Cook County Juvenile Temporary Detention Center
DOE V. COOK COUNTY ET AL.,
99 C 3945

MEMORANDUM OF AGREEMENT
AGGREED SUPPLEMENTAL ORDER

MODIFIED IMPLEMENTATION PLAN

January 3, 2007

EXPERTS

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A. Paragraph 7

1. ASO Requirements

"The Monitors, their designees, and the Compliance Administrator described in Paragraph 9 below, shall have reasonably prompt access to the staff and residents of the JTDC to permit them to carry-out their duties under the ASO. The Monitors, their designees, and the Compliance Administrator shall also have reasonable access to documents or other information that are relevant to the discharge of their duties. The Monitors, their designees, and the Compliance Administrator shall have the authority to collect information and to meet with the parties, their counselor, JTDC personnel and private contractors granted to the Monitors pursuant to Paragraphs 60 and 64 of the MOA. "

2. Solution/Plan

2.1 Documents and other information relevant to the discharge of the Monitors' and Compliance Administrator's duties shall include but not be limited to the following:

- The Compliance Administrator shall have independent access to all reports generated by a management information system. Any new reports shall be communicated to the Monitors and Compliance Administrator.
- All statistical information (raw data and spreadsheets) and reports generated by personnel (e.g. monthly grievance reports, monthly disciplinary reports.
- Reports and documents shall be submitted to the Compliance Administrator and Court Monitors based on the schedule outlined in Appendix D.

2.2 The facility shall comply with any and all reasonable requests from the Court Monitors to develop reports based on available data.

2.3 The Court Monitors and Compliance Administrator shall have the ability to interview residents and staff as well as review documents without staff supervision or intervention (pursuant to Paragraph 7 of the ASO and Paragraph 64 of the MOA).

2.4 Employees shall not be subject to retaliation due to communication with the Compliance Administrator or Court Monitors.

2.5 Within ten (10) days of the approval of the MIP, the Administration of the JTDC shall communicate in writing to all staff, the duties and responsibilities of the Compliance Administrator and the nature and extent of the cooperation to be provided to her by all staff.

B. Paragraph 8

"The Defendants shall implement the MIP within the timeframes provided for therein. The Defendants shall fully implement the MIP and shall also be in substantial compliance with the MOA within six (6) months of final approval of the MIP."

C. Paragraph 9

1. ASO Requirements

"The Compliance Administrator shall provide day-to-day, on-site coordination of efforts to bring the JTDC into compliance with the MIP and the MOA. The Compliance Administrator shall consult directly with the Superintendent of the JTDC and make necessary recommendations concerning the manner in which Defendants should proceed to fully implement the MIP and substantially comply with the MOA. Should the Superintendent choose not to accept and implement a material recommendation by the Compliance Administrator, the Superintendent shall provide in writing the reasons for rejecting the recommendation and propose alternatives to the Compliance Administrator, the Monitors and the parties."

2. Plan

2.1 The Superintendent or designee shall meet at least weekly with the Compliance Administrator. A summary of the weekly meetings shall be written by the Compliance Administrator and distributed to the Superintendent and Court Monitors.

2.2 It is recommended that the Superintendent provide a written response to any recommendations made by the Compliance Administrator. Should the recommendation be rejected, the Superintendent shall provide in writing the reasons for rejecting the recommendation and propose alternatives. Written responses to rejections of the recommendations from the Compliance Administrator shall be submitted within reasonable time frames.

D. Paragraph 10

1. ASO Requirements

"The Defendants along with the Monitors have met with representatives of the Illinois Department of Children and Family Services to review existing JTDC protocols for reporting alleged cases of abuse or neglect to DCFS. Defendants will amend the existing protocols to address any material deficiencies identified in the process. Any such changes will be approved by the Monitors. The Defendants agree to cooperate with any request by DCFS to reinvestigate any cases of alleged abuse or neglect that were not accepted by the DCFS hotline."

2. Plan

2.1 The Defendants shall make good faith efforts to convene a meeting with representatives of DCFS within 15 days of approval of the MIP. The purpose of the meeting shall be to review existing protocols and address any material deficiencies identified in the process. Issues to be discussed shall include the following: staff training, timely notification to the hotline, access to JTDC records (e.g. investigation reports, medical records, photos, witness statements, incident reports), access to residents, witnesses and staff, joint investigations with law enforcement, notification of DCFS findings, etc. The protocols shall include a procedure that will not jeopardize DCFS or law enforcements investigative efforts. The defendants will provide minutes or summaries of all meetings with DCFS to the Compliance Administrator and the Court Monitors.

2.2 The Defendants shall develop a protocol for prompt referral to law enforcement for incidents of any conduct that may violate the Illinois Criminal Code of 1961 or other acts prohibited by law.

2.3 The Defendants shall develop a protocol for reporting allegations made by residents against non JTDC staff (e.g. family, court personnel, social service agencies, employees of the Nancy B. Jefferson School) Reporting allegations as described in 2.2 above shall be included in this protocol.

2.4 The JTDC is strongly encouraged to hire at least one full time investigator to conduct abuse investigations or conduct that may violate the Illinois Criminal Code of 1961. The investigator should be a certified law enforcement officer. The investigator's duties may include but not be limited to abuse investigations, other employee misconduct investigations, gang intelligence, and resident rule violation hearings. A detailed job description shall be provided to the Compliance Administrator and the Court Monitors. If the JTDC rejects the recommendation of utilizing a full time investigator, the facility shall provide a credible alternative to investigate abuse allegations and staff misconduct.

3. Timeframe:

3.1 The protocols shall be submitted to the Court Monitors for approval, pursuant to Paragraph 10 of the ASO. The protocols will also be submitted to the Compliance Administrator.

3.2 It is recommended that an investigator be hired within 90 days of the approval of the MIP. Should the facility propose an alternative, the proposal shall be submitted to the Compliance Administrator and Court Monitors within 30 days of approval of the MIP.

MEMORANDUM OF AGREEMENT PROVISIONS

A. Oversight and Management: Paragraph #11

1. MOA Requirements

(a) adequately collect information from the institution regarding compliance with the Agreement or Implementation Plan;

(b) adequately collect data on all incidents raising concerns about deficiencies or problems in the care and treatment provided to detainees, including injuries, accidents, medical emergencies, discipline of detainees and staff, violence, abuse and neglect; and

(c) address and remedy any and all deficiencies or problems with compliance that arise in a timely manner.

2. Solution/Plan

2.1 Transfer the current management information system (MIS) from JTDC to the Cook County Bureau of Information Technology and Automation (management of information systems) or propose a specific alternative to accomplish the same objectives.

2.2 Re-install computers on the living units, identify through policy what information must be entered into the MIS system and identify and appropriately train staff.

2.3 The facility will develop a sequential plan to implement each segment of the system. A training plan for staff and supervisors will be included in the DSI Implementation Plan. Training for management and supervisory staff will include analysis and interpretation of data reports. This plan, including the names and qualifications of trainers to be used, will be submitted to the Compliance Administrator and the Court Monitors.

2.4 The defendants may need and benefit from technical assistance (e.g. lesson plan development, qualified trainers and policy development). The defendants are encouraged to request assistance according to Paragraph 12 of the ASO and do so with all deliberate speed.

3. Timeframes

3.1 The plan shall be submitted to the Compliance Administrator and the Court Monitors within 30 days of the approval of the MIP.

B. Quality Assurance & Improvement: Paragraphs #32, 34, 47, 55

1. MOA Requirements

The Implementation Plan will include a quality assurance and improvement program to:

(1) Health Care Unit: continuously assess the quality and adequacy of the health services provided, accurately evaluate the performance of staff in providing health services, and address identified deficiencies;

(2) Recreational and Social Programs: continuously assess the quality and adequacy of social and recreational programming provided, accurately evaluate the performance of staff in providing these programs, and promptly address identified deficiencies;

(3) Environmental Health and Safety: continuously assess the quality and adequacy of environmental health and safety, accurately evaluate the performance of staff in providing a safe and healthy environment, and promptly address identified deficiencies.

(4) Discipline and Order: continuously monitor use of discipline, and promptly address misuse or overuse of discipline and other identified deficiencies.

2. Solution/Plan:

2.1 The CCJTDC will develop a quality assurance and improvement program. It is recommended that the facility consider utilizing the Florida's Department of Quality Assurance's "Standards of Excellence" Program, performance based standards or other comparable programs.

2.2 The Superintendent or designee will lead the Quality Assurance Program and within 60 days of approval of the MIP, appoint a Quality Assurance Committee.

2.3 The facility shall develop monthly performance indicators to measure achievement in desired areas.

2.4 Health Care: Programs, systems, and protocols shall be regularly monitored to assure compliance with this Agreement. A quality assurance and improvement program shall be developed to:

a. continuously assess the quality and adequacy of the health services provided,
b. accurately evaluate the performance of staff in providing health services, and
c. address identified deficiencies.

2.5 The facility shall maintain National Commission of Correctional Health Care accreditation in full force.

3. Timeframe:

3.1 Within 60 days of the approval of the MIP, the facility will provide the Compliance Administrator and the Court Monitors with an Implementation Plan, including performance indicators incorporating 2.1 through 2.5 above.

C. Preventing Overcrowding: Paragraph #39

1. MOA Requirements

If the CCJTDC census exceeds 90% of its rated capacity for more than 10 days, or the CCJTDC has any detainees sleeping somewhere other than alone in an appropriate single room at the CCJTDC for more than 10 days, the Center will assure:

(1) that an appropriate range of Cook County programs providing less restrictive alternatives to detention, including home confinement and after school programs, have at least as many slots immediately available for detainees as the number of detainees over 90% of capacity housed at the CCJTDC;

(2) that the Presiding Judges of the Criminal and Juvenile Divisions and all judges of those divisions, supervising and officials in the Office of the State's Attorney, the Office of the Public Defender, Juvenile Probation Department, the Director of Public Safety and Judicial Coordination, Plaintiffs' counsel, Monitor(s) are promptly informed of the census at the CCJTDC and are asked to consider whether any such detainee can be transferred to a less restrictive alternative to detention and are reminded of the need efficiently to adjudicate any such cases.

(3) that the Juvenile Detention Alternatives Initiative Steering Committee, or other appropriate body, will evaluate the causes and circumstances leading to overcrowding and timely formulate plans to remedy any overcrowding at the CCJTDC and prevent future overcrowding; and

(4) that the defendants herein shall take all steps within their power to timely implement the plans referred to in Paragraph (3) above and shall use their best efforts to encourage the timely implementation of those elements of such plans that are not within their power.

Copies of all such evaluation and plans will be shared with counsel for the plaintiffs and the Monitors. If the census of the CCJTDC ever exceeds 90% of its available rated capacity for more than 10 days, or the CCJTDC has any detainees sleeping somewhere other than alone in an appropriate single room at the CCJTDC for more than 10 days, the Superintendent shall immediately request in writing, with copies to the Monitors and plaintiffs' counsel, an inspection by appropriate local public health officials. Any written findings of such inspections shall be publicly available and shall be promptly distributed to the Director of the Department of Public Safety and Judicial Coordination, appropriate representatives of the Court, appropriate juvenile probation officers, the Illinois Department of Corrections, plaintiffs' counsel and the Monitor(s). If the census at the CCJTDC remains at or above 90% of its available rated capacity for a

period of 90 days after such a request, the Superintendent will make another request in writing for another inspection.

2. Solution/Plan

2.1 "Rated Capacity" shall be defined as the number of fully operational units and rooms. The JTDC shall document the daily rated capacity. JTDC shall provide the Compliance Administrator with the daily rated capacity, the number of detainees that that have slept somewhere other than alone in an appropriate single room and population reports on a weekly basis.

2.2 All residents shall be assigned to a living unit and a room on that unit. The JTDC will use their best efforts to minimize the issues that result in the practice of "overflow" and "sleepers".

2.3 The facility shall develop a policy consistent with the notification requirements established in the MOA in the event the CCJTDC census exceeds 90% of its rated capacity. The facility will provide the Compliance Monitor with documentation of required notifications and their efforts to comply with the specifications of the MOA.

3. Timeframe:

3.1 Reporting shall be initiated within the first 30 days.

3.2 Data on daily population and rated capacity shall be compiled and submitted to the Compliance Administrator weekly.

D. Monitoring Compliance: Paragraph #64

1. MOA Requirements:

(1) The Center shall provide information regarding compliance with the Agreement, the Implementation Plan and the Annual Plans to the Monitor(s) and class counsel for plaintiffs on an annual basis commencing six months after final approval of the Settlement Agreement;

(2) The Parties and the Monitor(s) will jointly develop a set of performance standards to assist in evaluating the health, safety, and well-being of detainees detained at CCJTDC within sixty days of the appointment of the Monitor(s). To the extent possible, the parties and the Monitor(s) will endeavor to use these categories to develop standards to evaluate compliance with this Agreement. The content and format of the Annual Report shall be determined by the same process governing development of Implementation and Annual Plans set forth above, and shall whenever appropriate, be designed to use and not duplicate, data, information, reports or quality assurance mechanisms already used by CCJTDC, required by state or federal law, or provided for under the terms of other court orders;

(3) The parties and the Monitor(s) will reach agreement on a set of performance standards for the CCJTDC that will assist in assessing progress toward accomplishing the purposes of the Agreement; and

(4) Progress toward meeting these performance standards will, to the extent possible, be evaluated in light of outcome measures agreed upon by the parties and the Monitor(s). Outcome measures of this kind might include; for example, reducing the use of disciplinary room confinement, reducing injuries to staff and detainees, or increasing the percentage of detainees who attend a full day of school.

2. Solution/Plan:

2.1 The CCJTDC will develop a quality assurance and improvement program. The quality assurance and improvement program is contingent upon an adequate MIS system. It is recommended that the facility consider utilizing the Florida's Department of Quality Assurance's "Standards of Excellence" Program, performance based standards, or other comparable programs.

2.2 The Superintendent or designee will lead the Quality Assurance Program and appoint a Quality Assurance Committee within 60 days of approval of the MIP.

2.3 The facility shall develop monthly performance indicators to measure achievement in desired areas.

3. Timeframe:

3.1 Within 60 days of the approval of the MIP, the facility will provide the Monitors with an Implementation Plan, including performance indicators incorporating 2.1 through 2.4 above.

3.2 Written documentation regarding the progress toward meeting these performance measures shall be submitted to the Compliance Administrator and Court Monitors on a monthly basis following the submission of the Implementation Plan.

