). The lack of a Treatment Unit Administrator and full-time Clinical Psychologist are considered critical vacancies. This is particularly the case as DJJ moves toward implementing a core treatment model and seeks to expand the use of the JAIS.

RECOMMENDATIONS

The Treatment Unit Administrator and Clinical Psychologist positions need to be filled immediately. The lack of strong clinical leadership onsite and available to staff is a significant problem as this agency transitions to a more rehabilitative model.

Training

Clinical staff have been trained on the JAIS and Girls Matter (a gender specific training protocol offered by the developers of the JAIS). Staff also receive annual Cycle Training and training on the DJJ Master Plan. SPARCS training, which addresses trauma, has been provided to approximately 50% of the staff as a part of their annual cycle training. Continued SPARCS training will be offered.

RECOMMENDATIONS

Critical gaps in training should be addressed. Chief among these are mental health issues, substance use disorders, childhood trauma, adolescent development, brain development, de-escalation techniques, behavior management and crisis intervention.

Philosophical Change

Staff report that the change from DOC to a rehabilitative treatment model within DJJ has meant a change in job title but little else has changed. Staff also reported that they feel they have less authority than they did before the transition. They believe that no real programming exists at the facility and that the transition resulted in a loss of resources. The youth were described as having more freedoms and fewer consequences. They also report that staff assaults have increased. Whether or not the statistics support this report, the staff perception that assaults have increased is an important one.

RECOMMENDATIONS

While staff recognize that their mission has changed, they do not feel they have either the training or resources to fulfill the new mission. Training on the behavioral health needs of justice-involved youth is critical in helping staff shift to a more rehabilitative model.

Confinement

Since the transition from DOC, use of confinement has been significantly reduced, but confinement is still used for brief periods; they use mediation, peer conflict resolution; and role-playing (See Appendix G for PbS data on confinement time). During interviews with youth, it was confirmed that girls can get two days in confinement for assaulting a staff member.

RECOMMENDATIONS
While staff has made strides in reducing the use of confinement, it could be further reduced through staff training particularly in the areas of de-escalation and crisis intervention. It would also be helpful for staff to see the reduction in the use of confinement as part of the agency's shift to a more rehabilitative model. Without this important context, staff are likely to view it negatively rather than as an important transformational step for the youth and the facility.

Transitioning Youth
Staff cited the lack of funding for Aftercare services as one of the key weaknesses of DJJ. There are no parole agents in the field and there is no continuity from when youth are in custody to when they are on post-institutional supervision. Staff did indicate that the youth going on community passes was a positive and felt it did help them reintegrate into the community.

RECOMMENDATIONS
Re-entry planning should begin at Intake with monthly progress documented in the treatment plan. The mentoring program was seen as a positive by both staff and youth and a method to continue this (or establish something similar) post-release should be explored.

Increase educational staff and vocational programming to give the youth opportunity for meaningful work once they return to the community. Provide educational and vocational opportunities for those youth who have obtained their GED or are awaiting a case in adult court. Resources will need to be allocated to make post-high school courses and improved technology available to youth.

Family
Most youth do not get visits from families. Staff reported that only a few families come regularly. Family visiting is limited due to travel and resource limitations. Family therapy is very rare. Staff want more family involvement or mentors for youth. It was reported that over 100 adult mentors come to Warrenville but those relationships end when the youth leave.

RECOMMENDATIONS
Increase efforts to actively engage family members in both the treatment and re-entry process. There was little evidence that family engagement was seen as a priority and changing the YFS when the youth changes cottages does not support this process.

IYC PERE MARQUETTE

Site visit overview

The IYC Pere Marquette site visit was conducted on February 26, 2010 by Ned Loughran from CJCA and Gene Griffin from Northwestern University.

Facility Description

Opened: March 1963
Capacity: 20
Level: Minimum-Security Juvenile Female
Average Daily Population: 21
Average Age: 16[31]

IYC- Pere Marquette is a level five, minimum-security female facility with an open campus.

Youth Profile

According to the Institutional Monthly Youth Profile for IYC Pere Marquette dated 5/31/2010, the population was 70 percent Caucasian, 25 percent African American and five percent Hispanic. The average age of youth at IYC Pere Marquette was 16.5 years with 45 percent of the youth between the ages of 17 and 20 years old and 55 percent age 16 or younger. Forty-five percent of the youth at IYC Pere Marquette were classified as having minimum mental health needs (Level 1) and 55 percent were classified as having moderate mental health needs (Level 2).

Treatment Program

IYC Pere Marquette is the first juvenile facility totally dedicated to a modified therapeutic community treatment model, with a focus on regionalizing admissions based on commitment county. IYC Pere Marquette does not house any special offender population. Youth benefit from more intense intervention and treatment-oriented programming.

Levels:
C: Lowest level; no extra privileges
B: Middle level; extra phone calls, toiletry items, can purchase items in the commissary; all youth start at level B;
A: includes all privileges plus trips, parties, occasional food brought in, manicures;
Gold: Highest level; youth get a bedding set, a single room, maybe even a big bed and a visit to a beauty shop.

[31] http://www.idjj.state.il.us/subsections/facilities/information.asp?instchoice= per

FINDINGS

Existing mental health services

IYC Pere Marquette accepts youth with Mental Health Levels 0,1 and 2. Staff indicated that they believe 80 percent of the youth at Pere Marquette have a sexual abuse history.

The facility screens all youth within the first hour of arrival to IYC Pere Marquette. A psychological screening, the Suicide Probability Scale, the Mini-Mental Status Exam (MMSE) and the MAYSI-II are administered. Within seven calendar days a complete mental health assessment is conducted that incorporates a self-report, a strengths report, the Seeking Safety questionnaire and other information from the youth's master and medical files. This information is used in conjunction with JAIS to develop a mental health treatment plan.

Mental health staff include one psychologist, three Juvenile Justice Youth and Family Specialists (YFS), two contractual MHP (CiviGenics) and two contractual substance abuse counselors (CiviGenics). Additionally a psychiatrist is on site one time per month for eight hours and the Education Department has either a psychologist or a social worker on staff.

The psychologist submits a Clinical Services Request for all youth referred to the psychiatrist. The psychiatrist comes monthly. Currently there are 16-20 youth on psychotropic medications.

Mental health staff see all youth individually once a week. In fact, youth get four individual sessions per week: one session with a mental health staff member, a second session with another mental health staff member, a session with a substance abuse counselor and a session with a Youth Family Specialist (YFS). Mental health staff focus on a diagnosis and set monthly goals; sessions are 30-45 minutes. Substance abuse staff set goals, focus on behaviors and criminality; sessions are 15-30 minutes. Youth receive a minimum of 15 hours of therapy per week, plus other staff contact and meetings.

In addition to individual sessions, youth participate in 10-12 groups per week. Girls enter into agreements to foster safety and maintain confidentiality within groups. Groups offered at Pere Marquette include: Aggression Replacement Training; Seeking Safety; Coping; Self Empowerment Leads to a Better Future (S.E.L.F.); Positively Empowering Affirmative Change through Experience (P.E.A.C.E.); Holistic Empowerment to Appreciating Life and Love (H.E.A.L.); Healthy Living; Grief; and several additional groups through the Straight Ahead Program provided by CiviGenics. The Straight Ahead Program is a gender-responsive, recovery-based treatment approach to substance abuse and crime.[32]

CiviGenics conducts some pre/post behavioral assessments (Coping Behavioral Index), but DJJ does not receive these data. CiviGenics staff reported that it shows the youth gain in self-regulation and resourcing skills.

[32] Department of Juvenile Justice (n.d.) *IYC Pere Marquette CiviGenics Straight Ahead Program.*

For youth in substance abuse treatment, there is a daily morning meeting and a daily evening meeting plus a weekly community meeting. At the morning meeting they use peer facilitation, review the plan for the day and set individual goals for the day. The idea is to set a positive attitude and energize the youth. The peer-led evening meeting reviews the schedule for the next day and reviews the individual goals that were set in the morning. At the community meeting all staff and youth participate, including teachers, dietary, security, etc. They review outings, acknowledge accomplishments and give staff feedback.

IYC Pere Marquette is in the process of adding a Dialectical Behavior Therapy (DBT) team. The psychologist and other staff have received training in DBT. The facility is also trying to develop an integrated treatment plan for youth. Currently each youth has 4-5 plans; staff want an integrated treatment plan but say that each group cites HIPAA as reason for not integrating. Presently, DJJ's Chief Legal Counsel is writing policy to integrate all disciplines to form one individualized treatment plan.

The treatment team (mental health staff, youth & family specialists, and substance abuse staff from CiviGenics) meets weekly to review treatment plans. There is a monthly staffing meeting (teachers, mental health staff, security staff, CiviGenics, line staff) to review the youth's monthly progress and establish new goals.

RECOMMENDATIONS

The number of psychiatric hours available to support the clinical program should be increased.

Develop an agreement and mechanism for data-sharing between CiviGenics and DJJ.

Staffing

Four new Juvenile Justice Specialists were recently hired and security feels adequately staffed now that the new hires have arrived. There are two supervisors and seven line staff daily, which includes transport for all appointments.

Security staff stated that the greatest need is for an engineer. This position has been vacant for one year and there is no one to do daily upkeep and repairs; it falls on security staff to contract with someone when large repair needs arise.

The union is content with the relationship at IYC Pere Marquette. They feel they have input and are listened to; if they can convince the administration that something they are proposing will help the youth, the administration will usually let them make the change.

A specific staffing issue concerns the predominance of male staff at this all female facility. The superintendent said she requested that all new hires be female; she was glad that two of the four new staff are female.

Male staff must observe the females as they are in the bathroom and showers. The unit uses curtains that do not reach the floor, so that calves and ankles are visible. The lower section of the curtain is clear plastic allowing for viewing the calves to the knee. The curtain then covers the rest of the body but has clear plastic at the top section. Male staff look in mirrors on the ceiling rather than stare directly at the youth.

The facility had to dismiss three male staff in the last five years due to sexual abuse allegations.

RECOMMENDATIONS

Fill vacancies identified above and ensure all staff are adequately trained in appropriate staff/youth relationships.

Estimate the number of female staff needed to end male staff supervision in bathrooms and showers.

Training

Staff receive two days of training per year that includes a half day of training from the facility's psychologist.

At the time of the initial change from being a male facility to a female facility in 2004, staff received two weeks of training from Warrenville staff and learned how females think differently than males; females have a different abuse background; and females are more able to talk and more receptive to change than males. DJJ has provided all staff with Master Plan training, JAIS training and Girl Matters training to build a gender-responsive culture and environment. YDT training will also be implemented.

Some staff have had difficulty with the transition to a treatment model and need their role clarified regarding how to respond in specific situations.

RECOMMENDATIONS

Staff should continue to receive training to allow them to address and respond to the rehabilitative needs of youth.

Philosophical Change

Since the shift from DOC to DJJ in 2006, the facility has moved from a punitive culture to a recovery/treatment culture.

IYC Pere Marquette no longer uses confinement; confinement rooms were closed 1.5 years ago. The old confinement area has been converted to a weekend retreat area for girls who have achieved and remained on A level for four weeks.

A union staff person reported that most staff – approximately 80 percent – support the therapeutic community approach, but a few staff feel the confinement area should have been retained and some staff are not sure of their role in the therapeutic community.

RECOMMENDATIONS
Review the role of staff in the therapeutic community as part of ongoing staff training.

Confinement/restraint
As mentioned above, IYC Pere Marquette no longer uses confinement; confinement rooms were closed 1.5 years ago (See Appendix G for PbS confinement time data). Now, instead of confinement, youth are placed in their rooms to fill out a Self Improvement Inventory packet. The youth must then process the write up and get sign off from five staff members before returning to regular schedule, free time and getting property returned.

Security staff commented that it was essential to replace confinement with something. Security staff were skeptical initially, but have come around. Staff commented that it is harder to do self-examination than it is to put in time in confinement.

Youth are no longer transported in restraints and security staff are very supportive of this change.

RECOMMENDATIONS
Continue current practice of using the Self Improvement Inventory in place of confinement.

Transitioning Youth
Reentry is planned by field services and reentry staff. Reentry plans include a discharge referral to community agencies. A CiviGenics staff member follows up with youth a week after discharge and monthly after that.

Youth have a "transition party" when they are leaving where they can address the staff and youth and receive support. Youth used to meet with parole agents before leaving. These meetings no longer occur because parole is a shared service with DOC; parole agents and staff regret this change.

Staff help youth to get on Social Security and work with youth on independent living skills. There are some groups that address how to get along with parents and how to be a self-advocate back in the community, but staff indicated that they feel a need for more life skills training, such as how to handle money and budgets, job applications and job interviews. Staff also expressed the need for college courses/credit for youth who have already received a high school diploma. One teacher said it is his goal to make sure that all youth at least finish eighth grade.

RECOMMENDATIONS
Parole officers should visit with youth prior to discharge and participate in a formal, structured discharge planning process that engages the treatment teams at facilities, youth and families.

Expand educational programming and vocational training for youth who have high school diplomas/GEDs.

Family

Family contacts are few and infrequent. Approximately four families are visiting girls regularly. Other families will visit occasionally. Distance is not the main issue; it is the relationships.

The facility's psychologist works with families that visit, but does not conduct family therapy.

Recommendations

Efforts should be made to engage family members and make it easier for them to visit and maintain connections with the youth.

V. Reintegration of Institutionalized Youth to the Community

Interviews were conducted with the Administrator of Parole Adjustment Programs, parole supervisors, parole agents, Placement Resource Unit managers, and community-based program directors

Reintegration is a shared service with the Department of Corrections (DOC). The Governor's Transition Team had recommended that a juvenile parole/aftercare function be established within defined regional boundaries of DJJ with juvenile only caseloads. This recommendation was not heeded. Consequently, DOC Parole Services agents provide parole/aftercare supervision for youth who are released from DJJ institutions. Parole agents assigned to district offices throughout the state carry dual caseloads of 105-115 parolees. The juvenile portion of the caseload varies from district to district. Some parole agents carry caseloads of 13-15 juveniles, others 5-6, and a few supervise only 1-2 youth. The District I Juvenile Parole Office (Cook County) is the only DOC parole office that has juvenile offender only caseloads. Approximately 800 juveniles are under parole supervision in District 1. The parole supervisor for District 1 carries a caseload of 65 youth, as well as supervises eight parole agents who average 85 youth each on their caseloads.

