

Illinois ModelsforChange

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.

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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

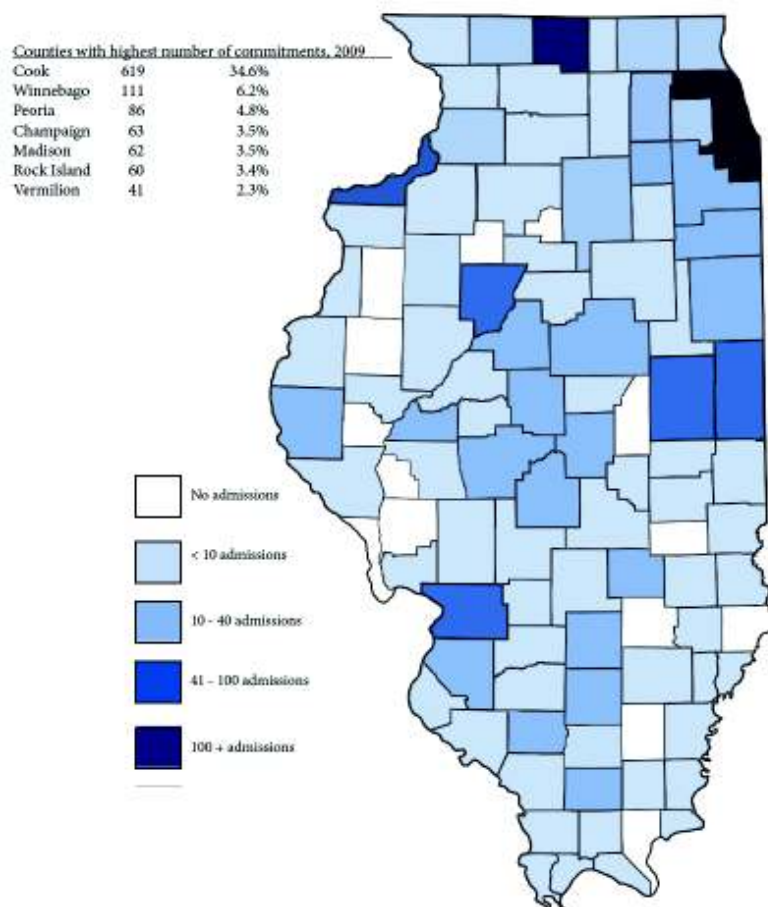
This report primarily focuses on youth committed to DJJ with an "indeterminate sentence" and placed in one of eight institutions operated by the department.³ Six of the Illinois Youth Centers (IYC) house males: Harrisburg, Murphysboro, Joliet, Kewanee, St. Charles and Chicago. Two facilities house females: 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 Coccozza 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. & Coccozza, 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

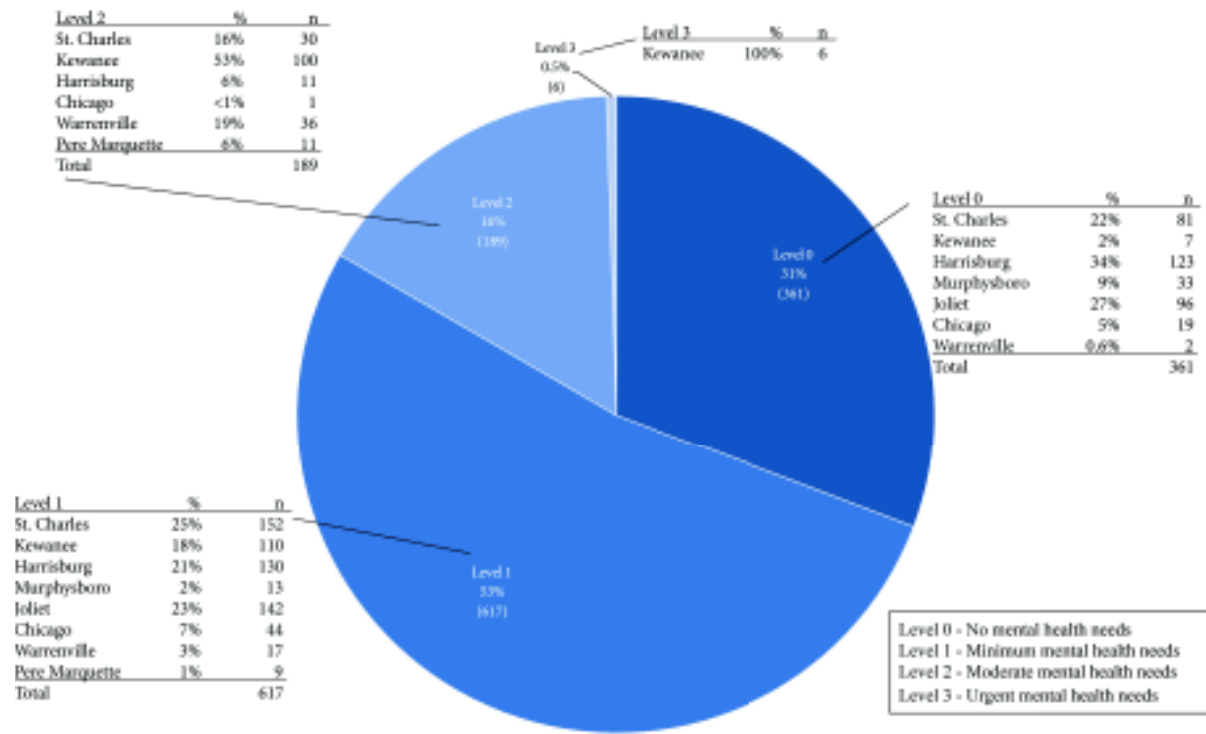
¹² DMJM Illinois | AECOM with Huskey & Associates. 2007. *Department of Juvenile Justice Comprehensive Master Plan*.

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



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 it 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.