E. Extraordinary Circumstances: Paragraph #65

1. MOA Requirements

For the purposes of this Plan, the phrase "extraordinary circumstances" means an unusual, unexpected and emergent situation that seriously jeopardizes the safety or security of the CCJTDC and the detainees, staff or others present within the JRDC. Any response to an extraordinary circumstance must be the least restrictive and intrusive appropriate to address the safety or security threat and should last only as long as the emergency circumstances exist. In such circumstances, resort to the use of force is prohibited except as a last resort when all other means are inadequate to prevent imminent injury to staff or detainees, prevent an escape, subdue a violent recalcitrant, or prevent imminent and serious property damage that jeopardizes the

security of the institution. The Center will assure that appropriate CCJTDC staff or other Cook County personnel or officials take the following actions whenever there is an extraordinary circumstance:

(1) As soon as possible, but no later than before being relieved of duties at the end of the scheduled shift, relevant facts will be thoroughly documented in a written report that will include a detailed description of the situation that gave rise to the threat to safety or security, the responses that were attempted, an explanation of the reasons no less restrictive response was appropriate, and a description of any actions that have been or in the near future will be taken to end any restrictions of detainee rights or privileges necessitated by the extraordinary circumstances.

(2) Copies of that report will be provided, with 24 hours, excluding weekends and holidays, to the Director of Public Safety and Judicial Coordination, and made available to the parent or guardian of, and counsel for, any detainees whose rights or privileges were affected by the response to the extraordinary circumstance, the Monitor(s), and plaintiffs' counsel in this litigation.

(3) Within ten working days after the extraordinary circumstance occurred, the Center will prepare and submit a written report and plan that analyzes the causes of the extraordinary circumstances and describes the specific actions to be taken reasonably to prevent such an event from happening again.

(4) If the Monitor(s) and the plaintiffs agree that this report and plan is a reasonable and appropriate response, the report and plan will be incorporated into and enforceable as part of this Agreement.

(5) If the Monitor(s) or the plaintiffs disagree with the report and plan in whole or in part, the Monitor(s) and the parties will engage in the mediation and dispute resolution process described in the MOA to determine the final contents of the plan, including the procedures therein for obtaining resolution by the Court of any disputes not resolved by mediation and negotiation.

2. Solution/Plan

2.1 The development of comprehensive emergency plans and a critical incident reporting system is required. All plans and procedures must comply with the provisions of Paragraph 65 of the MOA.

2.2 Room confinement for institutional emergencies (Paragraph 58) is considered an extraordinary circumstance and can only be authorized by the Superintendent, Assistant Superintendent or Duty Administrator.

2.3 The incident reporting process will be computerized, and the policy will be revised identifying certain incidents where a "de-briefing" will occur. The Superintendent or designee, with all involved staff members, reports and other pertinent documents will review the incident and submit a report to the Superintendent and Compliance Administrator.

2.4 Extraordinary or Unusual Occurrences. The facility shall comply with the following provision in Ill. Ad. Code, Title 20, 702.40. In addition to reporting to the Illinois Department of Corrections, the report shall be forwarded to the Compliance Administrator and Court Monitors.

All unusual incidents which involve or endanger the lives or physical welfare of staff members or youth must be reported to the IDOC Detention Standards and Services Unit utilizing form DC-7158, supplied by the Bureau. A copy of the report shall also be forwarded to the Presiding Judge of Juvenile Division of the Circuit Court of Cook County.

A) Reports shall be forwarded within 72 hours of the occurrence.

B) Extraordinary or unusual occurrences shall mean:

i) Death, regardless of cause.

ii) Attempted suicide (if hospitalization or medical treatment is required).

iii) Serious injury, to include accidental or self-inflicted.

iv) Escape.

v) Attempted escape.

vi) Fire.

vii) Riot.

viii) Battery on a staff member.

ix) Battery on youth by a staff member.

x) Battery on youth by another youth (only if hospitalization or extensive medical treatment is required).

xi) Sexual assaults.

xii) Occurrence of serious infectious disease or illness within the facility.

3. Timeframe:

3.1 Within 30 days of the approval of the MIP, Emergency Plans and a critical incident reporting policy and procedure shall be submitted to the Compliance Administrator and Court Monitors.

3.2 Reporting shall begin immediately upon approval of the MIP.

F. Staff Training and Discipline: Paragraphs #12 & 13

1. MOA Requirements

The Implementation Plan will describe appropriate hiring standards and procedures as well as a plan for staff training. Training will adequately cover all subjects necessary for the implementation of this Agreement, including:

(1) security procedures,
(2) supervision of detainee,
(3) prevention of physical and/or verbal abuse,
(4) signs of suicide risk, suicide precautions,
(5) communication skills,
(6) counseling techniques,
(7) medical emergencies,
(8) crisis prevention,
(9) social/cultural lifestyles of the juvenile population
(10) cultural diversity, and
(11) appropriate and safe use of interventions such as restraints and room confinement.

The implementation plan will require:

(1) ongoing professional training for all of medial and mental health staff, consistent with NCCHC standards Y-10 through Y-28, which will allow them to perform competently the duties required of them;

(2) a description of the actions to be taken to create a training program that reasonably assures that new and current staff maintain the appropriate levels of skills and knowledge within their field of expertise, and meet requirements for adequate professional training pursuant to continuing medical education licensure requirements of the State of Illinois; and

(3) creation and required use of a system for documenting and verifying completion of training requirements.

The Center will also maintain an adequate system of staff oversight and discipline, which reasonably assures that alleged incidents of abuse, neglect, and other staff misconduct are properly and promptly investigated and appropriate action is taken where warranted.

2. Solution/Plan

2.1 The facility will develop and maintain lesson plans for all existing and proposed training, including but not limited to in-service training, first responder training and remedial training. It is recommended that a recognized juvenile justice training organization should review these training materials and give its approval or endorsement that the materials meet minimum standards of acceptability based on current practices. Two organizations that can

provide this review and approval are the Center for Research & Professional Development at Michigan State University (the training division of the National Partnership for Juvenile Services) or the Juvenile Justice Trainers Association (JJTA), a partner organization within NPJS.

2.2 In order to comply with the ASO provision of the development of a special training curriculum for those staff members who have multiple abuse allegations, the following tasks need to be completed:

A. Pre- and post testing for each module.

B. Lesson Plans need to be developed for adolescent development, mental health issues, ethics, and principles of behavior management, ethics, anger management, stress management, problem solving strategies, resident discipline, juvenile rights, cultural diversity, juvenile supervision.

C. Training will be conducted by competent staff (staff that has successfully completed a certified train-the-trainer or platform skills course).

2.3 New policy and emergency plan manuals will be developed and all facility staff will be trained in the Center's policies. Manuals will be placed on-line. All old manuals will be collected and destroyed with the exception of those necessary as required by management, the State's Attorney's Office or by law.

2.4 Training that is relevant to other positions in the facility (e.g. caseworkers, recreational workers, clerical, all management and supervisory staff) will be developed.

2.5 The annual training for direct care staff shall include first aid and response to medical emergencies, recognition of signs and symptoms of common medical and mental health problems, suicide precautions, crisis intervention, communication skills, verbal de-escalation training, physical intervention and use of restraint training. This training shall have a competency based component. Individuals that do not demonstrate competency must be provided additional training until competency can be demonstrated.

2.6 Qualified trainers shall conduct identified training (e.g. behavior management, special treatment needs).

2.7 All staff that provide direct care to residents shall be provided with at least 40 hours of annual in-service training.

2.8 Staff will be identified and placed on each floor on the 1st (day) and 2nd (afternoon) shifts that have demonstrated competency in crisis intervention techniques (verbal, physical and mechanical restraints). Identified "first responders" shall include supervisory staff. "First responders" shall receive intensive training. "First responders" should be used in special needs units as well as units considered "highly aggressive".

2.9 A “roll call” for each shift will be established to enhance communication.

2.10 The JTDC shall incorporate a policy identifying the frequency of mandatory administrative and supervisory meetings with subordinate staff.

2.11 Staff meeting minutes or summaries shall be maintained and distributed to the Compliance Administrator.

2.12 Comprehensive policies or procedures regarding the reporting, investigation and access to records and alleged victims will be developed and submitted to the Compliance Administrator and Court Monitors within 90 days of the approval of the MIP.

2.13 A comprehensive policy regarding staff assignments pending abuse investigations or other staff misconduct shall be developed and submitted to the Compliance Administrator and Court Monitors within 90 days of the approval of the MIP. The policy shall describe an adequate system of staff oversight and discipline which reasonably assures that alleged incidents of abuse, neglect, and other staff misconduct are properly and promptly investigated and appropriate action is taken where warranted. Non-privileged information pertaining to such incidents and personnel (e.g. disciplinary referrals, disciplinary outcomes) shall be provided to the Compliance Administrator monthly.

2.14 The hiring process and criteria followed by JTDC and Cook County in general shall be submitted to the Compliance Administrator and the Court Monitors within 30 days of approval of the MIP.

3. Timeframe:

3.1 The facility shall develop a detailed annual training plan within 90 days of the approval of the MIP with monthly progress reports submitted to the Compliance Administrator and Court Monitors.

3.2 The facility shall provide monthly documentation of completed training to the Compliance Administrator.

3.3 All training curricula will be completed within 45 days of approval of the MIP.

3.4 Annual in-service training shall be initiated within 60 days of approval of the MIP. All in service training shall be conducted in accordance with the approved curricula.

3.5 Annual training for two-thirds of the direct care staff shall be completed within six months of the approval of the MIP.

G. Staffing: Paragraph #36

1. MOA Requirements:

The Implementation Plan will establish a system for:

(1) determining the appropriate number of staff,

(2) the appropriate use of staff resources to assure adequate safety for detainees and staff, and

(3) adequate delivery of programs and services.

2. Solution/Plan:

2.1 The NPJS strategy is an adaptation of the Program Specific Model (PSM) specifically designed for juvenile institutions. Using concepts and principles adopted by the National Institute of Corrections, the PSM incorporates a profiling of the facility to determine how its particular configuration creates an increased or decreased demand for staff, the establishment of the direct care staff ratio, and the computation of the institution's replacement factor. This information permits comparisons between (a) existing staffing patterns and (b) staffing projections based on requirements derived from professional standards, guidelines, and best practices. By using standards and empirical calculations to estimate various staff scheduling strategies, PSM supplies a constant and uniform estimate of the numbers of staff needed to accommodate each strategy.

Juvenile Detention Counselor. The PSM model predicts the need for 311 juvenile detention counselors. This estimate is the same as the 2005 John Howard Association staffing report. Table 2 presents the juvenile detention counselor projections from each of the external studies. All are remarkably similar in their projections. These projections differ somewhat from the internal staffing analysis done by CCJTDC staff which placed the need for juvenile detention counselors at 335. The CCJTDC projection implies that some important components of the staffing projections have not been included in the outside staff estimates. CCJTDC administration maintained that the number of staff who are not available to work in a direct supervision capacity, i.e., staff on disciplinary leave, administrative leave, workman's compensation, sick leave, light duty, and non-supervisory duty, exceeds the non-working calculations included in the relief factors in the outside staffing projections. Even though a relief factor of 1.72 is very high, the Court Monitors and CCJTDC administration maintain it still underestimates the actual need for relief staff. The need exists for a "transition" adjustment to the staffing projection based on the complexity of the Cook County hiring practices and training issues.

Given the fluid nature of the numbers of staff on inactive status and the number of staff requiring special assignment, it is recommended that the County hire juvenile detention counselor positions at 107% of the recommended level for a two year period of time to account for the transitions that will occur at that juvenile detention counselor level. Therefore, the

adjusted staffing recommendation for juvenile detention counselors should be 337 through July 2008. Natural attrition will allow the number to return to 315 by early 2009, provided an additional staffing analysis also projects the juvenile detention counselor needs at or about 310. The minimum counselor staffing is set at 315.

Table 2. Juvenile Detention Counselor Staffing Level Projections

Staffing Reports	**No.**
2002 John Howard Association Staffing Study	306
Cook County Bureau of Administration Study	300
2005 John Howard Association Staffing Study	311
2006 Agreed Supplemental Order Staffing Analysis	**315**
Average	308
107% of ASO Projection	337

Recreation Specialists. The number of recreational specialists needs to be expanded, so that there are 10 recreation specialists working each day. In order to have a recreation specialist on-duty in the afternoons and evenings (1:00 to 9:00 pm) on weekdays and for the majority of the day (10:00 am to 6:00 pm) on the weekend, the number of recreation specialists should be set at 17.

Caseworkers. Caseworkers will play an important role in the facility. The American Correctional Association recommends one caseworker for every 25 residents. This projects a minimum number of 20 caseworkers based on the CCJTDC capacity. To continue to provide the current seven-day week caseworker coverage requires a total of 34 caseworkers.

3. Timeframe:

A plan to accomplish the 2.6 above shall be submitted to the Court Monitors and Compliance Administrator within 90 days. The plan will also outline specific steps and an implementation schedule to accomplish the other items in this section.

The facility shall submit a staffing report to the Compliance Administrator and Court Monitors by the 10th working day of each month that includes:

- Total number of staff positions by job classification
- Total number of vacancies by job classification
- Status of hiring of vacancies
- Total number of staff suspensions by job classification and number of suspension days
- Total number of staff assigned to no direct care contact with residents
- Total number of staff on administrative leave due to investigations of misconduct
- Number of staff terminations and re-instatements
- Number of staff on inactive status (e.g. leave of absence)

H. Suicide Hazards: Paragraph #24

1. MOA Requirements

The Implementation Plan will include policies and practices consistent with Standard Y-53 of the NCCHC Standards for:

(1) identifying and reasonably minimizing suicide hazards in the general population, and

(2) providing an environment reasonably free of suicide hazards for those detainees who have been identified as being at risk for suicide.

2. Solution/Plan

2.1 The facility shall develop a suicide prevention policy. The policy shall be submitted to the Compliance Administrator and the Court Monitors.

2.2 Training of all staff shall be conducted on the new policy and procedures.

2.3 Floor supervisors and managers will carry "cut-down" tools.

2.4 The development of one or more "special needs units."

2.5 Elimination of any potential suicide hazards in all resident rooms, living units and other areas readily accessible to youth.

3. Timeframe

3.1 The development of policies and procedures shall be developed within 30 days of the approval of the MIP.

3.2 Training shall be initiated within 60 days and completed within 120 days of the approval of the MIP.

I. Education Plan Overview: Paragraph #10

1. MOA Requirements:

Within ninety (90) days of the entry of an order by the Court approving this agreement, the Center will create and implement a plan to provide all of the following services and programs within their control related to the aspects of detainees' education;

(1) maintaining an adequate physical facility for education,

(2) providing adequate security, and

(3) developing and implementing a schedule for transporting detainees to and from school that assures that detainees will have the opportunity to receive the hours of educational services mandated by law.

2. Solution/Plan

2.1 The JTDC will make every effort to develop and formalize an interagency agreement between the Chicago Public School System and the CCJTDC that:

- Provides adequate security within the school premises (including classrooms) for all youth including those youth requiring protective services or other special needs. Youth requiring protective services or other special needs shall have the same or equivalent educational services.
- Creates an alternative school for youth suspended from school.
- Provides a schedule for transporting detainees to and from school that assures that detainees will have the opportunity to receive the hours of educational services mandated by law and/or policies of the Chicago Board of Education.
- Outlines a cross training curriculum for Nancy B. Jefferson School employees and JTDC employees, an orientation curriculum and mandated annual training for employees of the school district.
- Provides that educational staff will be trained in the appropriate facility policies that relate to or may overlap with the school's operation. These will include the policies regarding rules, discipline and the behavior management program.
- Includes development of a plan and appropriate materials for various educational levels, to be distributed and explained to youth in the health care unit, in room confinement or otherwise unable to participate in normal school classroom activities.