Procedures for Parole Involvement with DJJ Youth:

- Youth in the IYC do not have a parole agent assigned to them while they are in the institution;
- Consequence: no one from the community is working with the youth or his/her family to prepare each for reintegration to the family and community;
- Parole agent does investigate a placement prior to the youth's departure from a facility. Potential placements include:
    - Home
    - Foster care
    - Residential Treatment Center
    - In-patient treatment
    - Placement with legal guardian (other than parent);
- Parole agent conducts the first appointment (a visit to the youth's home with family present) with his/her new parolee within 72-hours of his/her release from a facility;
- Parole agent makes unannounced visits to the parolee's home once per month
- If youth is experiencing problems in adjustment to home/community, the parole agent will see the youth more frequently;
- Parole agent will be present for a school staffing if the youth is returning to school (meeting with teachers and counselors).

Issues faced by Parole Agents:

- Parole agents estimate 15 percent to 50 percent of parolees have mental health issues;

- Parole agent works with the Division of Mental Health liaison who will try to set up mental health services in the community for a youth;
- Parole agent can also refer youth to out-patient mental health service if such service is available in the district, e.g., in Rockford, parole agents refer youth to the Mildred Berry Center;
- Because there is a dearth of mental health services in the rural districts, parole agents observe that youth with mental health treatment needs are revoked more readily than in districts having greater access to mental health services;
- Even in districts where mental health services are available, family oftentimes doesn't want to keep the youth in the home because s/he is not cooperating with the placement;
- Parole agents cite high caseloads as a barrier to spending the necessary time to work with families;
- Lines get blurred when families are having problems with their children; families want parole to intervene and remove the youth from home when youth is acting out, e.g., youth assaulted his mother (spit in her face) and ran off. Mother, who originally agreed to take the youth home, now wants the parole agent to remove the youth from the home;
- Parole agents are fairly successful in enrolling youth in counseling and school. The problem lies in getting the youth to attend counseling and school;
- Given the high caseloads, there is very little one to one supervision and intervention between the parole agent and the parolee; and
- The parole agents are forced to respond to negative behavior rather than working proactively with the youth.

Youth who are paroled from an institution with medication orders are a significant issue for parole agents. Many of these youth do not follow the medication orders. Parole agents do not monitor medication, nor does the agent monitor appointments with mental health professionals. Parole agents will check with families and will respond to a youth who is either not following his/her medication orders or keeping his/her appointments with mental health professionals. Many of the families of these youth lack knowledge about the mental health problems confronting their children. They usually ignore the problem until they become aware that their child is committing crimes. Their customary response is to call the parole agent to pick up their son/daughter and return them to an institution

The parole supervisor in Cook County, who carries a caseload, recounted a case he was currently involved with that illustrates the issue. Parents did not have adequate insurance or Medicaid to secure a residential placement to stabilize their son who was in crisis. Their son's parole was violated on a marijuana charge in order to obtain services for him. He was taken to IYC St. Charles; he had previously been in IYC Kewanee for approximately one year. He had been set up on a medication regimen when he left Kewanee. When he ran out of medication, his family did not refill the prescription. He then began to self medicate by taking marijuana laced with a hallucinogen. When he was paroled, his PRB orders included taking medication and attending outpatient mental health and substance abuse counseling. He did not comply with the Prison Review Board (PRB) orders, so his parents hospitalized him. His mother

had wanted to send him to Puerto Rico because he was involved in a gang, drugs and other criminal activity, but Puerto Rico does not participate in the juvenile interstate compact.

Removal from Home Placement Process:

If the home placement is not working out, as described in the above case, the parole agent works with the Placement Resource Unit (PRU), which will be discussed below on community-based services, to find an alternative placement for the youth or find a family member (aunt/uncle, grandparent), especially for older youth, who is willing to take the youth. Finding alternative housing is a major challenge. If the Department of Children and Family Services and PRU have no bed available, the youth will be returned to the institution from which he was placed. If a youth is returned to the institution, The Prison Review Board (PRB) will see the youth and hold a formal revocation hearing.

Parole Revocation hearings have two parts:

1. Preliminary hearing to establish probable cause;
2. Youth can waive the hearing. If the youth does not waive, the hearing is held:
   - If the youth is found to have violated parole, the PRB will revoke parole and a new ARD is established by institutional staff;
   - If the youth is found not to have violated parole, the PRB will notify the parole office that that the youth needs a placement – the parole office usually has 10 days to investigate a placement

Revocation of Rearrested Youth:

If there is an arrest, the Administrator of Parole Adjustment Programs (warrant officer) becomes involved. The warrant officer tries to exercise discretion in deciding whether or not to revoke a youth's parole. If there is a new charge, e.g., retail theft and the youth had been compliant with parole supervision, the warrant officer will allow the youth to remain in detention to deal with the new charge rather than return the youth to the institution.

If the warrant is withdrawn, parole has to monitor the case in court, and check with the family to see if the youth has been released home. If the youth is at home, the parole agent must visit the home and employ the graduated sanction matrix – looking at what the youth was arrested for, e.g., if the youth was arrested for substance abuse violation, the parole agent would try to get the youth into a substance abuse treatment program. The second highest graduated sanction would be to place the youth on electric monitoring. The highest graduated sanction would be to place the youth into the Halfway Back program, a 21-day adjustment program. Five years ago, the department had day reporting centers that were available as part of the graduated sanctions but the funding was eliminated. Youth have curfews and must attend supervisory conferences with their parole agents; youth have to document their daily activities in a log. The above are tried before making the decision to return a youth to an institution. If a youth has a technical violation, e.g., breaking curfew, the parole agent considers how cooperative the youth has been before filing for revocation.

FINDINGS

- DOC parole agents' caseloads are comprised predominantly of adult offenders.
- Parole agents receive no specialized training in working with juvenile offenders.
- Parole agents do not have the time to develop working relationships with families.
- Parole agents are not assigned a juvenile's case until the youth has been granted parole, returned home or placed alternatively from an institution.
- There is a paucity of mental health services for youth in the community, especially in the rural areas of the state.
- Youth with mental health treatment needs who are not following their medication orders and/or not following through with counseling, decompensate rapidly, and are subject to revocation more readily.

Most juvenile correctional agencies in the country have paroling authority. The majority of these agencies operate regional-based case management systems so that those who have knowledge of community resources and are closest to youth and families make placement decisions. Case managers are assigned to a youth within 48 hours of the youth's commitment to the agency. The same case manager follows the youth throughout his/her entire placement, participating in the development of a youth's treatment plan, periodic case reviews and reintegration plans. The case manager works closely with the family throughout the youth's entire placement.

RECOMMENDATIONS

- Legislation is needed to assign DJJ paroling authority;
- DJJ should establish regional/district offices to house case managers;
- DJJ should be funded to hire, train and supervise aftercare case managers;
- Case manager should participate in development of the youth's treatment plan and case reviews during the youth's residential stay;
- Case manager should develop a relationship with the youth during his/her placement that will continue when the youth is returned to the community;
- Case managers should begin reentry planning soon after a youth has been placed in an institution; and
- DJJ should engage families while youth are in confinement and support them when their children are returned to them.

Community-based Programs:

The use of community-based provider programs for youth returning to the community is also a shared service with DOC. DJJ contracts with the private providers for

residential and non residential programs and services but the DOC Placement Resource Unit (PRU) places youth in the programs and monitors the programs.

Protocol for DJJ Utilization of Contracted Programs:

- Parole agents work through the PRU to secure community placement for their soon to be released youth;
- The facility puts a placement package for a youth together;
- The DJJ deputy director reviews the packet;
- The packet goes to the PRU with the Prison Review Board (PRB) orders (may contain the same information and recommendations as in the PRU packet);
- PRU sends the packet to the provider; and
- Provider accepts or rejects youth.

FINDINGS

- The PRU tries to find resources for youth with mental health and substance abuse treatment needs;
- The PRU manages community contracts and deals with contractual issues:
- The PRU deals with the provision of services for the juvenile offenders;
- A PRU staff member participates in the monthly team meeting with the program staff, a DCFS representative, mental health/clinical coordinator, education representative, and parole agent;
- The DJJ budget for community based services is approximately $3M:
  - $2M from General Revenue funds;
  - $1M in Medicaid reimbursements for youth in substance abuse treatment programs;
- Most youth from Chicago go out of District 1 for either state or contracted residential placement; Chicago only has non-residential services - these youth are supervised by a parole agent in the region in which they reside;
- Parole agents struggle with finding placements for older juveniles; most of the private agencies that DJJ contracts with are designed to serve juveniles and are reluctant to comingle the older juveniles with younger ones;
- It is even more of a struggle to place youth with mental health treatment needs because of the lack of mental health services in the community;
- Some of the underlying emotional issues are not always seen in aggressive youth;
- The experience of the parole agents in working with DJJ youth with mental health treatment needs is that they decompensate quickly;
- The mental health providers are quality providers but the demand far exceeds the supply;
- Youth tend to have more complex issues than the adult offender population;
- Many youth have anger management issues that track back to their families; the treatment cannot be solely with the youth – it needs to involve the family.

There appears to be tension between the parole agents and the provider operated programs. When issues or problems arise with youth during their transition phase, the parole agent and the provider staff do not always agree on a resolution of the problem. The provider views the problem as a norm for a youth transitioning from confinement to

the community – testing of limits. The provider usually prefers to deal with the problem and retain the youth in the program. Some providers stated that some parole agents ignore the program's recommendation and violate the youth's parole. The perception of parole is that the provider wants to keep the youth in the program for monetary reasons.

DOC parole agents sometime disagree with DJJ Placement Review Unit staff regarding the course of treatment for a youth. This arises from the differing treatment philosophies of adult and juvenile corrections. This difference in philosophies influences the treatment and placement of the youth.

Some of the provider staff felt that DJJ does not engage the families therapeutically and does not deal with the youth's sexual abuse histories and resulting issues. Providers felt that more youth could be helped if DJJ were able to accomplish this treatment prior to placing the youth in a transitional program.

RECOMMENDATIONS

- DJJ should be staffed to manage and monitor community-based contract programs;
- DJJ should continue to calculate the number of youth reentering the community annually; estimate the number that will require mental health residential programs and non-residential services, and request and receive an allocation sufficient to purchase these programs and services;
- DJJ should work closely with the mental health community (state, private advocacy, and provider) to develop appropriate reintegration programs and services for youth with treatment plans calling for a continuation of services begun in the facilities.

Collaboration between DJJ and the Division of Mental Health (DMH):

There are two formal collaborative programs between DJJ and DMH:

1. The Juvenile Justice/Mental Health Reentry Project

   This inter-agency collaboration between DJJ and DMH began in 2007. DMH funds two Juvenile Justice Reentry Liaisons to plan the transition process for youth who have been identified by DJJ to have serious mental health issues. Each liaison carries a caseload of 60 youth beginning while the youth is still in an institution and continuing for six months after the youth's return to the community. The liaison begins thinking at intake what the post-placement needs of youth with mental health treatment needs will be. The liaisons are regarded as DJJ employees by the staff in the facilities. DMH reported that at least two Juvenile Justice Reentry Liaisons are required for each facility.

2. The Juvenile Forensic Trauma Project

   This project, begun in 2008, is jointly funded by DMH and the Illinois Children's Mental Health Partnership. The project has three goals: 1.To bring evidence informed trauma services to youth in DJJ institutions. 2. To provide training in trauma informed care to DJJ staff, and 3. To work in DJJ facilities to promote,

facilitate and support culture change. Staff members are trained to recognize the effects of Post Traumatic Stress Disorder in youth and to be more trauma-sensitive when treating youth in the facilities.

The program, conducted by two trained staff, is offered at two of the eight DJJ facilities: IYC Chicago and IYC Warrenville. The direct work with the youth has a skills-based orientation that is geared toward developing cognitive competencies in youth. The curriculum focuses on survivorship rather than victimhood. It is extraordinarily well received by both the staff and youth in the two facilities. Youth enjoy the program and want to attend the trauma groups.

The program is being evaluated for its effectiveness by the Models for Change Mental Health Action Network. Youth who participate are given a pre- and post-test to measure results such as youth improvement in self-regulation.

DMH feels that the trauma backgrounds and needs of youth in the DJJ institutions require two trauma specialists for each facility.

RECOMMENDATIONS

- Expand collaboration with DMH through the Juvenile Justice/Mental Health Reentry Project and the Juvenile Forensic Trauma Project.

- The team strongly recommends that DMH receive funding to increase the number of Juvenile Justice Reentry Liaisons by 14 in order to place two Juvenile Justice Reentry Liaisons in each facility.

- The team supports funding DMH to increase the number of trauma specialists to 14 in order to have two specialists at each facility.

VI. Facility-level Recommendations by Topic

This section presents the Behavioral Health Assessment Team's recommendations by topic. The team's recommendations for each facility are listed under each topic heading. Complete descriptions of the team's findings for each topic are located within each facility's site visit report located in Section IV of this document.

BEHAVIORAL HEALTH SERVICES

Facility	Recommendations
St. Charles	Increase programming throughout the facility. There is not sufficient therapeutic activity occurring and there is not enough variety in what is offered. Create individualized treatment plans that address specific areas of need and build upon identified youth strengths. Consider a low cost re-configuration of living units to allow for therapy groups to be held on the units. This could increase the number of groups offered as well as the number of groups in which a youth could participate. Discontinue the practice of taking youth out of school for groups. The majority of DJJ youth have significant behavioral health and educational needs. Treatment and remediation should be available for both, rather than offering one at the expense of another. The Information Technology system is antiquated and unstable. Ideally, it would allow for the tracking of behavioral data on each youth and interface with the PBIS system for youth enrolled in school.
Kewanee	Clinical staff should explore and identify appropriate evidence-based practices (EBPs) appropriate for youth in residential care and these EBPs should be included as a significant part of the treatment approach used at IYC Kewanee. The Mentally Ill Substance Abuse programs for youth with co-occurring mental health and substance abuse issues should be expanded to provide these services for youth who meet criteria for placement in this program.