In the absence of such an agreement, the facility will implement procedures and practices to comply with these provisions to the best of their ability.

2.2 Policies will need to be developed to reflect the interagency agreement.

2.3 The Superintendent or designee shall review all youth in confinement to assess the feasibility of an early release to attend school each day. A list of the residents that are not allowed to attend school and the reasons for the administrative restriction shall be documented and distributed to the Principal of the Nancy B. Jefferson School, the Assistant Superintendent designate as a liaison to the school daily and the Compliance Administrator on a weekly basis.

2.4 All instances in which school activities are suspended by the facility due to incidents or other extraordinary circumstances shall be reported to the Compliance Administrator within 24 hours.

3. Timeframe:

3.1 An interagency agreement or in the absence of such agreement, a plan by the facility will be developed to address issues of mutual concern of the facility and the Chicago Public School System within 60 days of the approval of the MIP.

J. Social and Recreational Programming: Paragraph #33

1. MOA Requirements

The implementation Plan will include a description of the actions taken to assure an appropriate quality and quality of recreational and social programming for all detainees.

2. Solution/Plan

Policy and practice need to reflect that health services personnel are consistently consulted in the determination of how much social, recreational and educational programming can be provided consistent with the resident's health and safety.

2.1 Substance abuse screening instruments (approved by the medical and mental health experts) will be administered to all residents upon intake and the outcomes documented in the DSI system.

2.2 Mental health screening instruments (approved by the medical and mental health experts) will be administered to all residents upon intake and the outcomes documented in the DSI system.

2.3 Caseworkers will hold groups at least two times a week that address a wide range of topics including but not limited to: problem solving and decision making skills training, thinking errors/cognitive distortions awareness training, healthy family relationships, goal setting and life skills. The group sessions will be tailored to the individual needs of the particular living unit (e.g. female specific, long term residents [automatic transfers], and special treatment units). Caseworker groups shall be documented in the unit log book.

2.4 Counselors will hold daily community meetings to discuss facility and group issues and concerns regarding the living unit, education, housekeeping issues, behavior management program, etc. Community meetings shall be documented in the unit log book.

2.5 Recreation specialists will develop programs suitable for the population on the living units (including medical).

2.6 Recreation specialists will assist in the development of structured activities on the living unit and floor (including medical).

2.7 Large muscle exercise shall be supervised by qualified recreation staff.

2.8 Ensure adequate security for all youth requiring protective services and special needs. Youth requiring protective services and special needs shall have the same or equivalent recreational services as youth in general population status.

2.9 The Superintendent or designee shall review all confinements for appropriateness for recreation each day. A list of the residents that are not allowed to participate in recreation and the reasons for the administrative restriction shall be documented and distributed to the Assistant Superintendent assigned to oversee recreational services and the Compliance Administrator on a weekly basis.

2.10 Each living unit will be equipped with adequate recreational equipment including but not limited to appropriate videos, games, books, magazines and competitive games.

2.11 A monthly schedule of activities will be posted on the living units.

2.12 A contract monitoring system needs to be established to monitor the service delivery of contractual agencies, including the review of existing substance abuse contracts. Criteria need to be established to identity those youth in need of substance abuse treatment versus drug education programs. The substance abuse contracts should be suspended until a system is in place to identify the residents that require substance abuse treatment and ensure contractual programs provide the level of care the residents need.

2.13 Identified youth will be referred to substance abuse providers for a substance abuse evaluation to determine the appropriate level of care.

2.14 Drug education programs will be delivered by caseworkers or other appropriate professionals on the living units.

2.15 The facility will ensure that any substance abuse program includes an educational as well as treatment component as defined in Illinois Alcohol and Other Drug Abuse Professional Certification Association Standards.

2.16 The facility will develop a contract monitoring tool to assess the service delivery to residents.

3. Timeframe

3.1 Caseworker groups and counselor community meetings shall be initiated within 90 days of approval of the MIP.

3.2 Recreational programming and related activities shall be initiated within 30 days of approval of the MIP.

3.3 Substance abuse screening shall be initiated within 30 days of the approval of the MIP.

3.4 Mental health screening shall be initiated within 30 days of the approval of the MIP unless a major change occurs in the delivery of mental health services (e.g. change in mental health provider). If such a change occurs, mental health screening shall be initiated within 30 days of the date the change is effected.

3.5 Substance abuse treatment and drug education shall be initiated within 120 days of approval of the MIP.

3.6 Contract Monitoring tools will be developed within 30 days of the utilization of any contractual agreement. Contract monitoring shall be conducted quarterly by designated staff. Copies of quarterly contract monitoring shall be submitted to the Compliance Administrator.

K. Discipline Overview: Paragraph #48

1. MOA Requirements

The Center will assure that all discipline is carried out in a manner that is safe, fair, and consistent. CCJTDC staff shall provide consistent supervision, direction and instruction to detainees in their care that is appropriate to the needs of the individual and group and which promotes both stability and good order. Center discipline policies will assure that:

(1) Minor or progressive sanctions may be imposed by the staff which are consistent with rendering supervision, but which do not impose individual restrictions on talking, movement, or participation for more than one hour, with floor supervisor review within 30 minutes to authorize an additional thirty minutes, for any incident.

(2) All restrictions or interventions shall be logged, including the result.

(3) In cases where minor interventions, including verbal correction or a limited sanction do not produce an acceptable modification in behavior, a supervisor or caseworker shall be called to assist.

(4) Imposition of additional sanctions shall require a written violation report and a timely due process review of formal charges as part of the formal disciplinary procedure.

(5) Use of consecutive sanctions for the same behavior shall not be allowed as a means of avoiding compliance with these provisions.

2. Solution/Plan:

2.1 The discipline process will be integrated with the behavior management system and housing classification system. The behavior management program will include a series of incentives for positive behaviors and a range of sanctions that will include immediate sanctions (fines) for minor rule violations. Living units will range from those of greater restrictiveness (fewer privileges) to lesser restrictiveness. Initial placement into one of the four levels will be based on

risk. Movement to a level of less restrictiveness will be based on positive behavior. Movement to a level of greater restrictiveness will be as a result of a major rule violation and a sanction imposed by a hearing officer. Room confinement will be used sparingly and as a result of major disciplinary issues.

2.2 Policies and procedures detailing the disciplinary process shall be submitted to the Compliance Administrator and the Court Monitors within 60 days of approval of the MIP.

2.3 Residents shall receive a copy of alleged rule violation(s) within one hour of the incident (if confined) and four hours (if not confined). The time the youth is served with the rule violation shall be documented with the resident's signature.

3. Timeframe

The disciplinary process policies and procedures shall be submitted to the Compliance Administrator and the Court Monitors within 60 days of the approval of the MIP.

L. Discipline Documentation: Paragraph #52

1. MOA Requirements

The Center will assure that any use of discipline is properly documented. The Superintendent will appoint a Disciplinary Practices Review Committee ("DPRC") to regularly review all use of discipline to assure that discipline is being used appropriately, and in accordance with the terms of this Agreement and applicable standards. In addition to appointment authority, the Superintendent will be an ex officio voting member of this Committee. The composition of this committee will be set forth in the Implementation Plan.

2. Solution/Plan

2.1 The facility will revise the disciplinary policies and procedures. The disciplinary policy shall ensure that the rights established by state law are not prohibited by any disciplinary practices except as permitted in Paragraph 65, Extraordinary Circumstances. Any instances(s) of such denials must be documented, describing the reasons for the denial of the residents rights and submitted to the Disciplinary Review Committee and the Compliance Administrator on a weekly basis. All disciplinary policies and procedures shall be submitted to the Compliance Administrator and the Court Monitors.

2.2 The Center will implement an orientation process that ensures every detainee receive a student handbook that outlines the disciplinary policy, behavior management program, the Center's rules, major and minor rule violations, student rights and responsibilities, the due process policy, the grievance policy and the reporting child abuse policy. Caseworkers will review the material with each youth and verbally explain these policies. Non-English speaking youth shall be given interpretive assistance. The detainee shall be required to sign appropriate documentation that acknowledges receipt of the student handbook.

2.3 The facility will use the DSI system for all incident reports, discipline, restraint usage, and grievances. The Committee shall use these reports in monthly reviews.

2.4 The Committee shall meet at least monthly and will generate a monthly report to the Superintendent and Compliance Administrator with an analysis of all available reports which describes staffs ability to use the full range of available behavior management incentives and sanctions, and comments regarding progress, areas of concern and corrective action plans as a result of an analysis of the grievance and disciplinary reports.

2.5 Appropriate staff will receive training on the DSI system.

3. Timeframes

The disciplinary policy shall be submitted to the Compliance Administrator and the Court Monitors within 60 days of the approval of the MIP.

M. Permissible Forms of Discipline: Paragraph #49

1. MOA Requirements

The Implementation Plan will include a system that:

(1) Ensures that discipline meted out is an appropriate response to the infraction,

(2) Carries out discipline in the least restrictive manner appropriate to the infraction,

(3) Ensure discipline is in accordance with all laws applicable to the operation of a juvenile temporary detention facility, and

(4) Is consistent with applicable NCCHC, ACA, and state regulatory standards.

The Implementation Plan will describe the actions taken to assure the following:

(1) Physical forms of discipline.

- *No physical restraint or any other physical use of force may be used as a form of discipline, although a staff member may use an approved method of physical restraint to accompany a detainee into room confinement, where no less restrictive method is appropriate.*
- *All use of restraint whether permissible or not, will be documented.*

(2) Disciplinary room confinement.

- *Disciplinary room confinement is only used when no less restrictive form of punishment is appropriate, and that youth confined to their rooms are permitted to rejoin the general population when capable of doing so without further disruption to the detention operations.*
- *The Implementation Plan will include training on consistent, appropriate, and equitable discipline from least restrictive to the next restrictive forms and types of sanctions based on inappropriate behavior of detainees.*
- *Use of room confinement for cooling off periods, not to exceed 30 minutes, shall not trigger due process requirements under formal disciplinary procedures, but will be documented.*
- *Any use of room confinement for cooling off purposes must be approved by an appropriate supervisor after thirty minutes and can be extended for an additional thirty minutes by the Supervisor.*
- *The use of room confinement for disciplinary purposes in all instances shall be limited to 36 consecutive hours for each detainee so confined absent extraordinary circumstances as defined in Paragraph 65 of the MOA.*
- *Room confinement should be limited to the amount of time necessary to assure the detainee's return to general population without further disruption of operations. It is recommended that room confinement not exceed 24 consecutive hours for each detainee. If, after 36 consecutive hours of room confinement for a particular CCJTDC detainee, CCJTDC staff determine that a detainee poses a risk of imminent physical harm to himself or others, confinement may continue only for therapeutic reasons or security reasons, and must meet the requirements for such confinement found in paragraphs 27 and 57 of the MOA.*
- *Once room confinement has been imposed for disciplinary purposes, it may not be imposed on the same detainee again for the same infraction absent extraordinary circumstances.*
- *All detainees who are placed in room confinement must be evaluated on a daily basis, including an initial evaluation within three hours of placement by a qualified health care professional.*
- *The daily health evaluation must include personal contact with the detainee, notation of bruises or markings suggesting injury or trauma, and an evaluation of the detainee's mental status.*
- *In addition to the checks by health care workers, staff will make a visual check of all detainees in room confinement at least every 15 minutes, and will make personal contact with the detainee every hour, while the detainee is awake.*
- *A log must be kept of all such checks and interactions with the detainee while in room confinement.*
- *Detainees in disciplinary room confinement must receive at least one hour of large muscle exercise outside of their rooms each day.*
- *Reasonable safety precautions shall be followed to prevent injuries to the detainee in room confinement. Room confinement rooms shall be adequately lighted, heated and furnished, and have easy access to appropriate toilet facilities. Youth will be permitted two books and two magazines inside their room. If a door is locked, someone with a key will be in constant attendance nearby.*

- *Youth will receive educational material and instructions regarding the material from a member of the Chicago Board of Education each day This will require the defendants to designate an individual to communicate with the school the names of those individuals not attending school on a given day. The assignments will be distributed to the appropriate detainee who will complete the assignments. The completed assignments will be returned to the appropriate teachers for review.*
- *The Hearing Officer, upon recommendation by the Floor Supervisor will review the status of detainees in disciplinary confinement overnight to determine whether they are candidates for early release in order to attend school. The status review will be documented. If early release is appropriate, the individual will be sent to school.*
- *The CCJTDC will follow all applicable laws and standards regarding the use, care and conditions of disciplinary room confinement, including NCCHC Standard Y-40, ACA Standards 3-JDF-3C-05 through 3-JDF-3C-12, and Ill. Ad. Code, Title 20, 702.70(D).*

Other forms of discipline: The Implementation Plan will create and assure use of a system in which the disciplinary response to any infraction is proportionate and the least restrictive response based on the detainee's behavior. The Implementation Plan will include a description of the actions the Center will take to assure the use of an effective behavior management system that creates incentives for good behavior among the detainees. The Plan will follow all laws applicable to the operation of a juvenile temporary detention facility, regarding the use of discipline. In the event that new laws and/or standards are implemented or existing laws and/or standards are modified and/or revised, the Center will be allowed a period of time not to exceed six months to implement such laws and standards.

2. Solution/Plan

2.1 An integrated housing classification and behavior management program will be implemented. Youth will be assigned to a living unit based on risk; movement to a living unit of greater or less restrictiveness (more or fewer privileges) will be based on the youth's behavior. Counselors and Caseworkers may levy fines for an immediate sanction of minor rule violations and fines in combination with room confinement may be imposed by hearing officers. A "loss of level" and/or movement to a living unit of greater restrictiveness may be imposed only by a hearing officer as an outcome of the due process hearing.

Significantly reducing the amount of time in room confinement is contingent on sufficient staffing in special needs units and staff being trained in the behavior management program.

Disciplinary hearings will be conducted by designated staff that are:

- appropriately trained,
- are not directly involved with the detainee on a daily basis, and
- not associated with the incident.

2.2 Policies and procedures detailing the disciplinary process shall be submitted to the Compliance Administrator and the Court Monitors.

2.3 The use of administrative room confinement beyond the 36 hours required by the MOA will cease.

2.4 The 15-minute check logs need to be revised to include a space for documentation of contact including a brief description of a personal contact and resident activity every hour the resident is awake.

2.5 The 15-minute check logs shall be posted on the confined resident's door at all times. Exact times of the visual inspections shall be recorded.

2.6 The 15-minute check logs shall be maintained in the youth's master file.

2.7 An electronic system for tracking and documenting required 15 minute checks may be utilized in lieu of the paper tracking system. The Compliance Administrator shall have access to any reports generated by such system. In the event that the electronic tracking system is inoperable, the paper system must be reinstituted.

2.8 The use of room confinement for disciplinary purposes in all instances shall be limited to 36 consecutive hours for each detainee so confined absent extraordinary circumstances as defined in Paragraph 65 of the MOA.

3. Timeframe:

3.1 All policies, procedures and forms pertaining to this paragraph shall be developed and submitted to the Compliance Administrator and the Court Monitors within 30 days of approval of the MIP. All other pertinent activities, including staff training shall be completed within 60 days of approval of the MIP. On-the-job training should be considered an on-going process.

3.2 All provisions with fifteen (15) minute checks shall commence within 7 days of approval of the MIP.

3.3 The facility should demonstrate substantial compliance with all provisions of this paragraph within the six months required by the ASO.

N. Due Process: Paragraph #50

1. MOA Requirements

The Implementation Plan will include the following specific requirements for providing due process to all detainees:

(1) All detainees will be given a copy of the rules of the facility within one hour of entering the CCJTDC. Additional copies will be prominently posted in each living unit, including the intake unit;

(2) All detainees must be given a due process hearing by someone independent of the unit staff prior to the imposition of any discipline, except in an emergency situation (i.e., there is a danger of imminent physical harm to a detainee or staff member, to prevent escape or regain custody, or to prevent damage to property that is serious or will have serious consequences). In the event of an emergency situation, the detainee must receive a hearing no later than four hours after the imposition of the discipline. The four hour time limit begins at the time the discipline is imposed, but will be tolled between the hours of 7:00 pm and 7:00 am.;

(3) The Implementation Plan will follow all laws applicable to the operation of a juvenile temporary detention facility and be consistent with the NCCHC Standards, ACA Standards and the Illinois Administrative Code, regarding the provision of Due Process;

2. Solution/Plan

2.1 Policies detailing the all due process requirements and practices shall be submitted to the Compliance Administrator and the Court Monitors.

2.2 Designated staff (independent of the unit staff) that will be conducting hearings shall be identified and a schedule developed to ensure that disciplinary hearings will be held in accordance within the timeframes outlined in the MOA within 15 days of the approval of the MIP.

2.3 A training curriculum shall be developed and identified staff shall be trained prior to conducting hearings.

2.4 All direct care staff will receive training regarding the disciplinary processes.

2.5 A new resident handbook will be issued to all residents within 1 hour of admission. Student rights, major and minor rule violations and the grievance policy will be visibly posted on all living units.

2.6 In the event of an emergency situation, the detainee must receive a hearing no later than four hours after the imposition of the discipline. The JTDC will develop a system that reflects the time that the resident was confined and the time of the hearing.

3. Timeframe:

3.1 Policies and procedures regarding due process shall be submitted to the Compliance Administrator and the Court Monitors within 30 days of approval of the MIP.

3.2 Training curriculum shall be developed within 45 days of approval of the MIP.

3.3 Hearing officer training shall be completed within 60 days of approval of the MIP.

3.4 Direct care staff and supervisory staff training shall be initiated within 60 days and completed within 120 days.

3.5 The new resident handbook shall be completed within 60 days of approval of the MIP.

3.6 Caseworkers will begin to meet with newly admitted youth in admissions units (or elsewhere) within 30 days of approval of the MIP.

O. Discipline Confinement: Paragraph #51

1. MOA Requirements

The CCJTDC will assure that all detainees in disciplinary confinement receive one hour of exercise outside of their rooms, unless, by releasing the detainee for such purposes, the detainee poses a threat to himself, other detainees or staff, to escape, of damage to property that is serious or will have serious consequences.

2. Solution/Plan

2.1 The requirement to provide one hour of exercise outside of their rooms for detainees in confinement (medical and unit confinement) shall be incorporated into the disciplinary policies as well as recreation policies.

2.2 The policies will include provisions that prohibition of recreation can only be authorized by the Superintendent, Assistant Superintendent, Duty Administrator or qualified health care provider. The policy shall include a description of the documentation required to exclude the resident in situations the resident poses a threat to himself, other detainees or staff, to escape or in the event release would likely result in damage to property that is serious or will have serious consequences. A daily list of any youth prohibited from recreation including the reason for the exclusion shall be prepared and distributed daily to the appropriate JTDC personnel and weekly to the Compliance Administrator.

2.3 Hearing officers shall receive appropriate training including a competency component.

2.4 The Disciplinary Practices Review Committee shall submit a monthly report that includes a list of youth who were denied recreation and the reasons for such denial to the Superintendent and Compliance Administrator.

2.5 Notation will be required on the 15 minute watch sheets that the youth was out of his/her room for one hour of large muscle activity.

3. Timeframe:

3.1 All provisions of this paragraph will be implemented within 30 days of approval.

P. Behavior Management: Paragraph #53

1. MOA Requirements

The Implementation Plan will describe the actions the CCJTDC will take to implement and maintain a behavior management system for detainees that are fair and effective. The behavior management program will provide:

(1) incentives for positive behavior and afford proportional measures of accountability for negative behavior, and

(2) written guidelines and parameters that are readily definable and easily understood by detainees and staff, and

(3) A verbal and written explanation of the behavior management system shall be provided to all detainees as part of the orientation process.

2. Solution/Plan

2.1 Policies and procedures detailing the behavior management system shall be submitted to the Compliance Administrator and the Court Monitors.

2.2 The behavioral management program will directly link to requirements established in the disciplinary policies and housing classification policies.

2.3 The behavior management program will be described in the resident handbook and discussed with the youth prior to his/her assignment to a living unit.

2.4 All direct care staff will receive training regarding the new behavior management program.

2.5 On-the-job training in the behavior management program shall be provided to all direct care staff and supervisory personnel.

2.6 The behavior management system including tracking of the status and levels of privilege shall be incorporated into the facilities DSI system and used to its fullest extent.

2.7 A commissary must be established. Residents should have input on items to be purchased through the commissary. The commissary will include at a minimum toiletries and snacks.

3. Timeframe:

3.1 Policies and procedures shall be submitted to the Compliance Administrator and Court Monitors within 60 days of the approval of the MIP.

3.2 Implementation of the behavior management program shall be initiated within 90 days of the approval of the MIP.

Q. Use of Force & Restraints: Paragraph #25

1. MOA Requirements

(1) The Center may not use any form of force against any detainee other than approved forms of mechanical and physical restraint, absent extraordinary circumstances.

(2) Use of force will be terminated as soon as force is no longer necessary.

(3) When the use of force is authorized, only the least force necessary under the circumstances shall be employed. CCJTDC personnel will not use guns, knives or other weapons capable of inflicting serious injury.

(4) Mechanical and physical restraint may only be used for therapeutic purposes (as described in Paragraph 27 of the MOA) or security purposes (as described in Paragraph 57 of the MOA).

(5) The defendants will not use any form of fixed restraint for disciplinary or security purposes or chemical agents (such as gas or pepper spray) at any time or for any reason.

(6) This prohibition does not preclude the use of fixed restraints in the event that a qualified health care professional has concluded that no other less restrictive treatment is appropriate for therapeutic purposes as described in Paragraph 27 below and the restraints are used in accordance with the Illinois Mental Health and Disabilities Code.

(7) Fixed restraints shall only be used for short periods of time until transportation is provided to a medical facility or the detainee is released from restraints.

2. Solution/Plan:

(1) The Center's Crisis Intervention Program including the training and operations of the First Responder Team will be reviewed and modified emphasizing verbal intervention as well as physical and mechanical restraints.

(2) Policies and procedures regarding the use of force shall be reviewed and revised. The policy shall include:

- A process to document the issuance and return of restraints
- Documentation of usage including but not limited to the events leading to the use of force, the duration of the application of restraints and medical review in compliance with the MOA

(3) Direct care staff shall receive training on relevant polices and procedures regarding the use of force.

(4) The use of force policy shall be submitted to the Compliance Administrator and the Court Monitors. The policy shall require documentation of any use of force. Documentation of all use of force shall be distributed to the Compliance Administrator weekly.

3. Timeframe:

3.1 Policies and procedures will be developed and submitted to the Compliance Administrator and the Court Monitors within 30 days of the approval of the MIP.

3.2 Staff training will be initiated within 60 days of approval of the MIP and completed within 120 days of the approval of the MIP.

R. Grievances: Paragraph #54

1. MOA Requirements

The Center will assure that all detainees have the opportunity to voice meaningful and confidential grievances. The Implementation Plan will include:

(1) A system for allowing detainee to file grievances confidentially,

(2) Mechanisms to prevent staff from interfering with the grievance system or retaliating against detainees who file grievances, and

(3) A protocol for CCJTDC staff to respond to grievances in a meaningful manner within 72 hours, excluding weekends and holidays, absent extraordinary circumstances.

In the event that grievances are emergent in nature (e.g. - one that pertains to life threats, physical or sexual abuse, or health related issues), floor managers will be required to respond to and address such grievances in an expeditious fashion. If, upon investigation, it is determined that the grievance is not emergent, the grievance will be reclassified and handled through the normal grievance process.

2. Solution/Plan:

2.1 The grievance policy, procedure and related forms will be completed and submitted to the Compliance Administrator and Court Monitors. The grievance procedure shall include the following:

- A one day response policy for grievances of an urgent nature (i.e. abuse, etc.)
- A three day response policy for grievances of a non urgent nature.
- An appeal process that includes the Superintendent or designee.
- All of the provisions outlined in the MOA.

2.2 The Superintendent's designee will manage the Grievance Process.

2.3 In the admissions unit, prior to assignment to a living unit, the youth will meet with a Caseworker who will review the student handbook with him/her and show him/her a video that explains the handbook. The Handbook will detail the disciplinary process, major and minor rule violations, student rights and responsibilities, the behavior management program, what is child abuse and how to make a report and the grievance process.

2.4 Grievance boxes and forms will be placed in each of the living units as well as the school. A designated staff person (who does not provide direct care to youth) will collect grievances each day, log in the grievances, forward grievances to appropriate staff, and ensure timely responses. Grievances of a serious nature (those that need to come to the attention of administration) or those that can not be resolved at the first level of intervention will be forwarded to the Superintendent or designee for further action. The youth will receive a notice that the grievance was resolved at the first level or forwarded for further action or investigation. A copy of that notice will be placed in the youth's institutional file. Once a determination has been made regarding the grievance, the designee will meet with the youth and explain the outcome. He/She will also explain the youth's rights to appeal the decision if so desired. Youth will have the opportunity to appeal the outcome of their grievance to the Superintendent or designee. The youth will be asked to sign the grievance resolution form and a copy will be given to the youth and a copy place in his/her Institutional file.

2.5 Grievances regarding emergent or other serious issues shall be reviewed by the Superintendent or Assistant Superintendent. All youth will receive a written and verbal (unless the youth has been released) response to his/her grievances.

2.6 Each month a report noting the number and nature of the grievances filed will be produced. The report will also show the living unit, the number of grievances resolved at each level, the nature of the grievance and the average length of time it took to resolve the grievance for that month. Copies of all original grievance reports by residents shall be submitted to the Compliance Administrator monthly. Copies of grievances that have been completed by staff and signed by the resident shall be submitted to the Compliance Administrator twice a month.

3. Timeframe:

3.1 Policies, procedures and related forms regarding the grievance process shall be submitted to the Compliance Administrator and the Court Monitors within 30 days of approval of the MIP.

3.2 Revised and approved grievance forms will be made available in living units and the school within 30 days of approval of the MIP.

3.3 Monthly reports regarding grievances shall be prepared and submitted within 60 days of approval of the MIP.

3.4 Direct care staff and supervisory staff training shall be initiated within 60 days and completed within 120 days of approval of the MIP.

3.5 Grievance boxes shall be installed as described within 30 days of the approval of the MIP.

S. Security: Paragraph #56

1. MOA Requirements:

The Center will assure that detainees are reasonably safe from harm while within the facility. The Implementation Plan will describe actions to create and maintain systems which reasonably assure the security of the detainees in the institution, including:

(1) maintaining security during movement of detainees;

(2) prevent the infiltration of contraband;

(3) enabling adequate communication between staff in case of emergencies;

(4) adequately controlling dangerous tools, equipment to staff; and

(5) providing adequate security equipment to staff; and

(6) establishing adequate safety and emergency procedures to prevent or respond to escapes, damage to security systems, physical plant, life safety systems, and emergency evacuation procedures.

2. Solution/Plan

2.1 Adequate staffing will need to be provided and maintained in order to ensure the safety of the residents and staff. Polices and procedures will need to be developed to reflect acceptable standards of care. Appropriate training will need to be provided. A quality assurance program will need to be implemented to ensure the policies and procedures are common practice. Identified administrative staff will be required to conduct a "systems check" monthly on every shift to identify potential operational issues. Corrective action plans will be submitted to the Superintendent and Compliance Monitor on a monthly basis. Any changes in policies and procedures (verbal or by any written documentation) shall be submitted to the Compliance Administrator. "Systems checks" forms shall be submitted to the Compliance Administrator monthly.

2.2 Implementation of a housing classification system that shall include identification of youth with protective custody, significant mental health, and other special needs shall occur.

2.3 Strip search of youth entering the Center including initial admission, returns from Court, youth returning from appointments outside the building shall be performed consistently.

2.4 Search of youth coming from visitation, school and recreation shall be perfomed consistently.

2.5 Caseworker working with unit counselors and mental health staff will develop "special management plans" for those youth who present significant or ongoing discipline problems. Daily room inspections will be conducted.

2.6 Weekly facility inspections will be conducted by the Superintendent or designee and a maintenance representative.

2.7 Effective communication in the following areas is required to maintain a safe environment for the residents of the CCJTDC:

- Between shifts
- Between disciplines (mental health, medical, case workers, food service)
- Between line staff and supervisory staff
- Between administration and line staff

In order to facilitate communication, a roll call system needs to be implemented.

2.8 It is not uncommon for disputes to arise in the school and continue onto the living units within the facility. The facility shall identify a school liaison(s) that will work with staff from the Nancy B. Jefferson School to ensure on-going communication regarding behavior or other resident issues.