BEHAVIORAL HEALTH SERVICES

Harrisburg	Increase programming throughout the facility. There is not sufficient therapeutic activity occurring and there is not enough variety in what is offered. Create individualized treatment plans that address specific areas of need and build upon identified youth strengths. Review the Mental Health Staff's proposal for a Behavior Management Unit and consider piloting it for a 90 day time period. Collect data on how this pilot affects the use of confinement, restraints and the number of tickets written.
Murphysboro	The Orientation Unit should conduct standardized, functional assessments of both the needs and strengths of youth, including mental health, developmental disabilities, substance abuse, and trauma needs. These same assessments should be repeated in order to determine whether youth are improving and as part of the Discharge planning. Treatment should include individual as well as group modalities and should include appropriate evidence-based practices. Treatment should also include family therapy. Therapists should receive appropriate clinical supervision. Youth should participate in outdoor recreational activities (weather permitting) daily after school prior to beginning therapy groups.
Joliet	Increase programming throughout the facility. There is not sufficient therapeutic activity occurring and there is not enough variety in what is offered. Create individualized treatment plans that address specific areas of need and build upon identified youth strengths. IYC Joliet staff should conduct standardized assessments of both the needs and strengths of youth and repeat these assessments in order to determine whether or not the interventions being provided are working. Include EBP (evidenced based programs) such as Aggression Replacement Training (ART). Increase educational staff and vocational programming to give the youth opportunities for meaningful work once they return to the community. Provide educational and vocational opportunities for those youth who have obtained their GED or are awaiting a case in adult court.

BEHAVIORAL HEALTH SERVICES

Chicago	The SPS is overused and has questionable utility with this population. Instead of completing the SPS form every time a youth returns to the facility from a trip outside when an MHP is not available, staff should administer a standardized interview. All youth who have been identified as in need of substance abuse treatment should receive such treatment. The administration should continue to work with the Wells Center to develop a 90-day program to coincide with the 90-day LOS at the facility.
Warrenville	Treatment planning is neither integrated nor individualized. In addition, the plan to base the provision of mental health services on a measure that is not a mental health assessment (the JAIS) is fundamentally flawed, particularly in light of the number of well-researched, empirically validated instruments available for this purpose.
Pere Marquette	The number of psychiatric hours available to support the clinical program should be increased. Develop an agreement and mechanism for data-sharing between CiviGenics and DJJ.

STAFFING LEVELS

St. Charles	Address critical staffing shortages. The caseloads maintained by the Mental Health Staff are unmanageable and do not allow for any meaningful treatment to occur. The caseloads of Youth & Family Specialists are equally high and do not allow for them to perform the vital case management functions in a detailed and timely fashion.
Kewanee	Increase the number of mental health staff and Youth & Family Specialists. The number of psychiatric hours available to support the clinical program should also be increased to 40 hours weekly.

STAFFING LEVELS

Harrisburg	Address critical staffing shortages. The most critical of these are the Assistant Superintendent for Programs, a Licensed Clinical Psychologist for Reception & Classification, Reception Unit Administrator, and Leisure Time Activity Specialists. In addition, the caseloads maintained by the Mental Health Staff are unmanageable and are a barrier for meaningful treatment to occur. Similarly, the caseloads of the Youth and Family Specialists are equally high and do not allow for them to perform the vital case management functions in a detailed and timely fashion. Youth and Family Specialist Supervisors are also required in Reception and in programming.
Murphysboro	Though not as major a problem as at some other youth centers, the department should address the staff vacancies. It should also review the history of injuries to see whether any training (such as de-escalation) or program changes might reduce the number of staff injuries. Further, if the youth center adds treatment programs, as recommended above, additional treatment staff will be required.
Joliet	Address critical staffing shortages. Fill key vacancies including the Assistant Superintendent for Operations position. The caseloads of YFS staff and mental health staff are unmanageable and do not allow for meaningful treatment or provision of vital case management functions in a detailed or timely manner. Address lack of computer infrastructure. Ensure communication and coordination among staff members increases when vacancies are addressed.
Chicago	Key vacancies should be filled.
Warrenville	The Treatment Unit Administrator and Clinical Psychologist positions need to be filled immediately. The lack of strong clinical leadership onsite and available to staff is a significant problem as this agency transitions to a more rehabilitative model.
Pere Marquette	Fill vacancies and ensure all staff are adequately trained in appropriate staff/youth relationships. Estimate the number of female staff needed to end male staff supervision in bathrooms and showers.

TRAINING

Facility	Recommendation
St. Charles	Develop a program of in-service training for staff. Consider requesting mental health consultation and in-service training support from the Division of Mental Health and other child-serving agencies. For example, consultation and in-service training support could be provided by the nearby DMH Elgin Mental Health Center. Such a formal in-service training program would facilitate individual professional development and supplement internal training efforts. Staff consistently mentioned lack of communication as a major problem. This was true for staff shift-to-shift on a living unit and across disciplines and across the facility. There should be a regular, more structured and reliable process for documenting and communicating important information about the youth.
Kewanee	Training of all staff at IYC Kewanee in the program's new juvenile orientation, adolescent development, youth mental health disorders, trauma and other such issues should be significantly expanded and strengthened.
Harrisburg	Develop a program of in-service training for staff. The Mental Health Staff is extremely dedicated and can offer training to Juvenile Justice Specialists, Youth and Family Specialists and other key staff. Consider requesting mental health consultation and in-service training support from the Division of Mental Health and other child-serving agencies. For example, Clyde C. Choate Mental Health & Developmental Disabilities Center is nearby and could potentially provide consultation and training either in person or via videoconference. At the time of the site visit, 68 percent of the youth populations at IYC Harrisburg were either African-American or Hispanic. Aggressive training efforts should be implemented to ensure cultural sensitivity and cultural competency in all services rendered to youth.
Murphysboro	IYC Murphysboro should train all staff in the program and DJJ's new orientation, adolescent development, youth mental health disorders, trauma and how these relate to the substance abuse work already being done.
Joliet	Prioritize staff training for all staff, including those who have been there since DOC, in the skills needed to address the rehabilitative needs of youth.
Chicago	All staff should receive training in Aggression Replacement Training (ART). All staff should receive training in the Core Treatment model.

Training

Warrenville	Critical gaps in training should be addressed. Chief among these are mental health issues, substance use disorders, childhood trauma, adolescent development, brain development, de-escalation techniques, behavior management and crisis intervention.
Pere Marquette	Staff should continue to receive training to allow them to address and respond to the rehabilitative needs of youth.

Policies and Directives, Philosophical Change

St. Charles	Prioritize staff training in the skills needed to address the rehabilitative needs of youth. The most critical of these seem to be mental health issues, substance use disorders, childhood trauma, adolescent development, brain development, de-escalation techniques, behavior management and crisis intervention.
Kewanee	Training of all staff at IYC Kewanee in the program's new juvenile orientation, adolescent development, youth mental health disorders, trauma and other such issues should be significantly expanded and strengthened. Policies regarding isolation, seclusion and restraint should be reviewed in light of generally accepted standards for juveniles with a particular emphasis on juveniles with mental health issues.
Harrisburg	Prioritize staff training in the skills needed to address the rehabilitative needs of youth. The most critical of these seem to be mental health issues, substance use disorders, childhood trauma, adolescent development, brain development, de-escalation techniques, behavior management and crisis intervention. Discontinue the use of confinement for suicidal and self-injurious youth. Develop a protocol for intervention with such youth using established techniques including 1:1, special and close observation that are less punitive, more effective and provide a more rapid functional improvement.

POLICIES AND DIRECTIVES, PHILOSOPHICAL CHANGE

Murphysboro	IYC Murphysboro needs to determine the general rules of conduct, consequences for infractions and positive responses for the youth. All staff should receive training on appropriate interventions and be provided with appropriate resources to support such a behaviorally-based program approach. Administration should review the use of tickets, the inconsistent use of discipline and possible abuse of discipline by staff.
Joliet	Training of all staff at Joliet in the agency's new juvenile orientation, adolescent development, appropriate intervention with juveniles and other such issues should be significantly expanded and strengthened. Policies regarding confinement should be reviewed in light of generally accepted standards for juveniles. Staff need training on other behavior modification techniques so that they can use various methods of behavioral interventions rather than rely on confinement.
Chicago	IYC Chicago administration should continue to support staff in adopting the Core Treatment Model through communication of goals and benefits of the model and training in implementation of the model.
Warrenville	While staff recognizes that their mission has changed, they do not feel they have either the training or resources to fulfill the new mission. Training on the behavioral health needs of justice-involved youth is critical in helping staff shift to a more rehabilitative model. While staff has made strides in reducing the use of confinement, it could be further reduced through staff training particularly in the areas of de-escalation and crisis intervention. It would also be helpful for staff to see the reduction in the use of confinement as part of the agency's shift to a more rehabilitative model. Without this important context, staff are likely to view it negatively rather than as an important transformational step for the youth and the facility.
Pere Marquette	Review the role of staff in the therapeutic community as part of ongoing staff training. Continue current practice of using the Self Improvement Inventory in place of confinement.

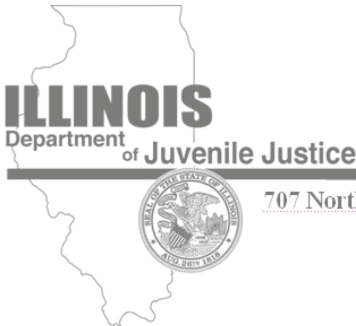
TRANSITIONING YOUTH AND FAMILY CONTACT

Facility	Recommendations
St. Charles	Transition/Discharge Planning should begin in R&C with progress documented in the monthly staff and reported on in the quarterly reviews. Parole officers should meet with youth and their family prior to release in order to establish rapport and identify potential challenges associated with community reintegration. Family involvement in transition planning is essential. Because youth and family involvement is associated with improved outcomes, a priority must be placed on engaging them in the process and developing a plan that reflects their unique needs. Efforts should be made to engage family members and make it easier for them to visit and maintain connection with the youth. Family input should be solicited in the development of the treatment plan and family participation in the treatment plan reviews, if only by phone, should be encouraged and supported. Additionally, clinical staff should be available on weekends to meet with youth and families during visitation. Adding family therapy to the behavioral health services offered would be of great benefit to the youth and their families.
Kewanee	Aftercare and Re-entry services provided by IYC Kewanee and DJJ should be enhanced in support of the work being done in this area by DMH. Strategies for facilitating family contact with youth such as providing outreach and transportation, should be examined and implemented.
Harrisburg	Transition/discharge planning should begin in R&C with progress documented in the monthly staff meetings and reported on in the quarterly reviews. Efforts should be made to engage family members and make it easier for them to visit and maintain connections with the youth.
Murphysboro	Vocational training should be restored and enhanced, including reconnecting with local colleges and volunteers. Parole officers should visit with youth prior to discharge and participate in the discharge planning. Appropriate, available, affordable community services need to be identified with linkage provided by the parole officer after discharge. The same assessment tools should be used to continue to measure the youth's progress. Counselors should engage families as resources both during the initial orientation and during the discharge planning.

TRANSITIONING YOUTH AND FAMILY CONTACT

Facility	Recommendations
Joliet	Transition/Discharge Planning should begin at intake with progress documented in the monthly staff meetings and reported on in the quarterly reviews. The level of family engagement and obstacles should be identified and efforts should be made to engage family members and make it easier for them to visit and maintain connections with the youth. Family members should be engaged at all levels such as school, mental health services and aftercare. A family advisory board of youth who are no longer in the facility should be considered to assist with this issue.
Chicago	
Warrenville	Re-entry planning should begin at Intake with monthly progress documented in the treatment plan. The mentoring program was seen as a positive by both staff and youth and a method to continue this (or establish something similar) post-release should be explored. Increase educational staff and vocational programming to give the youth an opportunity for meaningful work once they return to the community. Provide educational and vocational opportunities for those youth who have obtained their GED or are awaiting a case in adult court. Resources will need to be allocated to make post-high school courses and improved technology available to youth. Increase efforts to actively engage family members in both the treatment and re-entry process. There was little evidence that family engagement was seen as a priority and changing the YFS when the youth changes cottages does not support this process.
Pere Marquette	Parole officers should visit with youth prior to discharge and participate in a formal, structured discharge planning process that engages the treatment teams at facilities, youth and families. Expand educational programming and vocational training for youth who have high school diplomas/GEDs. Efforts should be made to engage family members and make it easier for them to visit and maintain connections with the youth.

Appendix A: DJJ Request



Pat Quinn
Governor

Kurt C. Friedenauer
Director

707 North 15th Street, Springfield IL 62702 - Phone: (217) 557-1030 / TDD: (800) 526-0844

September 3, 2009

Diane Geraghty
Illinois Models for change Initiative
Loyola University Chicago School of Law
25 E. Pearson Street – Room 1314
Chicago, Illinois 60611

Dear Ms Geraghty:

Please consider this a formal request to the MacArthur Foundation, Models For Change Initiative, to provide technical assistance to the Department of Juvenile Justice. The basis for this request are my ongoing concerns regarding the adequacy of Mental Health Services for the youth in our custody.

There is clearly a policy issue that needs to be examined regarding the appropriateness of the Juvenile Justice system as an environment for the treatment of certain juvenile offenders with significant mental health/psychological disorders. However, in reality these youth will never be completely excluded from the Juvenile Justice system given the overall prevalence of mental health issues within the juvenile justice population. A percentage of youth with significant mental health/psychological disorders will also always require placement in our system given the severity of their offense history. It is essential that we are able to provide adequate Mental Health Services for these youth.

Specifically, I am requesting technical assistance that would evaluate and provide recommendations in the following areas:

Assessment of Mental Health needs of youth in the IDJJ system.

Adequacy of Mental Health Professional staffing levels.

Adequacy of psychiatric services.

Adequacy of training for Mental Health Professionals.

Adequacy and appropriateness of type of services provided by Mental Health Professionals.

Appropriateness of the Department's physical plant facilities for housing and treatment of youth with mental health/psychological disorders.

Adequacy of the Department's administrative infrastructure to effectively monitor and manage behavioral health services.

I realize this is an ambitious request that will require a substantial commitment of time and resources by the Foundation. However, I believe it is imperative that a comprehensive evaluation of the Department Mental Health Services be undertaken. The Department's previous attempts to access resources for this evaluation have been unsuccessful.

It is my hope that this request is favorably received by the MacArthur Foundation. I will look forward to discussing it further with you at your earliest convenience.

Thank you for your consideration in this matter

Sincerely,

Kurt C. Friedenauer
Director
Illinois Department of Juvenile Justice

cc: Lisa Jacobs, Program Manager
Illinois Models For Change Initiative

Appendix B: Description of Assessment

Models for Change Initiative Supports Effort to Improve the Illinois Department of Juvenile Justice's Behavioral Health Program for Committed Youth

At the invitation of the Illinois Department of Juvenile Justice and its director, Kurt Friedenauer, Models for Change, an initiative supported by the John D. and Catherine T. MacArthur Foundation, has assembled a team of national and state experts to assess the Department's current capacity to serve the behavioral health needs of committed youth and make recommendations based on the assessment team's findings.

BACKGROUND

The Illinois Department of Juvenile Justice (IDJJ) was established in 2006. The Department's statutory mission includes the provision of "treatment and services through a comprehensive continuum of individualized education, vocational, social, emotional, and basic life skills to enable youth to avoid delinquent futures and become productive, fulfilled citizens." Today, approximately 1300 youth are housed in eight IDJJ secure confinement facilities across the state. A 2007 study found that 65% of youth in IDJJ care have one or more diagnosable psychiatric disorders; 70% have clinical levels of chemical dependence.

SCOPE AND TIMETABLE OF ASSESSMENT

Over the course of the next six months, the Models for Change Behavioral Health Assessment Team will conduct site visits to all IDJJ's facilities: IYC Kewanee, IYC St. Charles, IYC Warrenville, IYC Chicago, IYC Joliet, IYC Harrisburg, IYC Murphysboro, and Pere Marquette. Working in cooperation with Director Friedenauer and his staff, the team will assess the range of behavioral health needs of youth in the IDJJ system and the systems in place for identifying these youth, the adequacy of existing behavioral health policies, programs and staffing, the appropriateness of current approaches to transitioning youth with behavioral health needs out of IDJJ, and the level of collaboration between IDJJ and other Illinois systems responsible for meeting the needs of youth with mental health and substance abuse issues.

REPORT AND RECOMMENDATIONS

At the conclusion of the assessment phase of the project, the Models for Change Behavioral Health Assessment Team will issue a written report summarizing its findings and making recommendations. The report will be made public and will also be made available to state decision-makers and IDJJ personnel.

BEHAVIORAL HEALTH ASSESSMENT TEAM MEMBERS

Joseph Cocozza, Ph.D.
Director
National Center for Mental Health and Juvenile Justice
Delmar, NY

Debra Ferguson, Ph.D.
Associate Deputy
Division of Mental Health
State of Illinois
Chicago, IL

Eugene Griffin, J.D., Ph.D.
Associate Director of the Mental Health and Services Policy Program
Northwestern University Feinberg School of Medicine
Clinical Director, Illinois Childhood Trauma Coalition
Chicago, IL

Thomas Grisso, Ph.D.
Professor and Director
National Youth Screening and Assessment Project
University of Massachusetts Medical School
Department of Psychiatry
Worcester, MA

Antoinette Kavenaugh, Ph.D.
Forensic Psychologist
Chicago, IL

Edward Loughran, M.A. (Team Leader)
Executive Director
Council of Juvenile Correctional Administrators
Braintree, MA

Eric Trupin, Ph.D.
University of Washington
Public Behavioral Health and Justice Policy
Seattle, WA

INQUIRIES

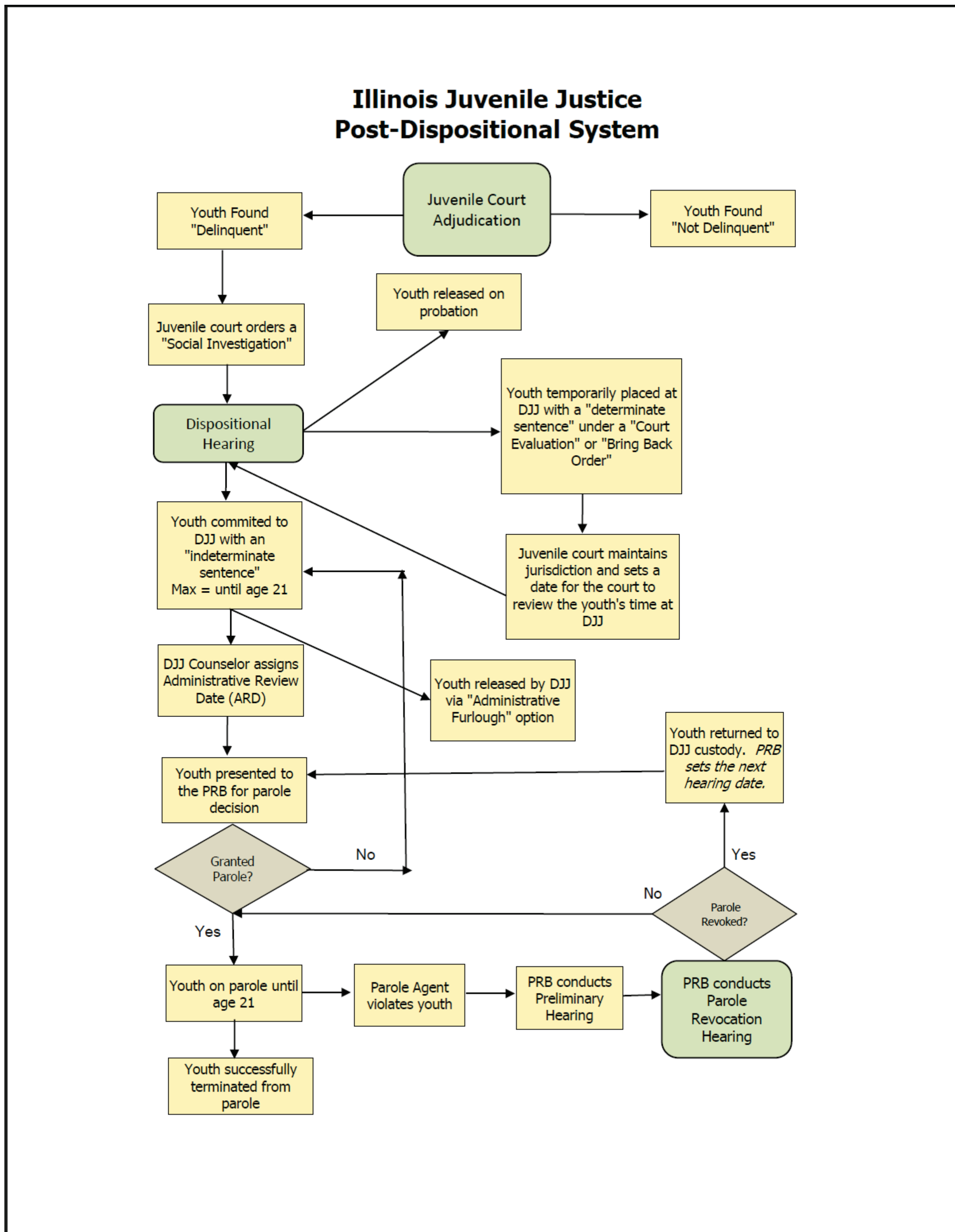
Inquiries should be made to Edward Loughran, Models for Change Behavioral Health Assessment Team Leader, Ned.Loughran@cjca.net/ 781-843-2663.

ABOUT MODELS FOR CHANGE

Models for Change is an effort to create successful and replicable models of juvenile justice reform through targeted investments in key states, with core support from the John D. and Catherine T. MacArthur Foundation. Models for Change seeks to accelerate progress toward a more effective, fair, and developmentally sound juvenile justice system that holds young people accountable for their actions, provides for their rehabilitation, protects them from harm, increases their life chances, and manages the risk they pose to themselves and to the public. One of the goals of the Illinois Models for Change initiative is to support the Illinois Department of Juvenile Justice in its efforts to transition from an adult model to a developmentally appropriate rehabilitative model of juvenile corrections.

December, 2009

Appendix C: Post-Dispositional System



Appendix D: Recommendations from Previous Reports

In December 2005, former Governor Blagojevich convened a Juvenile Justice Transition Team to make recommendations to inform and assist the separation of juvenile correctional services in Illinois from the adult corrections system. The Transition Team drafted core principles of the agency and recommendations in the areas of services, training, evaluation and administration/ organization. Recommendations relevant to the current evaluation of behavioral health services are listed below.[33]

Governor's Transition Team
Recommendations from the Services Workgroup

Intake & Assessment

1. Adopt the use of standardized intake and assessment practices including but not limited to the use of standardized instruments and Department-wide forms.
2. Administer a structured or semi-structured clinical interview along with the screening measure.
3. Implement and use instruments, practices and forms to support the collection of data recommended as necessary for measuring performance.
4. Create decision trees to aid staff in the selection of instruments and next steps in the intake, assessment and reception process for mental health or substance abuse problems, neuropsychological impairments, developmental disabilities or other special needs.
5. Require that only licensed and trained staff members administer and interpret assessment instruments other than the screening tool.
6. Maintain the current intake and assessment system at three reception centers.

Behavioral Health

Short term:

1. Include mission, values and vision statements for each of Mental Health, Substance Abuse and Healthcare services.
2. Develop/improve Individual Treatment Plans (ITP) for delivery of services.
3. Adopt a Suicide Prevention/Crisis Intervention program based on best practices and national standards.
4. Adopt standards from the National Commission on Correctional Health Care and/or the Council of Juvenile Correctional Administrators as applicable.
5. Develop/improve current Quality Assurance practices for Mental Health, Substance Abuse and Healthcare services, incorporating specific performance measures.

Long term:

1. Establish requirement that all clinical service providers hold applicable licensure and adhere to licensing standards.
2. Maximize and prioritize the services of clinicians and physicians with relevant specialties (e.g. Child & Adolescent Psychiatrists).
3. Implement telemedicine in rural and hard-to-staff areas.
4. Partner with the Illinois Children's Mental Health Partnership (ICMHP) to procure funds for mental health transition services.

Aftercare & Parole

Short term:

1. Establish juvenile parole/aftercare within DJJ (not as a shared service) with defined regional boundaries and juvenile-only caseloads.
2. Reclassify, rename and redefine two positions: Aftercare Counselor and Community Services Coordinator.
3. Adopt an appropriate model to engage families. The group recommends Washington State's model of Family Functional Parole.

[33] Governor's Transition Team for the Department of Juvenile Justice. 2006. *Transitional Team Recommendations.*

DJJ's *Comprehensive Master Plan*, published in 2007, also outlines operational principles and recommendations related to behavioral health services and reintegration of youth into the community. The Operational Principles and recommendations relevant to the current evaluation of behavioral health services are listed below.[34]

DJJ Comprehensive Master Plan
Operational Principles and Behavioral Health Recommendations

Operational Principles

1. Standardized, objective and functional assessments will be based on strengths and needs, the youth's competencies will be measured at intake, midway in the youth's stay, at discharge and will continue to be measured and tracked while on aftercare supervision. Positive performance outcomes will be integral to the measurement of the program's success.
2. Females will be housed and programmed in separate facilities.
3. Transition centers, community-based programs and aftercare services will be planned in each region.
4. Youth will receive their legally mandated (state and federal) educational services, and when the youth is 3 grades behind, they will be provided educational services more than the minimum.
5. Intake and assessment centers and facilities with sufficient size will have a medical infirmary and around the clock medical care.
6. Mental health services will be given to all youth, and they will reflect a continuum of assessment, outpatient and residential treatment, and they will place a high priority on trauma, gender-specific and culturally-relevant issues.
7. Substance abuse services will reflect a continuum of identification, assessment, referral, education, levels of care (outpatient and Therapeutic Community residential treatment), transition services, clinical reentry pre and post release and expanded wraparound services for youth in aftercare.
8. A normative culture based on teaching youth skills leading to positive behavioral change will guide operations and programs.
9. The families will be an integral part of the youth's treatment plan development and implementation.
10. Youth will be involved in constructive programming 14-18 hours each day.
11. Vocational education will be offered at each facility.
12. Youth will b e exposed to the community through community volunteers and community service projects, and every facility will have a Volunteer Advisory Board.
13. Youth and staff will be trained in cognitive behavioral skill development.

Mental Health Care Recommendations

1. Revise the current Mental Health Services Levels consistent with contemporary standards of practice to allow some level of mental health counseling to all youth due to the chronic trauma problems and the high incidence of mental health problems found within the profiles of these youth. Change the existing Level 0 to Level 1 and increase all of the other levels by 1.
2. Adopt the Core Treatment Model at all of its youth centers and in its transition centers and aftercare districts. This model is evidence-based and will reduce future recidivism of juvenile offenders in Illinois.
3. Maintain a ratio of 1 qualified professional to 25 youth consistent with contemporary standards of practice.
4. Increase the frequency of the therapy groups to 1.5 hours 2-3 times each week.
5. Increase the use of trained interns from local universities and/or utilize private contractors to provide group therapy to youth.
6. Provide core cognitive behavioral groups at all youth centers on the following topics: problem solving, decision making, conflict resolution, criminal thinking errors, parenting, life skills, and continue to provide these groups during the first six months after release from confinement.

[34] DMJM Illinois | AECOM with Huskey & Associates. 2007. *Department of Juvenile Justice Comprehensive Master Plan.*

DJJ Comprehensive Master Plan
Operational Principles and Behavioral Health Recommendations (continued)

Mental Health Care Recommendations (continued)

7. Monitor and report treatment outcomes using objective, valid and functional assessment instruments.
8. Provide dedicated therapy rooms and sufficient youth juvenile justice specialists so that therapy groups can be no larger than 10 youth in a group.
9. Prohibit the use of counselors taking youth out of class to attend therapy except in emergencies and implement treatment groups in the evenings.
10. Incorporate a statewide system of Treatment Teams and integrate this mechanism into the Core Treatment Model.
11. Develop special need treatment throughout the state for mentally ill, substance abuse and sex offenders using the cognitive behavioral treatment modality and relapse prevention theoretical framework in the context of the Department's Core Treatment Model.
12. Professional counseling staff should have permanent offices within each of the housing units.
13. Establish a workgroup on gender-relevant programming to expand the gender-specific and culturally relevant services to females and males in the youth centers and in reentry.