2.9 The following policies and procedures will need to be reviewed and revised:

- *10.07 Emergency Communications*
- *10.09 Emergency Equipment Testing*
- *10.10 Emergency Evacuation Procedures*
- *10.11 Emergency Plan Training*
- *10.12 Emergency Prompt Release*
- *10.13 Escapes*
- *10.14 Emergency Plan (Work Stoppage/Major Disturbance)*
- *10.15 Emergency Plan (Hostage Situations)*
- *10.16 Emergency Plan (Suicide Attempt-Cut Down Tool)*
- *15.01 Shift Assignments*
- *15.02 Communication*
- *15.03 Patrols and Inspections*
- *15.04 Resident Counts*
- *15.05 Resident Movement/Internal Supervision*
- *15.06 School Posts*
- *15.07 External transportation*
- *15.08 Mechanical Restraints*
- *15.09 Searches*
- *15.09a Search Teams*
- *15.10 Key Control*
- *15.11 Tool Control*
- *15.12 Use of vehicle*
- *15.13 Firearms/Weapons*
- *15.14 Overflow Residents/sleepers*

- *15.15 Accident/Injury Report*
- *15.16 Music, Video and Literature*
- *15.18 Contraband*
- *15.19 Current Table of Contents states Spill Kits but the policy is on Juvenile Movement*
- *15.21 Cellular Telephones and Pagers*
- *15.22 Use of rooms with Steel doors*
- *15.23 Use of Cook County Vehicles*
- *15.24 Use of radios*
- *15.25 Medical Emergencies*
- *16.02 Intake and Admissions*
- *16.03 Reception and Orientation*
- *16.04 Personal Property*
- *18.02 Protection from Harm*
- *18.03 Juvenile Rights-Access to Counsel*
- *19.01 Special Management*
- *29.01 Visiting*

3. Timeframe

3.1 All policies shall be submitted to the Compliance Administrator and the Court Monitors within four months of the approval of the MIP unless otherwise specified in the MIP. Policy development should occur with approximately 25% of the policies listed above developed each month.

T. Restraint for Security Purposes: Paragraph #57

1. MOA Requirements

The Center will assure that any restraint used for security purposes is used in the safest manner possible. The Implementation Plan will include the actions required to assure the safe use of restraint for security purposes and will include the following requirements:

(1) Mechanical or physical restraint may be used as a means of security only when necessary to prevent imminent physical harm to detainees or staff, escape, or damage to property that is serious or will have serious consequences.

(2) The Implementation Plan shall allow for the safe and appropriate use of handcuffs and/or leg shackles to transport detainees inside and outside of the CCJTDC, as a precaution during a mass evacuation, or where such use is necessary during a mass evacuation, or where such use is necessary during transport for safety of the public or individuals within the CCJTDC. If both handcuffs and shackles are used for transportation purposes, the handcuffs may not be joined in any manner to the foot cuffs.

(3) No fixed restraints are permitted at any time for security purposes, including during transportation outside of the facility, although they may be permitted for the medical purposes defined in Paragraphs 25 and 27.

(4) Use of mechanical restraints in emergency response to serious group disturbances that pose an imminent risk to the safety of detainees and staff or evacuation of the facility shall be permitted only in extraordinary circumstances and subject to the requirements of Paragraph 65.

(5) The CCJTDC shall provide initial and yearly follow-up training in the legal and appropriate application of restraint techniques.

(6) The facility shall prohibit the use of any type of restraint by an employee who has not received training in the safe and humane application of that type of restraint.

(7) CCJTDC will maintain records detailing which employees have been trained and are authorized to apply restraint, the date of the training and the type of restraint that the employee was trained to use.

(8) In no case may any staff use any type of force or physical restraint technique that risks placing any pressure on or near the neck, reducing a detainee's ability to breathe, or constraining circulation.

(9) The Center will prohibit the use of physical restraint except when all less restrictive methods are ineffective to prevent imminent injury to staff or detainees, prevent an escape or attempt to escape, subdue a violent recalcitrant, or prevent property damage that jeopardizes the security of the institution.

(10) Each use of physical restraint to prevent imminent injury to staff or detainees, prevent an escape or attempt to escape, subdue a violent recalcitrant, or prevent property damage that jeopardizes the security of the institution is limited to the amount of time reasonably necessary to prevent injury to staff or detainees, prevent and escape or attempt to escape, subdue a violent recalcitrant, or prevent property damage that jeopardizes the security of the institution.

(11) The use of physical restraint shall be limited to a period of time not to exceed five minutes absent extraordinary circumstances.

(12) Within one hour after a detainee has been released from physical restraint, a qualified healthcare professional will evaluate the detainee thoroughly to assure that no physical or psychological harm has occurred, will assure that appropriate actions are timely taken to prevent or respond to any injuries or needs, and will document the results of the evaluation and the actions that were taken. The examination will include complete vital signs, the level of consciousness, mental health exam, mood and signs of mental illness. The qualified health care professional performing the evaluation will when appropriate transfer the detainee to an emergency room, release the detainee from restraints, or arrange for examination by an appropriate specialist.

(13) Whoever orders physical restraint or physically restrains a detainee in an emergency situation for security purposes shall document its necessity and, within 24 hours, excluding weekends and holidays, place that documentation in the detainee's medical file and deliver a copy to the Superintendent and the Medical Director or Medical Administrator.

(14) All use of restraint, whether permissible or not, will be documented. The Superintendent or her designee and the Medical Director or Medical Administrator shall review all emergency restraint orders for security purposes daily and shall investigate to address any patterns of use of restraints that might be inappropriate.

2. Solution/Plan

2.1 Policies and procedures will need to be developed and submitted to the Compliance Administrator and the Court Monitors. Policies and procedures will incorporate all of the provisions in Paragraph #57 of the MOA. The corresponding health services policies will need to reflect changes in this policy.

2.2 Staff will be identified and an identified number placed on each floor on the 1st (day) and 2nd (afternoon) shift that have demonstrated competency in crisis intervention techniques (verbal, physical and mechanical restraints). Identified "first responders" shall include supervisory staff. "First responders" shall receive intensive training. "First responders" should be used in special needs units as well as units considered "highly aggressive" and at the school.

2.3 Training including competency testing shall be developed and scheduled. Documentation of all staff authorized to restrain residents shall be tendered to the Compliance Administrator and retained in employee's training file.

2.4 Anytime restraints are employed, the persons applying the restraints is responsible for entering the required information into the restraint log, maintained by appropriate supervisory staff and noting that restraints were used, the type and for how long on the incident report. This information must be submitted before that person is permitted to leave the Center at the end of his/her shift. Copies of the completed use of restraint form(s) shall be provided to the Compliance Administrator weekly.

2.5 Any use of a physical or mechanical restraint shall be followed by an exam by a qualified health care professional within one hour of the application of the restraint.

3. Timeframe

3.1 Policy development, training plans and a schedule of training shall be developed within 30 days of the approval of the MIP and submitted per 2.1 above.

3.2 Training shall be implemented during the first 60 days of approval of the MOA.

3.3 The plan shall be fully implemented within 90 days.

U. Room Confinement for Institutional Emergencies: Paragraph #58

1. MOA Requirements

Room confinement may only be used as a security or protective measure in response to or to prevent an emergency situation and to prevent imminent physical harm to detainees or staff. An individualized determination must be made as to the danger posed with respect to each detainee. In such a case, detainees must be released from room confinement as soon as the risk of imminent physical harm has passed and order has been restored, but in no case may they remain confined pursuant to this Paragraph longer than two hours, absent extraordinary circumstances.

(1) All uses of room confinement for institutional emergencies shall be described in a written report prepared by the staff members involved prior to leaving the facility.

(2) The report will include a description of the origin and behavior involved in the riot, group disturbance or other emergency, the detainees and staff who were involved, and the identity of every detainee who was confined as well as the locations and duration of their confinement.

(3) A copy of this document will be provided immediately to the Superintendent and within twenty-four hours, excluding weekends and holidays, to the Monitor(s), plaintiffs' counsel and counsel for each of the detainees who was confined.

(4) The Superintendent or designee shall review all room confinement orders of institutional emergencies daily and shall investigate to detect and address any patterns of use of confinement that might be inappropriate.

2. Solution/Plan

2.1 Policies and procedures shall be developed and submitted to the Compliance Administrator and the Court Monitors. The specifications outlined in the MOA shall be included in the policies and procedures. The Compliance Administrator shall be included in distribution list of reports generated by the facility implementing provisions of the MOA regarding room confinement for institutional emergencies.

2.2 The use of room confinement shall be tracked in the DSI system by living unit, shift and staff.

2.3 Technical assistance is recommended to develop a training module on the use of room confinement and train all group services staff (including supervisors and managers).

2.4 The use of room confinement for administrative convenience ("per administration") will stop. Any room confinement without due process or due to extraordinary circumstances shall dictate the initiation of provisions under the "extraordinary circumstances" provisions (Paragraph 65) in the MOA.

2.5 Eliminate the use of room confinement for group punishment.

2.6 Any group confinement for emergency situations will be communicated to and can only be authorized by the Superintendent or Assistant Superintendent within 30 minutes of the incident.

2.7 Any use of room confinement for institutional emergencies shall require a report that includes a description of the origin and behavior involved in the riot, group disturbance or other emergency, the detainees and staff who were involved, and the identity of every detainee who was confined as well as the locations and duration of their confinement. A copy of this document will be provided immediately to the Superintendent and within twenty-four hours, excluding weekends and holidays, to the Compliance Administrator, Monitor(s), plaintiffs' counsel and counsel for each of the detainees who was confined.

3. Timeframe

3.1 The policy shall be developed within 30 days of approval of the MIP.

3.2 Training shall be completed and the policy implemented within 60 days of approval of the MIP.

3.3 Copies of reports generated from the use of room confinement for institutional emergencies will be provided as listed within 24 hours of such occurrences.

V. Protective Custody: Paragraph #59

1. MOA Requirements

The Center will assure that detainees are not placed in isolated environments to protect them from harm from others, except where there is no other reasonable method for protecting the detainee. The Implementation Plan will include a description of the actions taken to protect vulnerable detainees, including the following:

(1) Detainees may not be placed in room confinement or other forms of seclusion to protect them from harm from others, ("protective custody"), except for brief periods of time where there is no other method of adequately protecting the detainee. Lack of adequate staffing or appropriate placement shall be a reason for placing a detainee in room confinement for protective custody purposes only for as long as is necessary to bring in or reassign replacement staff. If a detainee is placed in protective custody room confinement for such a situation, that room confinement may last no longer than three hours absent extraordinary circumstances. Protective custody room confinement shall not be used unless no other reasonable alternative for protecting the detainee's safety exists.

(2) If the Superintendent or designee determines that such confinement is necessary, the decision to maintain the detainee in protective custody must be documented in writing and the reasons for taking such action must be included in the documentation.

(3) Copies of the documentation must be delivered, within 24 hours of placement in protective custody, excluding weekends and holidays, to the Monitors, Compliance Administrator, and counsel for the plaintiffs, and made available to the attorney who is representing the detainee in juvenile court proceedings, upon request.

(4) Reasonable safety precautions shall be followed to prevent injuries to the detainee in protective custody room confinement.

(5) Room confinement rooms shall be adequately lighted, heated and furnished, and detainees will have immediate access to toilet facilities. If a door is locked, someone with a key shall be in constant close proximity nearby.

(6) All detainees who are placed in protective custody room confinement must be evaluated within the first three hours of confinement by a qualified health care professional and a qualified mental health professional. The health examination must include personal contact with the detainee, notation of bruises or other trauma markings, and comments regarding the detainee's attitude and outlook. The detainee's mental health status shall be assessed.

(7) If extraordinary circumstances are present and a detainee remains in protective custody room confinement for longer than three hours, the health evaluation must be repeated on a daily basis.

(8) In addition to the health evaluations, a staff member must make a visual check of every detainee in protective custody every 15 minutes, and must make personal contact with the detainee every hour while the detainee is awake. A log must be kept of all interactions with the detainees while in room confinement.

(9) The CCJTDC will create one or more detainee living units that will provide appropriate, enhanced protection and, supervision for detainees who are particularly vulnerable.

(10) In the event protective custody room confinement is necessary, the CCJTDC must assure that the detainees receives a full day of programming and education to the extent that is practicable while attempting to assure the detainee's safety.

(11) The Implementation Plan will describe the specific actions to be taken to minimize or prevent judicial placement of detainees into protective custody room confinement except where there is no other reasonable method for protecting the detainee.

(12) The CCJTDC will follow all laws applicable to the operation of a juvenile temporary detention facility regarding protective custody.

2. Solution/Plan

2.1 The Center will develop special needs unit(s) to provide a safe environment for those youth who may require separation from the general population due to factors including but not limited

to medical and trans-gender issues, high profile cases, age, and low functioning mental capacities.

2.2 Placement on a special needs unit may initially be made as a result of the classification process upon intake or subsequently by the Superintendent or designee.

2.3 All youth in special needs units will be provided with access to the same or comparable programs and services provided to other residents of the JTDC. JTDC staff will provide appropriate security and supervision to and from programs, services and other activities.

2.4 Staff assigned to special need units shall be selected based on interest and aptitude in working with such populations, including a review of educational credentials and work experience. Assignments to this unit should be exempt from any collective bargaining provisions. The facility shall develop a training curriculum for staff assigned to special needs units.

3. Timeframe: Sixty (60) working days after the approval of the MIP.

W. Food Service: Paragraph #37

1. MOA Requirements

The Center will assure that food served to detainees is nutritionally sufficient, safe and that food service policies at the CCJTDC are consistent with NCCHC Standard Y-47, ACA Standards 30-JDF-4A-01 through 3-JDF-4A-14, and Ill Ad. Code Title 20, 702.110.

The Implementation Plan will include standards for ensuring that:

(1) food served to detainees is nutritionally sufficient,

(2) food service menus will be reviewed for adequacy and compliance with the applicable standards and laws and approved by a registered dietician on a semi-annual basis.

(3) special diets relating to diabetic, prenatal, and other medical conditions will be taken from approved diet manuals and be reviewed and approved by a registered dietician on a semi-annual basis.

(4) the food services supervisor and health care administrator will maintain documentation of these reviews;

(5) food will be stored and served in a manner that is consistent with the applicable standards and laws;

(6) CCJTDC has properly functioning equipment, which complies with environmental health standards to adequately store, prepare and serve food for the population it houses, and

(7) there are an adequate number of food service workers and staff to provide adequate and appropriate food service to the detainees.

2. Solution/Plan:

2.1 The Food Service staff will continue to utilize the food delivery carts currently in use that are designed to keep food hot or cold.

2.2 Utensils will be counted and signed for by the counselor upon the delivery of the food to the living unit and counted and signed for by the staff member returning the cart to the kitchen and counted and signed for by the food service worker receiving the cart. No kitchen items will be stored on the living units at any time.

2.3 Unit staff, recreation staff and the dietary unit shall coordinate activities in order to develop a unit schedule that will ensure that food is served in a prompt manner after delivery to the units.

2.4 The Center will maintain a pest control contract with a licensed exterminating company making the need for 'pest strips" unnecessary, and pest strips will no longer be used in JTDC.

3. Timeframe:

Within thirty (30) days of the approval of the MIP.

X. Bedding, Clothing, and Furnishings: Paragraph #38

1. MOA Requirements

The Center will assure that all detainees have adequate living space, bedding, clothing and furniture consistent with NCCHC Standard Y-15, ACA Standards 3-JDF-JB-05 through 3-JDF-4B-15 and Ill. Ad. Code, Title 20, 702.80. The Implementation Plan will assure that:

(1) detainees are provided with appropriate attire for the season and adequate beds, mattresses, and bed linens.