Substance Abuse Treatment Recommendations

1. Ensure that the results of the Global Appraisal of Individual Needs (GAIN) assessment are communicated to every clinician working with the youth and that these results are used in the development of the Individual Treatment Plan.
2. Reassess the youth using the GAIN assessment during and at the end of treatment to measure progress on treatment.
3. Continue DASA licensed treatment programs in all of the youth centers and ensure that all treatment programs provide a comprehensive continuum of programming that includes assessment, drug education, outpatient, residential treatment, support, and increase clinical reentry management.
4. Examine the benefits of bundling all substance abuse programs/services into one contract for the state.
5. Enhance the current substance abuse treatment programs by incorporating a higher degree of cognitive behavioral principles and practices including "stages of change."
6. All treatment programs should provide a minimum of 15 hours of treatment per week.
7. Ensure that all youth who have been in a residential treatment unit while in the youth center will receive continuing care at a minimum of 6 months following release.
8. Prior to release, assess the youth using the American Society for Addiction Medicine (ASAM) guidelines, with the results of the GAIN and the treatment program, determine the level of treatment the youth should be continued in upon release and to ensure that providers can bill Medicaid for the services they provide base on ASAM criteria.
9. Retrofit spaces within each facility to be designated group therapy spaces and ensure that there is at a minimum one Juvenile Justice Specialist to 8 youth in addition to the therapist.
10. Create an evidence-based substance abuse treatment curriculum that is standardized for all youth centers and aftercare districts.
11. Continue substance abuse counselor certification training program for DJJ staff.
12. Maintain a 1:15 staff to youth ratio in the licensed treatment units.

The Behavioral Health Assessment Team has included these recommendations from previous reports to emphasize that many of the findings we report and recommendations we suggest in this document are not new. Many of the issues reported on have already been identified by previous reports, but many of the recommendations of previous reports have not been acted on or implemented. This report is another attempt to identify the strengths and inadequacies of DJJ's behavioral health program to assist the department as it works to improve the program for youth committed to its care.

Appendix E: Facility Profiles, Mental Health Services and Staffing

Rev.4/19/10
Ratios Reported as Youth:Staff

ST. CHARLES

Security Level:	Medium
Gender:	Male
Capacity:	417
Average Census:	260

PROGRAM BEDS:

Special Treatment:	48
Reception Classification:	119
Substance Abuse:	92
General Population	144

CONTRACTING AGENCY:
Health Professionals Limited (HPL) - Provides Mental Health Professionals (MHP) and Psychiatrist
Wells Center – Provides Substance Abuse Treatment
Adler School of Professional Psychology – Provides Interns, Post doctorate, & Supervision

STAFFING:

Licensed Clinical Psychologists:	11 (7-FT, 2-PT, 2-vacancies/state)
Licensed Social Worker:	1 Full time
Psychiatric Hours:	48 hrs weekly
Post doctorate Fellow:	20 hrs weekly
Adler Clinical Supervisors:	20 hrs weekly
Interns:	3 Full time
Externs:	10 Part time
Wells Center	3 Full time

MHP Ratios: Reception and Classification (SRC) - 70:1.5
General Population (STC) – 40:1
Special Treatment (SST) – 16:1
Substance Abuse (SA) - 46:1

Caseloads are the same as above.

St. Charles
(Continued)

Mental Health Staff -- IYC – St. Charles

*Mental Health Professional (MHP) does not include Psychiatrist

General Population = GP
Special Treatment = SST
Reception Classification = R & C

Degree	Licensure	Job Titles	Hours	Program	Employer
Psy.D.	LCP	Treatment Adm.	40	All	State
Psy.D.	LCP	Psychologist	40	GP	State
Psy.D.	LCP	Psychologist	40	SST	State
Psy.D.	LCP	Psychologist	40	R & C	State
Psy.D.	LCP	Psychologist	40	SST	HPL
Psy.D	LCP	Psychologist	20	R & C	HPL
Psy.D.	LCP	Psychologist	40	GP	HPL
Ph.D.	LCP	Psychologist	8	R & C	HPL
MSW	LSW	Mental Health Prof.	40	SST	HPL
M.D.	M.D.	Psychiatrist	20	All	HPL
M.D.	M.D.	Psychiatrist	16	All	HPL
M.D.	M.D.	Psychiatrist	12	All	HPL

2- MHP Vacancies GP

JOLIET

Security Level:	Maximum/Medium
Gender:	Male
Capacity:	344 (Fully operational and double bunked)
Average Census:	225

PROGRAM BEDS:

Substance Abuse:	30
General Population: (Includes Programming for wings 7-A and 8)	147
Parole Readjustment: (Medium Security Level)	48

CONTRACTING AGENCY:
Health Professionals Limited (HPL) – Provides Mental Health Professionals and Psychiatrist
Wells Center – Provides Substance Abuse Treatment

STAFFING:

MHP's:	4
Wells	3
Psychiatric Hours	8 weekly
Interns:	0

Ratios: General Population and Parole Readjustment: 60:1
Substance Abuse: 15:1

Caseloads: 18

Mental Health Staff -- IYC – Joliet

*Mental Health Professional (MHP) does not include Psychiatrists

Degree	Licensure Status	Job Titles	F/T / P/T	Employer
BSW	**No**	Social Worker II	40	St / IL
MS	Lic. Clin. Prof. Counselor	M. H. Admin.	40	St / IL
PsyD	Lic. Clin. Psych.	Lic. Clin. Psych.	40	*Contractual* (HPL)
MD	Medical Doctor	Staff Psychiatrist	8	*Contractual* (HPL)
PsyD	Lic. Clin. Psych.	Lic. Clin. Psych.	40	*Contractual* (HPL)

CHICAGO

Security Level: Minimum
Gender: Male
Capacity: 130
Average Census: 70

PROGRAM BEDS:
Substance Abuse: 22
General Population: 50
Half-way Back: 22

CONTRACTING AGENCY:
Health Professionals Limited (HPL) – Provides Mental Health Professionals and Psychiatrist
Wells Center – Provides Substance Abuse Treatment

STAFFING:

MHP's: 2 (part-time)
Well's: 3
Psychiatric Hours: 5 weekly
Interns: 4

Ratios: General Population: 80:1
Substance Abuse: 8:1

Caseloads: 5 Individual Therapy, 2 Groups

Mental Health Staff -- IYC – Chicago

*Mental Health Professional (MHP) does not include Psychiatrists

Degree	Licensure Status	Job Titles	F/T / P/T	Employer
Psy.D	Licensed Clinical Psychologist	Psychologist	20	HPL
Psy.D	Licensed Clinical Psychologist	Psychologist	20	HPL
M.D.	Psychiatrist	Psychiatrist	5	HPL

PERE-MARQUETTE

Security Level: Minimum
Gender: Female
Capacity: 40
Average Census: 20

PROGRAM BEDS:
Substance Abuse: 40

CONTRACTING AGENCY:
Civigenics – Provides Substance Abuse Treatment

STAFFING:

MHP: 2
Civigenics: 4.5
Psychiatric Hours: 4 weekly
Interns: 0

Ratios: 20:1

Caseload same as above.

Mental Health Staff -- IYC – Pere Marquette

*Mental Health Professional (MHP) does not include Psychiatrists

Degree	Licensure Status	Job Titles	F/T / P/T	Employer
M.A.	LPC	Psychologist	40	State
M.D.	M.D.	Psychiatrist	4	Contractual
M.S.W.	LSW	MHP	40	CEC/Civegenics

WARRENVILLE

Security Level:	Multi-level
Gender:	Female
Capacity:	174
Average Census:	85

PROGRAM BEDS:

Victory Program (Mental Health):	10
Reception Classification:	20
Substance Abuse:	30
Focus (Parenting Teens):	10
General Population:	100

CONTRACTING AGENCY:
Health Professionals Limited (HPL) - Mental Health Professionals and Psychiatrists
Wells Center – Provides Substance Abuse Treatment

STAFFING:

MHP's:	4.5
Well's:	4.5
Psychiatric Hours:	8 weekly
Interns:	4

Ratios: For all programs listed above (excluding Substance Abuse): 14:1
Substance Abuse: 15:1

Caseloads: 14

Mental Health Staff -- IYC – Warrenville

*Mental Health Professional (MHP) does not include Psychiatrists

Degree	Licensure Status	Job Titles	F/T / P/T	Employer
MSW	LCPC	Social Worker	40	HPL
MSW	None	Social Worker	40	HPL
MAT	LPC	Activity Therapist	20	HPL
MSW	LSW	Social Worker	40	State
Ph.D.	LCP	Psychologist	20	HPL
M.D.	M.D.	Psychiatrist	8	HPL

MURPHYSBORO

Security Level: Medium
Gender: Male
Capacity: 156
Average Census: 65

PROGRAM BEDS:
Substance Abuse: (167) All youth in facility participate in Substance Abuse Programming

CONTRACTING AGENCY:
Health Professionals Limited (HPL) – Provides Mental Health Professionals and Psychiatrists
Wells Center – Provides Substance Abuse Treatment

STAFFING:

MHP's: 2
Wells: 7
Psychiatric Hours: 3 weekly

Ratios: 63:1

Caseload: 26 (Solely Groups, all Individuals are PRN)

Mental Health Staff -- IYC – Murphysboro

*Mental Health Professional (MHP) does not include Psychiatrists

Degree	Licensure Status	Job Titles	F/T / P/T	Employer
M.S.Ed.	LCPC	Clinical Services Supervisor	40	State
M.A.	None	Psychologist	40	State
M.D.	M.D.	Psychiatrist	3	HPL

HARRISBURG

Security Level: Maximum/Medium
Gender: Male
Capacity: 495
Average Census: 275

PROGRAM BEDS:
Reception Classification: 34
Substance Abuse: 64
Maximum Security: 50 (25 rooms with double bunks)
Medium General Population: 300 (150 rooms with double bunks)
Pre-release Program: 38

CONTRACTING AGENCY:
Wexford – Provides Mental Health and Psychiatric Services
Civigenics – Provides Substance Abuse Treatment

STAFFING:
MHP's: 7
Civigenics: 7
Psychiatric Hours: 8 weekly
Interns: 2

Ratios: For all programs listed above (excluding Substance Abuse): 49:1
Substance Abuse: 10.5:1

Caseload: 24

Mental Health Staff -- IYC – Harrisburg

*Mental Health Professional (MHP) does not include Psychiatrists

Degree	Licensure Status	Job Titles	F/T / P/T	Employer
MSW	None	Social Worker	40	State
MSW	LCSW	Social Worker	40	Wexford
MSW	LCSW	Social Worker	40	Wexford
MSW	LCSW	Social Worker	35	Wexford
MRC	LCPC	Counselor	40	Wexford
MA	LCPC	Counselor	40	Wexford
M.S.	None	Mental Health Admin.	40	State
M.D.	M.D.	Psychiatrist	10	Wexford

KEWANEE

Security Level:	Medium
Gender:	Male
Capacity:	306
Average Census:	240

PROGRAM BEDS:

Special Treatment:	41
	11 – Not filled
Mental Illness/Substance Abuse (MISA):	24
Juvenile Sex Offender (JSO):	123
	39 – Not filled
Special Treatment/JSO:	19
General Population:	0

CONTRACTING AGENCY:
Wexford – Provides Mental Health Professionals and Psychiatrist
Alternative Behavior Treatment Centers – Provides Mental Health Professionals
Wells Center – Provides Substance Abuse Treatment

STAFFING:

MHP's:	13
Well's:	3
Psychiatric Hours	12 weekly
Interns:	0

Ratio: For all programs listed above (excluding Substance Abuse): 10:1
MISA: 9:1

Caseloads: 21

Mental Health Staff -- IYC – Kewanee

*Mental Health Professional (MHP) does not include Psychiatrists

Degree	Licensure Status	Job Titles	F/T / P/T	Employer
Psy.D	LCP	Psychologist Administrator	40	State
Ph.D	None	Clinical Director	40	ABTC
M.S.	LCPC	Treatment Therapist	40	ABTC
M.A.	LPC	Treatment Therapist	40	ABTC

MSW	LSW	Treatment Therapist	40	ABTC
MSW	None	Treatment Therapist	40	ABTC
M.S.	LPC	Treatment Therapist	40	ABTC
M.S.	None	Treatment Therapist	40	ABTC
M.S.W	LCSW	Treatment Therapist	40	ABTC
M.S.	None	Treatment Therapist	40	ABTC
Psy.D.	LCP	Psychologist	40	ABTC
Ph.D.	None	Psychologist	40	ABTC
Psy.D.	None	Psychologist	40	ABTC
M.D.	M.D.	Psychiatrist	10	Wexford
2 - Vacancies				

Appendix F: Institution Monthly Youth Profiles

JERRM117 ILLINOIS DEPARTMENT OF JUVENILE JUSTICE PAGE 8
JUVENILE TRACKING SYSTEM:RM RUN DATE: 06/01/10
AS OF DATE: 05/31/10 INSTITUTION MONTHLY YOUTH PROFILE RUN TIME: 8.33.13
SECURITY: MED INSTITUTION: ST CHARLES

	CATEGORY	NUMBER	%
RACE	WHITE	42	16
	BLACK	173	66
	HISPANIC	47	18
	AMER IND	1	0
	ASIAN	0	0
	UNKN/OTHER	0	0
TYPES	FELONS	23	9
	DELINQ	185	70
	HABIT/VIOLENT	4	2
	EVAL	45	17
	MURDER	2	1
	SECURE CARE	0	0
SEX	MALE	263	100
	FEMALE	0	0
AGE	AVG AGE	16.5	
	16 YRS. & UNDER	135	51
	17 TO 20 YRS.	128	49
	20.5 YRS. & OVER	0	0
COMMITTING COUNTY	COOK CO.	143	54
	COLLAR CO.	25	10
	METRO-EAST	2	1
	CENTRAL IL.	26	10
	SOUTH IL.	2	1
	NORTH IL.	61	23
	OTHER	4	2
OFFENSE CLASS	MURDER	3	1
	CLASS X	36	14
	CLASS 1	61	23
	CLASS 2	71	27
	CLASS 3	49	19
	CLASS 4	31	12
	CLASS A	10	4

	CATEGORY	NUMBER	%
STG AFFILIATION	BGD	0	0
	LATIN KINGS	19	7
	BLACK DISCIPLES	2	1
	EL RUKNS	0	0
	VICE LORDS	0	0
	OTHER	106	40
	NONE	136	52
RUN RISK	EXTREMELY HIGH	0	0
	HIGH	2	1
	MODERATE	127	48
	LOW	80	30
	PENDING	54	21
SUPERVISION	EXTREME SUPV	0	0
	HIGH	59	22
	MEDIUM	203	77
	LOW	1	0
	EXTERNAL	0	0
	PAROLE HIGH	0	0
	PAROLE MED	0	0
	PAROLE LOW	0	0
	PAROLE OUT OF STA	0	0
	PENDING	0	0
	NONE	0	0
TIME LEFT TO SERVE	PAST ARD	68	26
	< 3 MOS.	37	14
	3-6 MOS.	54	21
	6-12 MOS.	19	7
	12-18 MOS.	6	2
	18-24 MOS.	3	1
	24-30 MOS.	6	2
	> 30 MOS.	7	3
	LIFE	0	0
	SDP	0	0
	OTHER	63	24

	CLASS B	0	0
	CLASS C	0	0
	UNCLASS	0	0
	UNKNOWN	2	1
MENTAL HLTH LEVEL	NO LEVEL	81	31
	MINIMUM	152	58
	MODERATE	30	11
	URGENT	0	0
	HOSPITALIZED	0	0
DCFS	CUSTODY	14	5
PLACEMENT POTENTIAL	LEVEL 1	209	80
	LEVEL 2	7	3
	LEVEL 3	31	12
	LEVEL 4	13	5
	LEVEL 5	2	1

CRISIS CARE	OBSERVATION	0	0
	CLOSE SUPERVISION	12	5
	SUICIDE WATCH	0	0
	THERAPEUTIC RESTR	0	0
	EMERGENCY MEDS	0	0
	FORCED MEDS	0	0

GOODTIME		AVG. IN DAYS	TOTAL DAYS
MGT/SMGT PER YOUTH	MGT/SMGT AWARDED	0	0
	GCC REV/RPV EXT	0	0
	GCC RESTORED	0	0
	ARD EXTENSIONS	29	765
	ARD REDUCTIONS	30	30
	EARNED TIME EDUC	34	34
	EARNED TIME SUBST	0	0
	EARNED TIME INDUSTRY	0	0

	CATEGORY	NUMBER	%
RACE	WHITE	128	57
	BLACK	82	37
	HISPANIC	12	5
	AMER IND	1	0
	ASIAN	0	0
	UNKN/OTHER	0	0
TYPES	FELONS	9	4
	DELINQ	198	89
	HABIT/VIOLENT	0	0
	EVAL	13	6
	MURDER	0	0
	SECURE CARE	0	0
SEX	MALE	223	100
	FEMALE	0	0
AGE	AVG AGE	17.1	
	16 YRS. & UNDER	73	33
	17 TO 20 YRS.	150	67
	20.5 YRS. & OVER	0	0
COMMITTING COUNTY	COOK CO.	27	12
	COLLAR CO.	25	11
	METRO-EAST	17	8
	CENTRAL IL.	82	37
	SOUTH IL.	19	9
	NORTH IL.	53	24
	OTHER	0	0
OFFENSE CLASS	MURDER	0	0
	CLASS X	36	16
	CLASS 1	61	27
	CLASS 2	67	30
	CLASS 3	28	13
	CLASS 4	19	9
	CLASS A	12	5
	CLASS B	0	0
	CLASS C	0	0
	UNCLASS	0	0
	UNKNOWN	0	0
MENTAL HLTH	NO LEVEL	7	3

	CATEGORY	NUMBER	%
STG AFFILIATION	BGD	0	0
	LATIN KINGS	3	1
	BLACK DISCIPLES	0	0
	EL RUKNS	0	0
	VICE LORDS	1	0
	OTHER	37	17
	NONE	182	82
RUN RISK	EXTREMELY HIGH	0	0
	HIGH	1	0
	MODERATE	123	55
	LOW	98	44
	PENDING	1	0
SUPERVISION	EXTREME SUPV	0	0
	HIGH	210	94
	MEDIUM	12	5
	LOW	0	0
	EXTERNAL	0	0
	PAROLE HIGH	0	0
	PAROLE MED	0	0
	PAROLE LOW	0	0
	PAROLE OUT OF STA	0	0
	PENDING	1	0
	NONE	0	0
TIME LEFT TO SERVE	PAST ARD	89	40
	< 3 MOS.	40	18
	3-6 MOS.	27	12
	6-12 MOS.	36	16
	12-18 MOS.	10	4
	18-24 MOS.	4	2
	24-30 MOS.	0	0
	> 30 MOS.	7	3
	LIFE	0	0
	SDP	0	0
	OTHER	10	4
CRISIS CARE	OBSERVATION	0	0
	CLOSE SUPERVISION	42	19
	SUICIDE WATCH	12	5
	THERAPEUTIC RESTR	0	0
	EMERGENCY MEDS	0	0

LEVEL	MINIMUM	110	49
	MODERATE	100	45
	URGENT	6	3
	HOSPITALIZED	0	0
DCFS	CUSTODY	15	7
PLACEMENT POTENTIAL	LEVEL 1	65	30
	LEVEL 2	23	11
	LEVEL 3	86	39
	LEVEL 4	38	17
	LEVEL 5	7	3

	FORCED MEDS	0	0

GOODTIME		AVG. IN DAYS	TOTAL DAYS
MGT/SMGT PER YOUTH	MGT/SMGT AWARDED	0	0
	GCC REV/RPV EXT	113	450
	GCC RESTORED	0	0
	ARD EXTENSIONS	44	840
	ARD REDUCTIONS	26	105
	EARNED TIME EDUC	0	0
	EARNED TIME SUBST	0	0
	EARNED TIME INDUSTRY	0	0

SECURITY: MED INSTITUTION: HARRISBURG

	CATEGORY	NUMBER	%
RACE	WHITE	88	33
	BLACK	170	64
	HISPANIC	6	2
	AMER IND	0	0
	ASIAN	0	0
	UNKN/OTHER	0	0
TYPES	FELONS	14	5
	DELINQ	233	88
	HABIT/VIOLENT	0	0
	EVAL	16	6
	MURDER	0	0
	SECURE CARE	0	0
SEX	MALE	264	100
	FEMALE	0	0
AGE	AVG AGE	17.1	
	16 YRS. & UNDER	99	38
	17 TO 20 YRS.	164	62
	20.5 YRS. & OVER	0	0
COMMITTING COUNTY	COOK CO.	15	6
	COLLAR CO.	4	2
	METRO-EAST	26	10
	CENTRAL IL.	138	52
	SOUTH IL.	53	20
	NORTH IL.	28	11
	OTHER	0	0
OFFENSE CLASS	MURDER	0	0
	CLASS X	26	10
	CLASS 1	78	30
	CLASS 2	86	33
	CLASS 3	36	14
	CLASS 4	26	10
	CLASS A	12	5
	CLASS B	0	0
	CLASS C	0	0
	UNCLASS	0	0
	UNKNOWN	0	0
MENTAL HLTH	NO LEVEL	123	47

	CATEGORY	NUMBER	%
STG AFFILIATION	BGD	0	0
	LATIN KINGS	2	1
	BLACK DISCIPLES	2	1
	EL RUKNS	0	0
	VICE LORDS	1	0
	OTHER	67	25
	NONE	192	73
RUN RISK	EXTREMELY HIGH	0	0
	HIGH	13	5
	MODERATE	211	80
	LOW	15	6
	PENDING	25	9
SUPERVISION	EXTREME SUPV	0	0
	HIGH	168	64
	MEDIUM	94	36
	LOW	0	0
	EXTERNAL	0	0
	PAROLE HIGH	0	0
	PAROLE MED	0	0
	PAROLE LOW	0	0
	PAROLE OUT OF STA	0	0
	PENDING	2	1
	NONE	0	0
TIME LEFT TO SERVE	PAST ARD	75	28
	< 3 MOS.	76	29
	3-6 MOS.	58	22
	6-12 MOS.	33	13
	12-18 MOS.	2	1
	18-24 MOS.	1	0
	24-30 MOS.	1	0
	> 30 MOS.	8	3
	LIFE	0	0
	SDP	0	0
	OTHER	10	4
CRISIS CARE	OBSERVATION	1	0
	CLOSE SUPERVISION	5	2
	SUICIDE WATCH	0	0
	THERAPEUTIC RESTR	0	0
	EMERGENCY MEDS	0	0

LEVEL	MINIMUM	130	49
	MODERATE	11	4
	URGENT	0	0
	HOSPITALIZED	0	0
DCFS	CUSTODY	18	7
PLACEMENT POTENTIAL	LEVEL 1	178	77
	LEVEL 2	22	10
	LEVEL 3	22	10
	LEVEL 4	6	3
	LEVEL 5	2	1

	FORCED MEDS	0	0

GOODTIME		AVG. IN DAYS	TOTAL DAYS
MGT/SMGT PER YOUTH	MGT/SMGT AWARDED	0	0
	GCC REV/RPV EXT	141	990
	GCC RESTORED	0	0
	ARD EXTENSIONS	41	1,242
	ARD REDUCTIONS	27	401
	EARNED TIME EDUC	0	0
	EARNED TIME SUBST	0	0
	EARNED TIME INDUSTRY	0	0

SECURITY: MED INSTITUTION: MURPHYSBORO

	CATEGORY	NUMBER	%
RACE	WHITE	8	17
	BLACK	35	76
	HISPANIC	3	7
	AMER IND	0	0
	ASIAN	0	0
	UNKN/OTHER	0	0
TYPES	FELONS	0	0
	DELINQ	35	76
	HABIT/VIOLENT	0	0
	EVAL	11	24
	MURDER	0	0
	SECURE CARE	0	0
SEX	MALE	46	100
	FEMALE	0	0
AGE	AVG AGE	16.3	
	16 YRS. & UNDER	25	54
	17 TO 20 YRS.	21	46
	20.5 YRS. & OVER	0	0
COMMITTING COUNTY	COOK CO.	14	30
	COLLAR CO.	3	7
	METRO-EAST	2	4
	CENTRAL IL.	15	33
	SOUTH IL.	4	9
	NORTH IL.	8	17
	OTHER	0	0
OFFENSE CLASS	MURDER	0	0
	CLASS X	0	0
	CLASS 1	15	33
	CLASS 2	13	28
	CLASS 3	10	22
	CLASS 4	5	11
	CLASS A	3	7
	CLASS B	0	0
	CLASS C	0	0
	UNCLASS	0	0
	UNKNOWN	0	0
MENTAL HLTH	NO LEVEL	33	72

	CATEGORY	NUMBER	%
STG AFFILIATION	BGD	0	0
	LATIN KINGS	3	7
	BLACK DISCIPLES	1	2
	EL RUKNS	0	0
	VICE LORDS	0	0
	OTHER	15	33
	NONE	27	59
RUN RISK	EXTREMELY HIGH	0	0
	HIGH	0	0
	MODERATE	5	11
	LOW	41	89
	PENDING	0	0
SUPERVISION	EXTREME SUPV	0	0
	HIGH	0	0
	MEDIUM	46	100
	LOW	0	0
	EXTERNAL	0	0
	PAROLE HIGH	0	0
	PAROLE MED	0	0
	PAROLE LOW	0	0
	PAROLE OUT OF STA	0	0
	PENDING	0	0
	NONE	0	0
TIME LEFT TO SERVE	PAST ARD	7	15
	< 3 MOS.	17	37
	3-6 MOS.	10	22
	6-12 MOS.	0	0
	12-18 MOS.	0	0
	18-24 MOS.	0	0
	24-30 MOS.	0	0
	> 30 MOS.	0	0
	LIFE	0	0
	SDP	0	0
	OTHER	12	26
CRISIS CARE	OBSERVATION	0	0
	CLOSE SUPERVISION	2	4
	SUICIDE WATCH	0	0
	THERAPEUTIC RESTR	0	0
	EMERGENCY MEDS	0	0

LEVEL	MINIMUM	13	28
	MODERATE	0	0
	URGENT	0	0
	HOSPITALIZED	0	0
DCFS	CUSTODY	0	0
PLACEMENT POTENTIAL	LEVEL 1	35	92
	LEVEL 2	1	3
	LEVEL 3	1	3
	LEVEL 4	0	0
	LEVEL 5	1	3

	FORCED MEDS	0	0

GOODTIME		AVG. IN DAYS	TOTAL DAYS
MGT/SMGT PER YOUTH	MGT/SMGT AWARDED	0	0
	GCC REV/RPV EXT	159	159
	GCC RESTORED	0	0
	ARD EXTENSIONS	8	101
	ARD REDUCTIONS	0	0
	EARNED TIME EDUC	0	0
	EARNED TIME SUBST	0	0
	EARNED TIME INDUSTRY	0	0

SECURITY: MAX INSTITUTION: JOLIET

	CATEGORY	NUMBER	%
RACE	WHITE	7	3
	BLACK	192	81
	HISPANIC	38	16
	AMER IND	0	0
	ASIAN	0	0
	UNKN/OTHER	1	0
TYPES	FELONS	40	17
	DELINQ	179	75
	HABIT/VIOLENT	2	1
	EVAL	11	5
	MURDER	2	1
	SECURE CARE	0	0
SEX	MALE	238	100
	FEMALE	0	0
AGE	AVG AGE	17.5	
	16 YRS. & UNDER	58	24
	17 TO 20 YRS.	180	76
	20.5 YRS. & OVER	0	0
COMMITTING COUNTY	COOK CO.	164	69
	COLLAR CO.	25	11
	METRO-EAST	2	1
	CENTRAL IL.	15	6
	SOUTH IL.	1	0
	NORTH IL.	30	13
	OTHER	1	0
OFFENSE CLASS	MURDER	6	3
	CLASS X	37	16
	CLASS 1	60	25
	CLASS 2	60	25
	CLASS 3	40	17
	CLASS 4	34	14
	CLASS A	1	0
	CLASS B	0	0
	CLASS C	0	0
	UNCLASS	0	0
	UNKNOWN	0	0
MENTAL HLTH	NO LEVEL	96	40

	CATEGORY	NUMBER	%
STG AFFILIATION	BGD	0	0
	LATIN KINGS	17	7
	BLACK DISCIPLES	13	5
	EL RUKNS	0	0
	VICE LORDS	1	0
	OTHER	149	63
	NONE	58	24
RUN RISK	EXTREMELY HIGH	3	1
	HIGH	15	6
	MODERATE	196	82
	LOW	24	10
	PENDING	0	0
SUPERVISION	EXTREME SUPV	0	0
	HIGH	180	76
	MEDIUM	58	24
	LOW	0	0
	EXTERNAL	0	0
	PAROLE HIGH	0	0
	PAROLE MED	0	0
	PAROLE LOW	0	0
	PAROLE OUT OF STA	0	0
	PENDING	0	0
	NONE	0	0
TIME LEFT TO SERVE	PAST ARD	89	37
	< 3 MOS.	46	19
	3-6 MOS.	30	13
	6-12 MOS.	23	10
	12-18 MOS.	13	5
	18-24 MOS.	8	3
	24-30 MOS.	3	1
	> 30 MOS.	18	8
	LIFE	0	0
	SDP	0	0
	OTHER	8	3
CRISIS CARE	OBSERVATION	1	0
	CLOSE SUPERVISION	0	0
	SUICIDE WATCH	2	1
	THERAPEUTIC RESTR	0	0
	EMERGENCY MEDS	0	0