(2) clothing and bed linen are maintained in a sanitary condition;

(3) Mattresses are not placed directly on the floor unless necessary to protect the safety of the detainee;

(4) bed frames will be secured to the floor no later than one year of the court ordered approval of this agreement;

(5) detainees have areas to store personal hygiene items in a sanitary condition; and

(6) that there are an adequate number of chairs and table for detainees to use for dining, completing homework, and participating in social and recreational programming.

2. Solution/Plan:

2.1 Policies and procedures will be developed and submitted to the Compliance Administrator and Court Monitors that ensure the provisions of Paragraph 38 are addressed.

2.2 All mattresses with significant damage (including rips/tears larger than 1 inch in which contraband could be stored) will be replaced promptly.

2.3 The practice of having youth wash their personal underwear in the sinks, showers and toilets and left to dry in their rooms or on the living units will stop. Youth will be issued institutional underwear and laundry services will be provided by the facility.

2.4 Each youth will receive two sheets, one pillow and pillowcase and one blanket. From October 15 through May 1, youth will receive two blankets.

2.5 Each youth will have a clear plastic container where they may place their personal hygiene items. These containers will be marked and stored in a secure area and given to the youth in the morning at wake up and at shower time. Youth may request access to their items at other times during the day.

2.6 The facility shall provide a sufficient number of underwear and socks to permit daily changes. Soiled undergarments shall be stored in a sanitary manner in the resident's rooms or on the living units. Soiled clothes and clean clothes shall not be maintained in the same area. Clean clothes shall be issued at least three times a week. Bedding and linens shall be maintained in accordance with state standards**.** Residents will not be permitted to disinfect mattresses.

2.7 Each youth will be provided with soap, toothbrush, toothpaste, toilet paper, and towels.

2.8 Pursuant to Illinois State Standards and ACA 3-JDF-4B-11, policy, procedure and practice require that the facility provide for the thorough cleaning and when necessary disinfecting of juvenile personal clothing before storage.

3. Timeframe:

All provisions shall be implemented within 30 days of approval of the MIP.

Y. Pest Control: Paragraph #40

1. MOA Requirements

The Center will take appropriate measures to assure that the facility is reasonably free from insects, rodents, and other pests consistent with applicable NCCHC, ACA and state regulatory standards. The Implementation Plan will provide for an effective pest control management, ectoparasite control and oversight.

2. Solution/Plan:

2.1 The Center must enter into a contract with a licensed pest control company. Exterminating services must be provided at least monthly and otherwise as needed.

2.2 Pest strips in living areas are prohibited.

3. Timeframe:

Implementation shall be demonstrated upon approval of the MIP.

Z. Plumbing and Sanitation: Paragraph #41

1. MOA Requirements

The Center will assure that the plumbing and sanitation systems within the facility are functioning adequately and are consistent with applicable NCCHC, ACA and state regulatory standards. The Implementation Plan will include reasonable measures to assure that:

(1) the water quality is within acceptable levels;

(2) plumbing is functioning properly;

(3) malfunctioning plumbing is promptly repaired; and

(4) water pressure and temperature is adequate.

2. Solution/Plan

2.1 The Center shall revise its current policies and procedures regarding Plumbing and Sanitation in Paragraph #41, to assure that plumbing and sanitation systems are addressed and reviewed on a regular basis.

2.2 The policies shall articulate standards, provide environmental housekeeping and cleaning schedules, sanitation checklists and inspection reports, including the writing and management of

work orders and any follow up corrective action plans. The policies shall be submitted to the Compliance Administrator and the Court Monitors.

2.3 Residents rooms that do not meet standards will be clearly identified as "closed." Notation as to the reason for the room closure will be documented in the unit log and a work order shall be submitted for the repairs.

2.4 Internal QA reviews will occur and will assess and provide correction action and document compliance.

2.5 Maintenance orders will be prioritized by designated JTDC administrators and forwarded to the Department of Facilities Management in a timely fashion. Meetings between JTDC Administrators and Facilities Management personnel will be held as needed but not less than monthly. Documentation of monthly meeting with Facilities Management personnel shall be submitted to the Compliance Administrator.

2.6 Pursuant to ACA 3-JDF-4B-03, the facilities potable water source and supply whether owned and operated by the public water department or the institution, is approved by an independent, outside source to be in compliance with jurisdictional laws and regulations. This provision should ensure that the water temperature for laundry services meets acceptable standards.

3. Timeframe

3.1 Policies and procedures will be developed and approved within 60 days of the MIP's approval.

3.2 An independent inspection of the water supply shall be completed within 90 days of the approval of the MIP.

3.3 Implementation of the policies will be fully demonstrated in 90 days of approval of the MIP.

AA. Lighting: Paragraph #42

1. MOA Requirements

The Center will assure adequate lighting within the facility consistent with ACA Standard 3-JDF-2D-01. The Implementation Plan will require adequate natural and artificial lighting in living spaces, classrooms, stairwells, elevators, and hallways.

2. Solution/Plan

2.1 ACA Standard 3-JDF-2D-01 states: Written policy, procedure, and practice require that all lining areas provide at a minimum of the following:

- Lighting of at least 20 foot candles at desk level and in the personal grooming area.

- Natural light available from an opening or window that has a view to the outside, or from a source within 20 feet of the room as well as other lighting requirements for the facility determined by tasks to be performed.

Inspection of resident rooms, living areas and other areas shall be conducted by a licensed electrician quarterly to determine compliance. Inspection reports shall be submitted to the Compliance Administrator and appropriate JTDC personnel.

2.2 The policy shall include that lighting is included in the safety and sanitation inspections conducted at the facility and correction action plans are conducted when lighting issues are identified.

2.3 Counselors on third shift will be provided with flashlights so they may see into the youth's room when conducting their room checks at night.

2.4 The trim, doors and wall panels, now painted an institutional dark olive will be re-painted with a lighter color that reflects light and has a less institutional appearance.

2.5 The Superintendent or designee shall ensure polices reflect all requirements of the MOA that address Lighting in Paragraph #42. The policy will articulate standards, produce environmental housekeeping and cleaning schedules, sanitation checklists and inspection reports including the writing and management of work orders and any follow up corrective action plans.

2.6 Residents rooms that do not meet standards will be clearly identified as "closed." Notation as to the reason for the room closure will be documented in the unit log and a work order shall be submitted for the repairs.

2.7 Internal QA reviews will occur and will assess and provide correction action and document compliance.

3. Timeframe

3.1 Policies will be developed and approved within 60 days.

3.2 Re-painting shall be initiated within 30 days and completed within 160 days.

3.3 An inspection by a licensed electrician shall occur within 15 days of the completion of the re-painting.

BB. Heating, Cooling & Ventilation: Paragraph #43

1. MOA Requirements:

The Center will provide air quality and temperature that meet applicable standards and is consistent with ACA Standards 3-JDF-2D-01 through 3-JDF-2E-13 and Illinois Administrative Code, Title 20, 702.80. The Implementation Plan will describe the actions reasonably necessary to assure that air quality is properly monitored and maintained and that temperature is maintained within appropriate levels.

2. Solution/Plan:

2.1 The Center shall revise its current policies to assure that heating, cooling and ventilation systems are addressed and reviewed on a regular basis and in accordance with Paragraph #43. This will be accomplished by contracting with a licensed heating and air conditioning contractor who will assess and repair, if necessary the Center's heating, air handling and cooling systems, ensuring that they meet industry standards.

2.2 The Superintendent or designee will ensure policies include all requirements of the MOA that address Heating, Cooling and Ventilation in Paragraph #43.

2.3 The policy will articulate standards, produce environmental housekeeping and cleaning schedules, sanitation checklists and inspection reports, including the writing and management of work orders and any follow up corrective action plans.

2.4 Internal QA reviews will occur and will assess and provide correction action and document compliance.

3. Timeframe:

3.1 Policies and procedures will be developed and approved within 60 days.

3.2 Implementation of the policies will be fully demonstrated within 90 days of approval of the MIP.

CC. Fire & Electrical Safety: Paragraph #44

1. MOA Requirements

The Center will assure that the facility is reasonably free from fire and electrical hazards consistent with applicable NCCHC Standards. ACA Standards and state regulatory standards. The Implementation Plan will assure:

(1) adequate staff training regarding fire safety;

(2) proper maintenance and repair of fire equipment, fire doors, exit lighting, and fire resistant material on furnishings;

(3) electronic supervision of all locked doors that may provide egress in case of fire:

(4) an appropriate plan for manually opening doors in case of electronic malfunction;

(5) an appropriate evacuation plan for persons with disabilities;

(6) that all mattresses used by detainees for sleeping are fire resistant;

(7) routine testing of all fire equipment and systems including regular fire drills for detainees and staff;

(8) that all electrical outlets, wires, and equipment are in proper working order and do not pose electrical hazards; and

(9) an appropriate plan to thoroughly inspect the facility at regular intervals to assure compliance with fire safety plans, procedures, and equipment requirements.

2. Solution/Plan:

- 2.1 The Center's emergency plans, including fire emergency plan need to be updated and the emergency plans distributed to all living units and control rooms. The following Center policies will need to be reviewed and revised:

- *10.01 Fire Safety*
- *10.02 Fire Inspections*
- *10.03 Fire Safety Performance Requirements*
- *10.04 Non Combustible Receptacles*
- *10.05 Flammable, Toxic, Caustic Materials*

2.2 The Center shall enter into a contract with a licensed Fire Safety Company that will test and maintain all fire safety equipment in accordance with ACA Standard 3-JDF-3B-01.

2.3 The Center will appoint one or more Fire Safety Officers who will be responsible for providing a comprehensive and thorough monthly inspection for compliance with safety and fire prevention standards. There shall also be a weekly fire and safety inspection of the facility by a qualified department staff member. The Fire Safety Officer(s) shall receive training appropriate for their duties. Checklists and inspection forms shall be developed to assist the Fire Safety Officers. Staff shall be trained in the use of the fire extinguishers. The names of the Fire Safety Officers, a description of the training provided, evidence that the Fire Safety Officers completed training, and inspection forms shall be submitted to the Compliance Administrator and Court Monitors.

2.4 The Key Control System will ensure that fire exit keys are color code and notched. Each Floor Manager and Supervisor will have in their office a glass locked and sealed box marked "Fire Keys", which will be colored coded and notched providing access to fire safety equipment and all doors leading to the evacuation areas.

2.5 The Superintendent or designee shall ensure all polices meet all the requirements of the MOA that address Fire and Electrical Safety in Paragraph #44.

2.6 The policy will articulate standards, produce environmental housekeeping and cleaning schedules, sanitation checklists, and inspection reports, including the writing and management of work orders and any follow up corrective action plans.

2.7 Internal QA reviews will occur and will assess and provide correction action and document compliance.

3. Timeframe:

3.1 The Superintendent shall appoint a fire safety officer(s) within 15 working days of the MIP's approval. The Fire Safety Officer(s) shall receive training appropriate to this position within 60 days.

3.2 Policies will be developed and submitted to the Compliance Administrator and Court Monitors within 30 days of approval of the MIP.

3.3 Implementation of the policies will be fully demonstrated in 120 days of approval of the MIP.

DD. Sanitation: Paragraph #45

1. MOA Requirements

The Center will assure that the facility is adequately clean and sanitary consistent with applicable NCCHC Standards, ACA Standards and state regulatory standards. The Implementation Plan will include an appropriate housekeeping plan as well as a plan to monitor and correct deficiencies promptly and appropriately.

2. Solution/Plan

2.1 The Center shall review and revise its current policies to assure that sanitation standards are met.

2.2 Following submission and approval of the new policy, a staff training schedule and operational sequence will be established and implemented with a revised curriculum and competency testing to insure staff understands the policy requirements and procedures.

2.3 In addition to regular inspections by governmental officials, there will be daily safety and sanitation inspections conducted on all living units, medical and the food service area. These reports will be maintained in a file in the Floor Manager, Medical Director and the Food Service Directors office. The reports will note corrective action and maintenance requests.

2.4 The Superintendent or designee will conduct a bi-weekly inspection of the Center, documenting the Center's sanitation and maintenance issues and issuing work orders to repair items that are broken, or require painting and instructions on areas that require cleaning.

2.5 Residents rooms that do not meet standards will be clearly identified as "closed." Notation as to the reason for the room closure will be documented in the unit log and a work order shall be submitted for the repairs.

2.6 Internal QA reviews will occur and will access and provide corrective action and document compliance.

2.7 Review and amend, if necessary, contractual janitorial service contracts.

2.8 A contract monitoring procedure will be implemented for any contractual sanitation services.

2.9 The Superintendent will appoint a staff person to conduct quarterly contract monitoring of contractual services.

3. Timeframe

3.1 Policies will be developed and approved during the first 60 days of approval of the MIP.

3.2 Implementation of the policies will be fully demonstrated in 90 days of the approval of the MIP.

3.3 Daily safety and sanitation reports shall be submitted weekly and the bi-weekly Superintendents facility inspection report shall be submitted twice a month to the Compliance Administrator.

EE. Routine Maintenance: Paragraph #46

1. MOA Requirements

The Center will assure that the facility is properly maintained. The Implementation Plan will include a description of the actions necessary to reasonably assure timely repair of anything in the facility that is in disrepair.

2. Solution/Plan

2.1 The Center shall revise current policies to assure that routine maintenance issues are identified and appropriate actions are taken to facilitate repairs.

2.2 Maintenance requests will be prioritized into three categories: emergency, urgent, and general requests. Emergencies are those repairs that must be completed immediately, such as no heat, no water, broken pipes. Urgent requests would include showers not working, unit doors not locking; general requests would include a wall that requires painting, missing tile in a hallway. Emergency requests will be addressed immediately, urgent requests within two working days, and general requests within fifteen working days. A list of all maintenance requests shall be maintained. A copy of the pending maintenance log list shall be submitted to the Compliance Administrator weekly.

An Assistant Superintendent will meet monthly with Facilities Management personnel to review the status of maintenance requests.

2.3 Following submission and approval of the new policy, a staff training schedule and operational sequence will be established and implemented with a revised curriculum and competency testing to insure staff understands the policy requirements and procedures.

2.4 Internal QA reviews will occur and will assess and provide corrective action and document compliance.

3. Timeframe

3.1 Policies and procedures will be developed within 60 days of approval of the MIP.

3.2 Implementation of the policies will be fully demonstrated within 120 days of approval of the MIP.

FF. Health Care Overview: Paragraph #13

1. MOA Requirements

(1) The Implementation Plan will assure that all detainees are provided with those services that meet the NCCHC Standards that are cited in the MOA.

(2) The MOA Implementation Plan will include: a description of the actions the Center will take to assure that all detainees are appropriately screened for physical, dental, and mental health problems, are promptly treated when appropriate, and are provided with regular mental, physical and dental health care in accordance with the standard of care for the appropriate medical discipline.

(3) The Implementation Plan shall acknowledge and reasonably accommodate the operational, custodial, scheduling and supervision of security and movement requirements of the CCJTDC.