LEVEL	MINIMUM	142	60
	MODERATE	0	0
	URGENT	0	0
	HOSPITALIZED	0	0
DCFS	CUSTODY	13	5
PLACEMENT POTENTIAL	LEVEL 1	171	72
	LEVEL 2	12	5
	LEVEL 3	36	15
	LEVEL 4	13	5
	LEVEL 5	5	2

	FORCED MEDS	0	0

GOODTIME		AVG. IN DAYS	TOTAL DAYS
MGT/SMGT PER YOUTH	MGT/SMGT AWARDED	0	0
	GCC REV/RPV EXT	140	1,680
	GCC RESTORED	0	0
	ARD EXTENSIONS	85	1,530
	ARD REDUCTIONS	50	300
	EARNED TIME EDUC	0	0
	EARNED TIME SUBST	0	0
	EARNED TIME INDUSTRY	0	0

	CATEGORY	NUMBER	%
RACE	WHITE	7	11
	BLACK	48	75
	HISPANIC	9	14
	AMER IND	0	0
	ASIAN	0	0
	UNKN/OTHER	0	0
TYPES	FELONS	0	0
	DELINQ	41	64
	HABIT/VIOLENT	0	0
	EVAL	23	36
	MURDER	0	0
	SECURE CARE	0	0
SEX	MALE	64	100
	FEMALE	0	0
AGE	AVG AGE	16.0	
	16 YRS. & UNDER	46	72
	17 TO 20 YRS.	18	28
	20.5 YRS. & OVER	0	0
COMMITTING COUNTY	COOK CO.	45	70
	COLLAR CO.	7	11
	METRO-EAST	0	0
	CENTRAL IL.	0	0
	SOUTH IL.	0	0
	NORTH IL.	12	19
	OTHER	0	0
OFFENSE CLASS	MURDER	0	0
	CLASS X	1	2
	CLASS 1	17	27
	CLASS 2	24	38
	CLASS 3	9	14
	CLASS 4	9	14
	CLASS A	4	6
	CLASS B	0	0
	CLASS C	0	0
	UNCLASS	0	0
	UNKNOWN	0	0
MENTAL HLTH	NO LEVEL	19	30

	CATEGORY	NUMBER	%
STG AFFILIATION	BGD	0	0
	LATIN KINGS	8	13
	BLACK DISCIPLES	1	2
	EL RUKNS	0	0
	VICE LORDS	0	0
	OTHER	24	38
	NONE	31	48
RUN RISK	EXTREMELY HIGH	0	0
	HIGH	0	0
	MODERATE	3	5
	LOW	60	94
	PENDING	1	2
SUPERVISION	EXTREME SUPV	0	0
	HIGH	57	89
	MEDIUM	5	8
	LOW	0	0
	EXTERNAL	0	0
	PAROLE HIGH	0	0
	PAROLE MED	0	0
	PAROLE LOW	0	0
	PAROLE OUT OF STA	0	0
	PENDING	2	3
	NONE	0	0
TIME LEFT TO SERVE	PAST ARD	8	13
	< 3 MOS.	22	34
	3-6 MOS.	21	33
	6-12 MOS.	13	20
	12-18 MOS.	0	0
	18-24 MOS.	0	0
	24-30 MOS.	0	0
	> 30 MOS.	0	0
	LIFE	0	0
	SDP	0	0
	OTHER	0	0
CRISIS CARE	OBSERVATION	0	0
	CLOSE SUPERVISION	0	0
	SUICIDE WATCH	0	0
	THERAPEUTIC RESTR	0	0
	EMERGENCY MEDS	0	0

LEVEL	MINIMUM	44	69
	MODERATE	1	2
	URGENT	0	0
	HOSPITALIZED	0	0
DCFS	CUSTODY	1	2
PLACEMENT POTENTIAL	LEVEL 1	60	94
	LEVEL 2	2	3
	LEVEL 3	2	3
	LEVEL 4	0	0
	LEVEL 5	0	0

	FORCED MEDS	0	0

GOODTIME		AVG. IN DAYS	TOTAL DAYS
MGT/SMGT PER YOUTH	MGT/SMGT AWARDED	0	0
	GCC REV/RPV EXT	0	0
	GCC RESTORED	0	0
	ARD EXTENSIONS	13	90
	ARD REDUCTIONS	11	42
	EARNED TIME EDUC	0	0
	EARNED TIME SUBST	0	0
	EARNED TIME INDUSTRY	0	0

SECURITY: MAX INSTITUTION: WARRENVILLE

	CATEGORY	NUMBER	%
RACE	WHITE	19	35
	BLACK	31	56
	HISPANIC	5	9
	AMER IND	0	0
	ASIAN	0	0
	UNKN/OTHER	0	0
TYPES	FELONS	1	2
	DELINQ	47	85
	HABIT/VIOLENT	0	0
	EVAL	7	13
	MURDER	0	0
	SECURE CARE	0	0
SEX	MALE	0	0
	FEMALE	55	100
AGE	AVG AGE	16.9	
	16 YRS. & UNDER	22	40
	17 TO 20 YRS.	32	58
	20.5 YRS. & OVER	0	0
COMMITTING COUNTY	COOK CO.	21	38
	COLLAR CO.	3	5
	METRO-EAST	5	9
	CENTRAL IL.	15	27
	SOUTH IL.	2	4
	NORTH IL.	8	15
	OTHER	1	2
OFFENSE CLASS	MURDER	0	0
	CLASS X	1	2
	CLASS 1	6	11
	CLASS 2	9	16
	CLASS 3	21	38
	CLASS 4	7	13
	CLASS A	10	18
	CLASS B	0	0
	CLASS C	0	0
	UNCLASS	0	0
	UNKNOWN	1	2
MENTAL HLTH	NO LEVEL	2	4

	CATEGORY	NUMBER	%
STG AFFILIATION	BGD	0	0
	LATIN KINGS	1	2
	BLACK DISCIPLES	0	0
	EL RUKNS	0	0
	VICE LORDS	0	0
	OTHER	2	4
	NONE	52	95
RUN RISK	EXTREMELY HIGH	0	0
	HIGH	0	0
	MODERATE	40	73
	LOW	7	13
	PENDING	8	15
SUPERVISION	EXTREME SUPV	0	0
	HIGH	1	2
	MEDIUM	39	71
	LOW	5	9
	EXTERNAL	0	0
	PAROLE HIGH	0	0
	PAROLE MED	0	0
	PAROLE LOW	0	0
	PAROLE OUT OF STA	0	0
	PENDING	10	18
	NONE	0	0
TIME LEFT TO SERVE	PAST ARD	16	29
	< 3 MOS.	13	24
	3-6 MOS.	12	22
	6-12 MOS.	8	15
	12-18 MOS.	0	0
	18-24 MOS.	0	0
	24-30 MOS.	0	0
	> 30 MOS.	0	0
	LIFE	0	0
	SDP	0	0
	OTHER	6	11
CRISIS CARE	OBSERVATION	0	0
	CLOSE SUPERVISION	4	7
	SUICIDE WATCH	3	5
	THERAPEUTIC RESTR	0	0
	EMERGENCY MEDS	0	0

LEVEL	MINIMUM	17	31
	MODERATE	36	65
	URGENT	0	0
	HOSPITALIZED	0	0
DCFS	CUSTODY	7	13
PLACEMENT POTENTIAL	LEVEL 1	42	78
	LEVEL 2	2	4
	LEVEL 3	4	7
	LEVEL 4	6	11
	LEVEL 5	0	0

	FORCED MEDS	0	0

GOODTIME		AVG. IN DAYS	TOTAL DAYS
MGT/SMGT	MGT/SMGT AWARDED	0	0
PER YOUTH	GCC REV/RPV EXT	90	180
	GCC RESTORED	0	0
	ARD EXTENSIONS	31	520
	ARD REDUCTIONS	0	0
	EARNED TIME EDUC	0	0
	EARNED TIME SUBST	0	0
	EARNED TIME INDUSTRY	0	0

SECURITY: MIN INSTITUTION: PERE MARQUETTE

	CATEGORY	NUMBER	%
RACE	WHITE	14	70
	BLACK	5	25
	HISPANIC	1	5
	AMER IND	0	0
	ASIAN	0	0
	UNKN/OTHER	0	0
TYPES	FELONS	0	0
	DELINQ	18	90
	HABIT/VIOLENT	0	0
	EVAL	2	10
	MURDER	0	0
	SECURE CARE	0	0
SEX	MALE	0	0
	FEMALE	20	100
AGE	AVG AGE	16.5	
	16 YRS. & UNDER	11	55
	17 TO 20 YRS.	9	45
	20.5 YRS. & OVER	0	0
COMMITTING COUNTY	COOK CO.	0	0
	COLLAR CO.	0	0
	METRO-EAST	4	20
	CENTRAL IL.	8	40
	SOUTH IL.	7	35
	NORTH IL.	1	5
	OTHER	0	0
OFFENSE CLASS	MURDER	0	0
	CLASS X	0	0
	CLASS 1	2	10
	CLASS 2	5	25
	CLASS 3	8	40
	CLASS 4	4	20
	CLASS A	1	5
	CLASS B	0	0
	CLASS C	0	0
	UNCLASS	0	0
	UNKNOWN	0	0
MENTAL HLTH	NO LEVEL	0	0

	CATEGORY	NUMBER	%
STG AFFILIATION	BGD	0	0
	LATIN KINGS	0	0
	BLACK DISCIPLES	0	0
	EL RUKNS	0	0
	VICE LORDS	0	0
	OTHER	0	0
	NONE	20	100
RUN RISK	EXTREMELY HIGH	0	0
	HIGH	0	0
	MODERATE	7	35
	LOW	13	65
	PENDING	0	0
SUPERVISION	EXTREME SUPV	0	0
	HIGH	0	0
	MEDIUM	17	85
	LOW	3	15
	EXTERNAL	0	0
	PAROLE HIGH	0	0
	PAROLE MED	0	0
	PAROLE LOW	0	0
	PAROLE OUT OF STA	0	0
	PENDING	0	0
	NONE	0	0
TIME LEFT TO SERVE	PAST ARD	7	35
	< 3 MOS.	10	50
	3-6 MOS.	2	10
	6-12 MOS.	1	5
	12-18 MOS.	0	0
	18-24 MOS.	0	0
	24-30 MOS.	0	0
	> 30 MOS.	0	0
	LIFE	0	0
	SDP	0	0
	OTHER	0	0
CRISIS CARE	OBSERVATION	0	0
	CLOSE SUPERVISION	2	10
	SUICIDE WATCH	0	0
	THERAPEUTIC RESTR	0	0
	EMERGENCY MEDS	0	0

LEVEL	MINIMUM	9	45
	MODERATE	11	55
	URGENT	0	0
	HOSPITALIZED	0	0
DCFS	CUSTODY	2	10
PLACEMENT POTENTIAL	LEVEL 1	15	75
	LEVEL 2	1	5
	LEVEL 3	2	10
	LEVEL 4	1	5
	LEVEL 5	1	5

	FORCED MEDS	0	0

GOODTIME		AVG. IN DAYS	TOTAL DAYS
MGT/SMGT PER YOUTH	MGT/SMGT AWARDED	0	0
	GCC REV/RPV EXT	90	90
	GCC RESTORED	0	0
	ARD EXTENSIONS	46	230
	ARD REDUCTIONS	14	69
	EARNED TIME EDUC	0	0
	EARNED TIME SUBST	0	0
	EARNED TIME INDUSTRY	0	0

Appendix G: Performance-based Standards Confinement Time Data

Performance-based Standards: Illinois Average Duration of Confinement, Oct. 2007 - April 2010

	Oct-07	Apr-08	Oct-08	Apr-09	Oct-09	Apr-10	Reduction in Confinement Time
	Average Duration of Confinement (hours)						**Percentage change***
IYC - Chicago	**65.618**	29.25	25.2	19.235	9	4.25	94%
IYC - Harrisburg General Population	**127.472**	69.833	90.213	72.705	69.209	51.917	59%
IYC - Joliet General Population	119.229	43.868	150.854	**194.312**	104.711	70.429	64%
IYC - Joliet Parole Readjustment	87.687	41.497	**120.935**	101.73	0	0	100%
IYC - Kewanee Mental Health	**134.783**	93.642	82.651	74.682	97.66	89.317	34%
IYC - Kewanee Sex Offender	51.396	44.696	**62.033**	41.455	47.603	22.897	63%
IYC - Murphysboro	14.06	12.563	**66.967**	48.906	17.072	4.828	93%
IYC - Pere Marquette	24.721	**48.009**	0	14.219	0.744	5.79	88%
IYC - St. Charles Correction	65.064	47.517	**54.888**	19.714	35.054	36.989	33%
IYC - Warrenville General Population	35.664	52.313	54.671	**84.81**	20.432	12.915	85%
IYC - Harrisburg Reception	98.083	50.603	**77.8**	65.39	51.525	14.665	81%
IYC - St. Charles Reception	52.073	71.375	60.16	**72.845**	26.474	21.456	71%
IYC - Warrenville Reception	49.52	61.958	**165.17**	109.667	0	0	100%

*Percentage change in average confinement time for each site was calculated using the highest average confinement time reported between October 2007 and April 2009 (**bold text**) as the baseline for comparison with data reported in the most recent data collection period (April 2010).