2. Solution/Plan:

2.1 The following paragraphs define the characteristics of an adequate system of care to comply with this paragraph.

2.2 Maintain NCCHC accreditation.

2.3 All health services policies and procedures shall be submitted to the Compliance Administrator and Court Monitors.

GG. Health Screening: Paragraph #14

1. MOA Requirements

The MOA Implementation Plan is required to describe the actions to be taken so that every detainee upon arrival at the CCJTDC:

(1) Receives a screening that complies with Standard Y-34 of the NCCHC Standards;

(2) Receives a health assessment that complies with Standard Y-35 of the NCCHC Standards; and

(3) Receives a mental health assessment that complies with Standard Y-36 of the NCCHC Standards; and

(4) Receives oral screenings, education and examinations that comply with Standard Y-37 of the NCCHC Standards.

The Implementation Plan will describe the specific actions that defendants will take to assure that appropriate services are timely provided to address the health, mental health, or dental needs of each detainee identified in the screenings and evaluations described above. Such services will be structured and delivered in a manner that complies with Standards Y-1 through Y-71 of the NCCHC Standards.

2. Solution/Plan

<u>Medical</u>

2.1 The intake nurse must be provided with a private area to observe the skin of the trunk and extremities. This requires the youth to partially undress. A curtain on an overhead track that easily moves into and out of place would provide adequate privacy in the current intake space.

2.2 Initial screening by the intake nurse must include observation of the skin of the trunk and extremities for evidence of communicable diseases in a private area.

2.3 Nursing must document all skin lesions or marks on a body chart. This is necessary both for identification purposes and to accurately record all injuries present at the time of admission.

2.4 The initial screening of females should include inquiry about last sexual intercourse and use of contraception at that time. Youth who admit to unprotected intercourse within 72 hours of admission who do not wish to become pregnant should be offered emergency contraception. Youth who admit to unprotected intercourse greater than 72 hours prior to admission should have a serum pregnancy test on admission and again two weeks after admission to diagnose pregnancy as early as possible.

2.5 The health history should include a brief review of symptoms which are common in adolescence or indicative of a serious health problem.

2.6 The health history should include inquiry about injection drug use and shared needles for injection, tattooing or piercing in order to identify youth at higher risk for HIV, hepatitis B and hepatitis C infection.

2.7 In addition to the question about current contraception, the health history should also ask females if they wish to receive information about contraception or initiate contraception. The request for contraception information and services should be listed on the problem list and systematically addressed via group education and individual counseling and prescription when indicated.

2.8 The physical examination form should provide more space to properly document the examination and should include prompts regarding lymph nodes, pulses, and the stage of sexual maturity.

2.9 Height and weight should be plotted on standard growth curves for children and assessed for abnormalities of growth and development such as obesity, short stature, delay in growth and maturation, etc.

2.10 Every youth admitted to the facility should have vision screening by a nurse using a standard Snellen wall chart.

2.11 Every female admitted to the facility should have a complete blood count at least annually to assess for anemia as recommended by the American Academy of Pediatrics.

2.12 Urine specimens for STD testing should be obtained from every youth admitted to the facility. Infected youth who are released prior to treatment should be referred to the appropriate health department.

2.13 A separate full page form should be provided for the doctor or nurse practitioner performing the history and physical examination to document their assessment and management plan. The assessment is a brief discussion of each active health problem which includes the examiner's findings and diagnostic ideas. The management plan for each active health problem should include diagnostic, therapeutic, patient education and follow-up components.

2.14 The problem list should be completed for every youth including all current, active health problems as well as past health problems that may influence care now, such as prior traumatic injuries to the head or major organs.

2.15 Additional efforts are needed to monitor the assessments, plans and initial orders to determine whether all problems are being addressed and improve performance of the physicians and nurse practitioner who do the initial medical assessments.

2.16 Youth held for three months or more should be considered to be long-term residents. Long term residents should be provided with a more comprehensive medical assessment including broader health history, health information from parents and prior health care providers in the community, hearing acuity screening using a standard pure tone device at various frequencies and loudness, additional laboratory tests recommended by the American Academy of Pediatrics to be provided at least once during adolescence including chemical and microscopic urine analysis, and complete blood count. Youth at risk for liver disease based on history of injection drug use or multiple sexual partners should have liver function tests. Youth at risk for atherosclerosis due to family history of early heart attack or stroke should have lipid screening.

2.17 Dental screening by the initial examining doctor or nurse practitioner should be documented on the physical exam form.

2.18 More follow-up dental treatment should be provided to all youth with restorative needs such as cavities.

2.19 Youth in residence for three months or more need a comprehensive dental program that includes diagnostic, preventive and restorative care initiated by the dental program staff.

2.20 Access to medical and surgical specialty consultation services must be truly available. Truly available means timely appointments are available, and facility transportation is provided to transport youth to their appointments on time.

2.21 Additional recommendations regarding improvements in the completeness of pelvic examinations and cervical cytology testing may be made after review of these services.

Mental Health

2.1 There continue to be two intake units for males. There shall be one designated intake unit for females. As previously understood through the research of Dr. Linda Teplin which was completed at the CCJTDC, females have higher incidences of mental health problems. Currently, much of this is being missed and simply not identified. In the event the female intake unit is needed to house residents other than intake, criteria shall be developed to identify who may share this unit.

2.2 The Center will give a MAYSI-II and a SASSI or MAST, or other appropriate alcohol and substance abuse screening tools to all youth within 24 hours. In association with these two scales, a brief validated scale will also be used.

2.3 For those youth who will be leaving the detention facility within the first few days, a process must be put into place where the initial assessment is reviewed and determinations regarding acute need for hospitalization, community based services or referral to the youth's school system for a case study evaluation needs to be made. This should be reviewed with the youth's guardian with specific contact information.

2.4 For those youth that will be in the facility longer, a more comprehensive assessment needs to be completed, using validated instruments. An example of such a validated scale would be the Diagnostic Interview Schedule for Children (DISC). There are other validated scales which could also be used.

2.5 Cognitive and educational testing must be given. Cognition and achievement for many of the youth entering the detention facility is simply not known. The WISC-IV and the WAIS instruments are recommended. In association with these achievement tests, using either the Woodcock-Johnson or WIAT would be adequate. These tests would take approximately two hours or so per student to implement. This should be used for youth who have not had IQ and achievement testing in the past year. Since cognitive and educational testing are needed both for purposes of mental health diagnosis and treatment and for educational assessment and placement, responsibility for this testing should be shared by CCJTDC and the Chicago Board of Education, which provides educational services to incarcerated youth.

2.6 Intake must be its own separate entity. Staff should not be taken away from other clinical duties to complete intake. There should be a psychologist that oversees intake. This would be a 1.0 FTE position. Based on the number of students coming through intake, there is also a need for a 1.0 psychiatrist within intake. Within each intake unit, there will need to be at least 3 Master's level psychometricians to assist with the implementation of testing. Persons with a minimum of a Bachelor's degree in an appropriate field (e.g.-psychology, social work, and counseling) with training in psychometric testing may be hired as psychometricians. Testing will be structured and results will be reviewed by the psychologist.

2.7 All youth that are on psychotropic medications or that are presenting with more acute mental health issues will be assessed by the psychiatrist on intake. If the youth is on psychotropic medication or in need of psychotropic medication, informed consent will be obtained (this will

be discussed later in the psychiatric section). If the youth is previously on medication, medication will be obtained on the same day of their arrival at the facility (even if on a weekend), as the delay in giving medication potentially could be life threatening. Once a comprehensive treatment assessment is completed there needs to be a multidisciplinary treatment plan developed while youth are still in intake units so that appropriate placement within the facility and the school system can be made.

2.8 Experts in computerized management information systems (MIS) shall be utilized so that intake information can be immediately input into the computer and then be reviewed by appropriate mental health staff and potentially used for future assessment. This will require specific consultation for implementation.

3. Timeframe

3.1 Hiring of additional staff shall be initiated within 7 days of approval of the MIP and completed within 60 days of approval of the MIP.

3.2 Policies and procedures relating to health services shall be developed within 60 days of approval of the MIP.

3.3 In-service training for existing staff shall be initiated within 30 days and completed within 90 days of approval of the MIP. All aspects of the MIP and pertinent policies and procedures shall be included in the training.

3.4 Revised intake screening procedures shall be initiated within 30 days and fully implemented within 90 days of approval of the MIP.

4. Measure of Compliance Performance Standards

4.1 The center will identify the specific mental health screening instruments to be used as described.

4.2 The center will develop and initiate appropriate training for staff.

4.3 The time frame for implementation of intake unit needs to be established within 30 days of approval of the MIP. The development of the structure of the intake unit including implementation of intake schedules, office space, day-to-day schedules, supervision, the development of multidisciplinary treatment plans, protocols for psychiatric referrals, etc., should all be established over the next six months.

5. Performance Indicators:

The following will be performance indicators to document that the measurements have been met.

5.1 There need to be monthly summaries covering each section described in this implementation plan, what they have accomplished and what the goals are for the following month.

5.2 Specific staff training, continuing education and continuing medical education need to be firmly established. An annual training plan needs to be developed and maintained.

HH Preventative Services: Paragraph #15

1. MOA Requirements

The Implementation Plan shall include a description of the actions the Center will take to reasonably assure that appropriate preventative services are provided to detainees while detainees are within the facility. The preventative health care program will include:

(1) appropriate immunizations,

(2) periodic health evaluations of all detainees,

(3) appropriate health education of detainees and staff,

(4) a plan for communicable disease control,

(5) reproductive health services, and

(6) a plan to assure that the diet provided to all detainees, including those whose health or religion requires special dietary accommodations, meets appropriate minimum standards for quality and quantity.

2. Solution/Plan

2.1 An organized, aggressive approach to obtaining parental consent for immunizations to overcome the barrier to provision of immunizations to youth should be included in the protocol.

2.2 In particular, youth in residence for three months or more should be brought fully up to date for their age for all recommended childhood and adolescent immunizations. Obtain history of childhood chickenpox from parents, titers for those with no chickenpox disease history, and provide the two shot vermicelli vaccine series for those who are not immune. When storing varicella vaccine prior to use, special attention must be given to maintaining adequately low freezer temperatures to ensure vaccine efficacy is maintained.

2.3 The content of the annual medical and dental assessments should be enhanced to provide for systematic review to determine that comprehensive services for longer term residents are being provided to each youth that has been in residence for one year or more.

2.4 Nurses assessing patients in the satellite offices must be provided with sinks to wash their hands or hand sanitizer to use between patients.

2.5 Contraception information should be provided to every female. Contraception services should be provided to females who request such services. Completeness of initial assessment of contraception, contraception education and contraception services should be monitored.

2.6 Prenatal care should be provided by a physician trained in obstetrics. Protocols for prenatal care should be developed, reviewed, and approved by this physician and should be consistent with current standards of care. A statement from the Health Services Administrator and Medical Director attesting to these facts should be provided. A system for referrals and discharge planning for pregnant females should be developed and maintained.

2.7 All diets and menu plans should include nutritional analysis, demonstrating compliance with USDA school nutrition standards, including standards for fat, saturated fat, and recommended dietary allowances. A dietary manual, including instructions for food services staff for preparation of a range of commonly prescribed medical diets, should be developed by a registered dietitian. This should include policy and procedure for management of alleged food allergies. A dietitian should also be available to assist with unusual special diets. Provisions should also address religious diets.

2.8 A variety of health education materials should be available in the clinic and on every unit, including pamphlets, videos, and/or educational software.

2.9 Group health education classes following a standard curriculum developed for high risk youth should be provided continuously. Health educators, health professionals or line staff can be trained to deliver standard health education curricula. Outside organizations may be funded by public health, public education, or foundations to provide such services in juvenile facilities.

2.10 Facilities policies and procedures for personal hygiene and clothing, bedding, and linen must comply with all applicable NCCHC, ACA, and state regulatory standards. Policies must address (a) bathing; (b) toothbrushing; (c) ready access to menstrual supplies; (d) changes of clothing (outer clothing and underwear); (e) changes of bedding and linen; (f) disinfection of mattresses and pillows after each user; (g) measures to prevent transmission of foot fungus, such as individual closed toe shower shoes, sani-mist or other brand of disinfection; (h) consultation with a podiatrist and sanitarian regarding re-issuance of shoes and proper disinfection to prevent transmission of foot fungus.

3. Timeframe

Within three months of approval of the MIP.

II. Identification of Health or Mental Health Concerns: Paragraph #16

1. MOA Requirements

(1) The Implementation Plan shall describe the actions taken to identify detainees who have developed health or mental health concerns since the admission screening, those whose health or mental health care needs have changed, or those who health or mental health care needs were not detected upon admission.

(2) The Implementation Plan will include a training program to help non mental health staff identify mental health needs that arise, following intake.

(3) The Plan will also require that when medically indicated, the CCJTDC will prepare a discharge plan to provide for continuity of care according to the requirements in Paragraph 30 below.

(4) Such services will be structured and delivered in a manner that complies with NCCHC Standards Y-1 through Y-71.

2. Solution/Plan

Medical

2.1 Implement the performance measures for NCCHC standards Y-E-02 and Y-E-04 to review health problems missed with intake screening and initial assessment.

2.2 Establish logs of health problems identified on admission and routine review of follow-up planned and follow-up achieved.

2.3 Establish logs of health problems assessed at sick call and routine review of compliance with nursing assessment protocols, follow-up and physician referrals.

Mental Health

2.1 Policies and procedures regarding specific mental health referrals from non-mental health staff needs to be clearly reviewed and restructured. All policies and procedures pertaining to mental health services should be highly clinically correlated to actual practices at CCJTDC. Time and time again during the interview process, the treaters reported the lack of correlation between policy and procedures and what is done clinically. Policies and procedures must be developed and revised in such a way that facilitates clinical implementation and practice.

2.2 There must be clear oversight and appropriate reporting lines regarding these issues.

2.3 There needs to be clear didactics for mental health and non-mental health staff. Training must be developed for non-mental health staff, as well as psychiatric and other mental health staff. Training should include having outside experts come in to help train staff and making

opportunities available for local CE and CME credit to be obtained. In addition, staff should be able to participate in CE and CME activities outside the Chicago land area to ensure the highest likelihood of being consistent with national norms.

2.4 There must be appropriate staff in place so that referrals for youth with acute mental health issues can be made and appropriate follow up can occur.

2.5 It is recommended that referrals, assessments and treatment notes ultimately be computerized so that other mental health staff have ease of access to this information. This will also allow for quick assessment of referral questions by administrators and allow one to address any potential concerns regarding follow up.

3. Timeframe

A review equivalent to an accreditation survey by the medical and mental health experts should occur within six months. There should be a stepwise pattern including hiring of an appropriate administrator who can assist with policies and procedures that have a clear correlation to clinical practice. Hiring of the appropriate staff needed and consideration for a computerized system, minimally clear policy and procedures must be developed. Within the first four to six weeks following acceptance, a training protocol should be developed and begin to be implemented. Psychiatrists and psychologists should be required to participate in continuing education (including continuing medical education). All curricula should ultimately be approved by the mental health administrator.