Copyright © 2010 Council of Juvenile Correctional Administrators (CJCA)

Appendix H: Profiles for Kewanee, Murphysboro and St. Charles

Table 2

Profiles for Kewanee, Murphysboro, and St. Charles

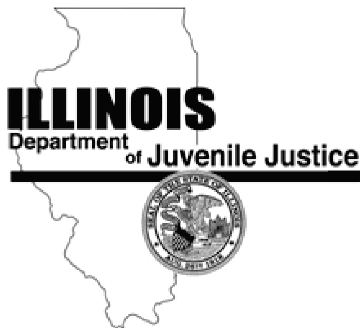
		Kewanee		Murphysboro		St. Charles	
		N	%	N	%	N	%
Total		**253**	**100.0%**	**87**	**100.0%**	336	100.0%
Age							
Age at Admission	13-15	61	24.1%	26	29.9%	76	22.6%
	16	69	27.3%	24	27.6%	104	31.0%
	17	49	19.4%	30	34.5%	100	29.8%
	18	35	13.8%	6	6.9%	30	8.9%
	19-21	39	15.4%	1	1.1%	24	7.1%
	Missing	0	0.0%	0	0.0%	2	0.6%
Offense Characteristics							
Holding Offense Class	Murder	0	0.0%	0	0.0%	3	0.9%
	Class X	52	20.6%	0	0.0%	36	10.7%
	Class 1	63	24.9%	22	25.3%	71	21.1%
	Class 2	62	24.5%	35	40.2%	94	28.0%
	Class 3	35	13.8%	18	20.7%	57	17.0%
	Class 4	27	10.7%	9	10.3%	52	15.5%
	Misdemeanor	14	5.5%	3	3.4%	21	6.3%
	Missing	0	0.0%	0	0.0%	2	0.6%
Holding Offense Type	**Violent Crimes**	**202**	**79.8%**	**32**	**36.8%**	**169**	**50.3%**
	Non-violent Crimes	51	20.2%	55	63.2%	167	49.7%
Prior DJJ Commitment	No	159	62.8%	59	67.8%	228	67.9%
	Yes	**94**	**37.2%**	**28**	**32.2%**	**108**	**32.1%**
Sex Offender Register Flag	No	71	28.1%	87	100.0%	328	97.6%
	Yes	182	71.9%	0	0.0%	8	2.4%
	Missing	0	0.0%	0	0.0%	0	0.0%
Risk Classification							
Risk Classification	Low	76	30.0%	34	39.1%	70	20.8%
	Moderate	83	32.8%	34	39.1%	103	30.7%
	High	51	20.2%	13	14.9%	96	28.6%
	Very High	**43**	**17.0%**	**6**	**6.9%**	**67**	**19.9%**

D:\Profiles_Institution041108.doc

Profiles for Kewanee, Murphysboro, and St. Charles							
		Kewanee		Murphysboro		St. Charles	
		N	%	N	%	N	%
Total		**253**	**100.0%**	87	100.0%	**336**	**100.0%**
Juvenile Risk and Needs Characteristics							
Number of Criminal Arrests at Admission	None or One	97	38.3%	20	23.0%	63	18.8%
	Two to Four	85	33.6%	28	32.2%	95	28.3%
	Five or More	71	28.1%	39	44.8%	178	53.0%
Age at First DJJ Commitment	16 Years or Older	155	61.3%	54	62.1%	216	64.3%
	15 Years or Younger	98	38.7%	33	37.9%	120	35.7%
Drug/Alcohol Abuse	None	68	26.9%	4	4.6%	18	5.4%
	Drug or Alcohol	34	13.4%	19	21.8%	51	15.2%
	Drug and Alcohol	**151**	**59.7%**	**64**	**73.6%**	**267**	**79.5%**
Mental Health Level / Psychological Drug Prescription	None	26	10.3%	50	57.5%	93	27.7%
	Mental Health Level or Psychological Drug	82	32.4%	27	31.0%	157	46.7%
	Mental Health Level and Psychological Drug	**145**	**57.3%**	**10**	**11.5%**	**86**	**25.6%**
Both Substance Abuse and Mental Health Problem	No	84	33.2%	51	58.6%	106	31.5%
	Yes	**169**	**66.8%**	**36**	**41.4%**	**230**	**68.5%**
Street Gang Member	No	204	80.6%	35	40.2%	76	22.6%
	Yes	49	19.4%	52	59.8%	260	77.4%
Number of Prior Arrests Violent Offenses	None	80	31.6%	31	35.6%	85	25.3%
	One	66	26.1%	20	23.0%	84	25.0%
	Two or More	**107**	**42.3%**	**36**	**41.4%**	**167**	**49.7%**
Number of Prior Arrests Sex Offenses	None	162	64.0%	86	98.9%	322	95.8%
	One or More	91	36.0%	1	1.1%	14	4.2%
Number of Prior Arrests Robbery	None	239	94.5%	78	89.7%	283	84.2%
	One	12	4.7%	8	9.2%	40	11.9%
	Two or More	2	0.8%	1	1.1%	13	3.9%
Number of Prior Arrests Burglary	None	200	79.1%	61	70.1%	227	67.6%
	One	30	11.9%	15	17.2%	68	20.2%
	Two or More	23	9.1%	11	12.6%	41	12.2%
Number of Prior Arrests Property Offenses	None to Two	192	75.9%	62	71.3%	221	65.8%
	Three or More	61	24.1%	25	28.7%	115	34.2%

D:\Profiles_Institution041108.doc

Appendix I: Murphysboro Transition Memo



Pat Quinn
Governor

Kurt C. Friedenauer
Director

IYC Murphysboro, 636 Elza Brantley Dr, Murphysboro IL 62966
Phone: (618) 684-8500 / TDD: (800) 526-0844

MEMORANDUM

DATE: June 29, 2010

TO: Kurt Friedenauer
Director

FROM: Patricia DeMent
Acting Superintendent

SUBJECT: Transition Information

The past philosophy at IYC-Murphysboro was that of a military style regimen with a focus on education and rehabilitative treatment. The new philosophy is that education and rehabilitation remains without the strict military regimen. All terminology relating to the military was discontinued, i.e. Cadet, Platoon, squad, etc.

Boot camp components that remain or were modified include: single file line movement (without marching); minimal talking during line movement while keeping hands to self. Dining room procedures remain orderly with minimal talking during meals. Youth are still expected to address staff by using ma'am and sir. Arguing with staff is not tolerated. Youth must follow staff direction at all times.

Leatherneck Cards have been removed, however staff still use firm intervention and verbal correction. The Youth Disciplinary Report is the final step in the disciplinary process at IYC-Murphysboro. Youth hair is kept clean and neat but is no longer shaved unless requested. Facial shaving is encouraged but not mandatory. Youth still awaken in the morning at first call and stand in front of their bunks for count. They make their beds and ensure units, lockers and restroom areas are kept neat, clean and orderly. Physical training is voluntary and is encouraged.

Lights out at night time is mandatory; no reading books or magazines, etc after lights out or during Substance Abuse groups or BUILD. Youth are now allowed to sit on their bunks during the day and evening.

The former Merit System and Cadet Duty Book which includes military ranks have been modified to include a more traditional level system.

Components of the boot camp that were eliminated include the following: calling the unit to attention upon entry of a Superintendent.; taking one step back and doing an about face after receiving orders; standing at attention when addressing staff; left face, right face when ordered has also been eliminated. Youth still maintain common courtesy and politeness.

Transition Goals for IYC-Murphysboro

In order for IYC-Murphysboro to successfully transition away from the Boot Camp model the following goals were implemented:

May 1, 2010

- Establish new Orientation procedure to be presented by Youth & Family Specialists
- Rewrite Youth Orientation Manual
- Develop an incentive based level system that encourages youth to perform to the best of their ability
- Establish new LTS schedule to include more structured activities
- Superintendent and DAO's to attend Roll Calls to address transition, staff expectations and timelines

May 3, 2010

- Transition staff into new uniforms
- Transition youth into new dress code
- ➢ Blue pants, retain current brown t-shirts or gray sweatshirts, tennis shoes

May 6, 2010 (Statewide Day)

- Stop Boot Camp Intake and begin orientation that will be conducted by Youth and Family Specialists
- Discontinue Military Program components for whole facility
- ➢ Marching, about face, running from point A to point B, etc.
- ➢ Cease all Boot Camp style discipline/ follow DR 504 process
- ➢ Offer voluntary morning exercise program

- Implement incentive level system
- Implement new facility activities schedule

June 1, 2010

- Concessions for youth
- ➢ Maintenance to secure lockers on unit to store purchases
- ➢ Allow money to be sent in from families

Long Range Goals

- Establish more off grounds activities
- Purchase different type tables for Dietary

The transition is still going smoothly at IYC Murphysboro. Two months into the transition, staff are buying into the changes more everyday. Major points to report are as follows:

- Positive results were shown in the use of Confinement and "Time Out" during the month of May. During April 2010, 11 youth were sent to Confinement and 36 youth to Time Out for a total of 98.5 hours. During the May 2010 transition, nine youth were sent to Confinement and 25 youth to Time Out for a total of 32.5 hours. Use of isolation hours were reduced by one third in May.
- During the PbS reporting in April, several staff reported that they feared for their safety….staff have commented to me that if the same survey were given today they would answer differently. An informal staff survey may be given this month to compare responses before and after transition.
- IYC-Murphysboro Maintenance staff and Illinois Department of Transportation staff have begun tearing down the obstacle course. In place of the Obstacle Course, tentative plans include adding a volleyball court, a bigger basketball court and a baseball field, if space allows.
- Maintenance staff and youth enrolled in the wood working class are repairing weight lifting benches.
- Consolidated Communications moved public phones on June 6, 2010 from YSF Offices onto the units for easier youth access to phones.
- Concessions items include snacks and hygiene items.
- Received a bid of approximately $1,500 to install satellite services for the facility.
- Received a bid of $4166.40 for purchase of game tables for every unit.
- We have found four youth who are talented artists to team with one of our artistic JJ Specialists to draw appropriate murals on the walls in the gym and units. We are awaiting paint to be purchased or donated. The murals will hopefully soften up the feel of the facility.
- I met with Dona Howell and Wells Center staff on June 2, 2010 to discuss adjustments for treatment group schedules due to transition away from boot camp. Their programming will include didactic interventions along with treatment and will pair up with LTS staff for activities as a way to teach appropriate stress relieving activities as opposed to turning to

substance abuse. Dona Howell and Sara Carter are at the facility June 29 & 30 to train Substance Abuse Counselors in these new interventions. The target date for new Wells Center schedules and curriculum will be July 1, 2010. Per contract with the Wells Center the number of hours that they provide services for MPB will not change. They will be offering fresh materials and curriculum with Dona Howell overseeing the transition of Substance Abuse programming.

- A new Barber Contract PBC has been started due to the old contract requiring close shave buzz cuts.
- A new goal oriented program as an incentive for good behavior has begun. Youth will set different goals to obtain everyday. The program is called "Aim High to Achieve". Rewards for accomplishing goals will be available.

Another major renovation planned to be phased in during the latter part of the transition period at IYC-Murphysboro includes a new Activities Center with video games, etc. However, staff are currently improvising by using of the empty dormitory units.

Murphysboro staff continue to provide this CAO with new, creative ideas of how to provide better programming for the youth. The boot camp transition is an ongoing process that will flourish with time.

Appendix J: Intake Procedures Survey

Information Survey

Intake Procedures in Your Facility

January, 2010

Dear Illinois DJJ Superintendents:

The Illinois Department of Juvenile Justice has asked a team of MacArthur Foundation experts to assist the Department in a review of its policies, programs and practices regarding mental health needs of youth in DJJ custody. I am part of that team, and I have been asked to focus on a review of intake screening/assessment practices as they pertain to youths' mental health needs. My objective is to be able eventually to advise the Director of IL DJJ regarding any possible ways in which the Department might want to modify practices and manage resources in the best interest of youth mental health needs as they enter DJJ facilities.

Toward that end, the Department requests your cooperation in completing the brief survey below. It primarily asks for basic information about the intake process at your facility. It also asks that, when you return this completed survey, you attach or enclose certain documents that you use in intake.

We define "initial intake process" as the time from entry at the reception door to the point at which the youth is completely logged in and is in his/her assigned facility location.

The information that you provide will be included in a report that I will prepare and submit to the Director of the IL Dept of Juvenile Justice. The IL DJJ will use it to make internal policy decisions and, at the Department's discretion, it may reveal the contents to other parties. I will be revealing the information to no one other than the Department.

Thank you for devoting your time to meeting this request. I urge you to return the survey with the other documents by **January 15, 2010**. Please return them to Janice Shallcross, Acting Deputy Director-Programs, 3802 Lincoln Highway, St. Charles, IL 60175

Thomas Grisso, Ph.D.
University of Massachusetts Medical School
IL DJJ Consultant

FACILITY INFORMATION

Name of Facility

Person completing this form

Name

Phone

Email

Location (mailing address) and contact info

Facility
Street address
City, state, zip

INFORMATION ABOUT POPULATION

Approximate number of youth admitted monthly (for facilities with a Reception Unit and Special Treatment Unit report numbers out separately)

Approximate number of youth in the facility on an average day (average daily census) (for facilities with a Reception Unit and Special Treatment Unit report numbers out separately)

STAFF INVOLVED IN INTAKE PROCESS

Supervisor with Primary Responsibility for Intake Process

Name:

Duties:

Number of staff who perform intake procedures (all shifts)

INITIAL INTAKE PROCESS

We define "<u>initial intake process</u>" as the time from entry at the reception door to the point at which the youth is completely logged in and is in his/her assigned facility location.

Initial Intake Process Description

Please describe each step in the intake process.

Who accompanies the youth through the reception door? (e.g., an intake Juvenile Justice Specialist/ Juvenile Justice Supervisor and the staff responsible for transporting the youth)

Where does the youth go then? (e.g., youth is patted down, taken to a bench in a temporary holding area)

What happens then? (e.g. when JJ Specialist/ Youth and Family Specialist/ Administrator is ready to interview--usually within 10 minutes—mechanical restraints are removed and youth is escorted to a chair by the intake interview desk)

Continue this description at this level of detail until the point at which the youth is no longer considered to be in the "intake process" (e.g., is completely logged in and is in his/her assigned facility location).

Protocols and Tools Used During Initial Intake

In the process you have described, is there a form that lists the interview questions that the youth is asked, and a way to record the youth's answers? **If yes, please attach a blank copy of the intake interview when you return this form.**

Are there any mental health screening tools, tests, or instruments that are used during the initial intake process? **If yes, please name them.**

Are there any other (non-mental-health) tools, tests or instruments that are used during the initial intake process**? If yes, please name them.**

Extended Intake Phase

After initial intake, many facilities continue to obtain information about a youth during the next few days or weeks, in order to make informed decisions about youths' programming.

Are there any other screening or assessment tools that are given to youth in your facility during the days following initial intake? **If so, please provide the names of the tools.**

Tools that assess a youth's needs?

Tools that assess a youth's substance abuse problems?

Tools that assess a youth's level of risk of aggression?

Tools that assess a youth's mental health problems?

Tools that assess a youth's level of academic performance?

INFORMATION FROM ASSESSMENT UNITS

When you receive youth who have been through one of the assessment programs (Warrenville, Harrisburg, St. Charles)....

Do you receive information from the assessment process?

If so, when do you receive it?

How is that information used in your programming for the youth?