4. Measurement of Compliance:

The following standards will include:

4.1 Clear policy and procedures regarding referrals with a clinical correlation to these policies and procedures.

4.2 The need for staff, mental health and psychiatric training as described in Section 2.3.

4.3 Ongoing assessment of the referral process and a single person (PhD level) ultimately being responsible for its implementation and success.

4.4 A consistent quality improvement program, including all documentation for mental health services must be developed.

JJ. Assessment & Treatment of Acutely Sick Detainees and Injured Detainees: Paragraph #17

1. MOA Requirements

The Implementation Plan shall establish a program to administrator appropriate health services to address acute illness and injury while detainees are within the facility. The Plan will describe:

(1) procedures and practices that reasonably assure the detection and care of illnesses and injuries;

(2) a system for management and dispensing of medication;

(3) a system for monitoring side effects of medication;

(4) a plan for follow-up care;

(5) a system to allow detainees unimpeded, confidential access to medical staff;

(6) a protocol for referring detainees to specialists employed by the Cook County Bureau of Health Services ("BHS"), and, in the event appropriate specialists are not available through the BHS, to outside service providers; and

(7) a protocol for responding appropriately to medical emergencies.

The Plan will also require that, when medically indicated, the CCJTDC will initiate a discharge plan to provide for continuity of care according to the requirements in Paragraph 30 of the MOA.

2. Solution/Plan

2.1 Detection of illnesses and injuries

Sick call request forms must be readily available on the units, not under the control of unit staff and only available upon request.

The facility should ensure that all youth subject to restraint of any kind are immediately examined by appropriate health care staff. Youth should have a nursing assessment after every restraint to document any injuries or that there were no injuries. Nurses should document allegations of abuse during restraint, report them to the facility administration and report to DCSF as mandated by state law.

The Compliance Administrator shall be provided with a copy of the injury log and injury reports on a weekly basis.

2.2 Sick call

Nurses should be provided with regular and ongoing in-service training on the rationale for and consistent use of the nursing assessment protocols.

There should be regular and ongoing monitoring of a sample of sick call notes to determine that the nursing assessment protocols are being followed, that physician referrals are consistently made when indicated, and that the care at sick call is consistent with contemporary standards.

The youth's health record should be available to the nurse when the patient is being assessed at sick call. To accomplish this will require that the health records are obtained by the medical record clerks in advance based on a list of sick call requests and provided to the nurse prior to the designated sick call time.

The nurses should document their assessments at sick call in chronological order in the progress notes, not on the sick call request forms. In this way, each provider who sees the youth will be able to review their recent health care by looking in only one section of the chart, the progress notes.

A sick call log should be maintained that lists the unit, date, nurse, youth, complaint, nurse’s assessment and plan. The sick call logs should be reviewed daily by a physician or nurse to monitor for significant problems in need of prompt physician follow-up.

All aspects of sick call shall be conducted in a confidential, private setting.

All satellite health rooms shall be furnished with basic medical equipment to permit adequate examination and hygiene.

2.3 Medication management

The practice of pre-pouring the medicines and placing them in unmarked envelopes must cease. All prescriptions should be filled on unit dose blister cards. The pharmacy label is usually affixed to the upper margin of the card. New medication carts should be obtained that are designed to hold the standard blister cards upright in the drawer. This will enable the nurse to maintain them in alphabetical order by unit and readily search by name. No pre-pouring is needed with unit dose cards filed alphabetically by unit.

In order to determine that orders are transcribed accurately onto the medication administration records routine review and correction by a second nurse should be implemented. The nurses should continue to place copies of the original prescriptions in the medication notebooks to permit the medication nurse to confirm the specific details of a prescription when needed.

To reduce missed doses due to prescriptions not delivered, the nurses should keep a running log of prescriptions ordered, track when they are delivered, and follow-up with the pharmacy daily regarding prescriptions not yet filled after the expected 24 hour turnaround time. Develop a protocol for physician review of unfilled prescriptions to determine which ones need to be filled immediately by the local pharmacy rather than waiting still longer for the Oak Forest pharmacy to obtain the drugs.

Implement use of a standard two page medication administration record rather than the current four (4) page form that contains no additional useful information.

Include information about the common clinical side effects of medicines in the medication notebooks to alert nurses to important symptoms they might observe during medication administration.

2.4 Plans for follow-up care

Follow-up should be part of the management plan for every health problem assessed. "No follow-up needed" or "Follow-up PRN" is a valid follow-up plan that shows the provider considered the need for follow-up and decided "as needed" was adequate.

The health program needs to log and track all requests for outside services (x-ray, prescriptions, lab tests, specialty referrals, etc.) to determine which are done timely and follow-up on those that are not. Otherwise they are lost to follow-up until someone notices by chance that the needed service was never done.

There needs to be an appointment system to be used to establish and track dates for scheduled follow-up of youth with ongoing health needs.

Liver function tests need to be conducted initially and monitored every 6 to 8 weeks for those receiving preventive therapy with INH for latent tuberculosis infection.

2.5 Specialist referrals

Detention center physicians should make better use of specialists. Consultations are often needed to make a diagnosis, to recommend treatment, and prior to surgery. A good rule for a general pediatrician, family physician or internist to follow is to refer when there is no diagnosis after they have done their usual workup for a problem, or the patient is not improving clinically after they have provided their usual treatment for a problem. This approach allows the generalist physician to do what he or she knows how to do, and provides access to the expertise of a specialist when the problem has not responded to the generalist's initial efforts.

The program should log and track specialist referrals to determine when additional efforts are needed to obtain a timely consultation. This will help prevent needed consultations from being lost to follow-up.

Sufficient line staff must be available to reliably transport youth to off-site appointments on time. Cancellation of appointments due to lack of transportation must be a rare exception to the established rule that all appointments are kept on time.

When needed services are not available timely from the institutions operated by the Cook County Bureau of Health Services, those services must be obtained elsewhere. In order to accomplish this, the health program will need to determine what services are likely to be needed (e.g. - neurology) and develop agreements with willing providers in the community.

2.6 Emergency response

Policies and procedures for emergency response should be jointly developed by facility and health services administrators. These policies must include provisions clearly delineating medical autonomy in emergency situations, which includes decisions to transport by ambulance and hospitalize youth without delay whenever clinically indicated. Protocols must include provisions for deciding when health staff will respond to the site of an emergency and when facility staff will bring youth to the health care unit. Procedures must also clearly articulate the chain of command for emergency responses to ensure that appropriate staff is available at all times and that ambulances can access the facility without delay. One or more equipment bags or carts containing emergency equipment and supplies must be maintained at all times. The contents of this bag should be described in a document and submitted to the medical expert for approval.

3. Timeframe

Within 30 days of approval of the Modified Implementation Plan.

KK. Special Services for Detainees with Chronic or Disabling Medical Conditions: Paragraph #18

1. MOA Requirements

The Implementation Plan will include a program to administer appropriate health treatment for chronic or disabling medical conditions. The plan will include an appropriate and organized system of care for chronically ill detainees including:

(1) An appropriate plan for detection and care of chronic or disabling conditions,

(2) A system for regular physician follow-up visits,

(3) Screening tests to diagnose and treat complications,

(4) Patient education to recognize acute complications early and initiate intensive management,

(5) A system for management and dispensing of medication,

(6) A system for monitoring and addressing side effects of medication,

(7) A system to allow detainees prompt, confidential access to medical staff, and

(8) A protocol for referring detainees to specialists and outside service providers when appropriate.

(9) The Plan will also require that, when medically indicated, the CCJTDC will initiate a discharge plan to provide for continuity of care according to the requirements in Paragraph 30 of the MOA.

2. Solution/Plan

2.1 The CCJTDC health services unit needs to establish treatment guidelines for chronic illness care that give guidance to the physicians and nurse practitioners on how to improve management among those who have not achieved optimal control of their disease.

2.2 Revise chronic illness forms to make them more effective tools for improving the quality and completeness of chronic illness care. The information to be obtained once at a first visit should be on an Initial Visit form, while the information to be gathered at follow-up visits should be on a separate, Follow-up Visit form. As there are often many aspects of a chronic illness to keep track of (tests for adequacy of management, tests for identification of complications, immunizations, specialty consultations, etc.) it is useful to have a Flow Sheet for each chronic illness where such tests, exams, consultations and immunizations are summarized for easy review.

3. Timeframe

Within 90 days of approval of the MIP.

LL. Mental Health Treatment: Paragraph #19

1. MOA Requirements

The Implementation Plan will describe actions to be taken to assure:

(1) appropriate provision of mental health counseling and treatment;

(2) that all detainees are treated in the least restrictive manner appropriate;

(3) that detainees whose mental health needs cannot be met within the institution are timely referred to competent specialists and other professionals or outside service providers;

(4) that all staff who interact with detainees are adequately trained and a plan is implemented for appropriate treatment of mental health emergencies; and

(5) and in the event that appropriate specialist are not available through the facility, to competent and outside providers; and

(5) that detainees who require hospitalization for acute mental health problems are promptly referred to an appropriate hospital program for children or adolescents for evaluation and treatment.

The Plan will also require that, when medically indicated, the CCJTDC will prepare a discharge plan to provide for continuity of care according to the requirements in Paragraph 30 of the MOA.

2. Solution/Plan

2.1 Development of appropriate levels of mental health staffing will involve a two-stage process which is described in Appendix B and is incorporated herewith as part of the MIP

2.2 As soon as possible, a Director of Mental Health needs to be in place. The person chosen for this position should have a clinical background, have a Ph.D. or equivalent degree, and should be interviewed and supported by the current mental health staff for the position. The Director of Mental Health may perform clinical duties as deemed appropriate by current staffing and resident needs.

2.3 There will be a need for additional consulting staff to assist with further development of policy and procedures, clinical implementation, development of a cohesive mental health program and hopefully with additional consulting to assist in computerizing the medical and mental health programming.

2.4 There will be a significant need for outcomes data and outcomes research. Allocating and ultimately hiring a .5 FTE psychologist to assist with development of protocols and assisting with any ethical issues regarding research and to work with the staff so that outcomes data can be generated and evaluated to assess the effectiveness of treatment interventions.

2.5 There is a need for special needs units which will accommodate youth with significant mental health needs. At the present time, one such unit for males and one unit for females are recommended. This will be for the most significantly mentally ill youth. These youth will be identified at intake. In addition, there will likely be youth that become more progressively mentally ill during their time at the facility who may also make use of this unit. The two units will need 1.0 FTE psychiatrist and 1.0 FTE psychologist who will oversee two social workers in each unit who will assist with day-to-day groups, individual treatment and crisis situations for the youth in addition to assisting with case management and family issues.

2.6 At the present time there are almost no appreciable family interventions. This needs to be developed and be part of the mental health interventions. The level of disruption and dysfunction in many of the families of the youth within the detention facility is a well-known fact. Any assistance with helping the dynamics will only be of benefit to the youth.

2.7 There needs to be a specialized substance abuse unit. The protocols for this unit should include both drug/alcohol education and intensive substance abuse treatment. A .5 FTE psychology position and a 1.0 FTE social work position need to be involved and assist with individual treatment and groups within this program. One of the reasons that there is a need for specialized programming besides offering a level of responsibility to specific treatment, has to do with the longstanding difficulties of getting children to mental health. Within the units, adequate space for mental health staff to see youth needs to be developed. The provision of substance abuse education and treatment shall occur under the supervision and coordination of the Mental Health Services Administrator. If the facility contracts for substance abuse programming, the staffing requirement for the psychology position and social work position may be incorporated in such contract.

2.8 There needs to be better communication and coordination between security and mental health staff.

2.9 There needs to be a clear quality assurance program that assesses mental health and psychiatric services with interventions and feedback for situations in which deficits exist and treatment is not consistent with policy and procedures.

2.10 There needs to be clear suicide risk interventions and protocols. A youth who is identified as a suicide risk must be kept under one-to-one supervision until evaluated by a mental health staff. There must be clear suicide watch protocols; for example, one-to-one observation, 15 minute checks, 30 minute checks, suicide precaution level. Within this plan there must be an understanding of when a child can remain on the unit and be observed within arms reach of staff and when a child needs to be placed in a mental health or other special management unit. In association with this, there needs to be some level of differentiation between the medical unit, special management units for aggressive youth, and a mental health unit.

2.11 If a youth is placed in room confinement, there need to be clear protocols, policies and procedures and assessment regarding why the youth is placed in his/her room. These youth will be at high risk for self-harm. If they are expressing any thoughts of self-harm, aggressiveness or had something traumatic happen within their family, mental health should be contacted. The youth should not remain in their room for more than one hour. If there is a need to keep the youth in their room for more than one hour, mental health needs to be contacted. More specific policy and procedures need to be developed regarding placing the youth in room confinement.

2.12 Clear policy and procedures regarding psychiatric services need to be better established with appropriate follow through. For example, at the present time, charts do not contain informed consent forms. Establishment of clear criteria for youth who need to be evaluated which should include youth that have either 1) previously been on psychotropic medication, 2) youth that are

currently on psychotropic medication, 3) youth that are presenting with acute mental health disturbance, or 4) youth that continue to present diagnostic questions.

2.13 There needs to be policy and procedures and work with the juvenile court judges regarding the clinician's roles with clinical services. At the present time, it appears that youth are being seen for clinical purposes with the understanding that their data will be kept confidential but their data is then used within juvenile court without their release and potentially used against them, dependent upon the information presented.

2.14 There needs to be mental health training for non-mental health staff, mental health training with CE credits for psychology and social work, and mental health training with CME credits for the psychiatric staff. In addition to having trained staff give some of the lectures and trainings, there also needs to be a consistent effort to have experts from outside the facility coming in for training and tutorials on specific topics and to offer staff the ability to attend pertinent conferences, such as the NCCHC and specialty conferences so that they can learn more up to date treatment topics on such topics on posttraumatic stress disorder, dialectical behavior therapy and others.

2.15 There is a need for developing a cohesive and consistent mental health program which focuses on individual treatment, group therapy, and family therapy. There needs to be additional focus on the specific sequela with so many of the females within the facility. At the present time, there is a relative paucity of treatment for the females within the facility.

2.16 There needs to be the development of a generalized substance abuse education program for youth within all of the living units that can be implemented by staff.

2.17 For the purpose of placement within a specialized substance abuse unit and the special needs units, for both males and females, the Center will develop eligibility criteria to identify detainees for placement into special need/management living units. A decision needs to be made regarding the level of protection that these youth will need. Separate educational programming for these youth needs to be considered and discussed further.

2.18 There needs to be special need unit(s) for particularly young or vulnerable youth. If part of this unit or separate from this unit there needs to be a unit for those youth that are presenting with acute suicidal thoughts or are at risk for self-harm.

3. Timeframes

These projects will be completed within six months of approval of the MOA. Development of therapeutic programs will be accomplished within six months. The process and specific sequence of events regarding the development of the more appropriate mental health program can be further discussed.

MM. Sufficient Staff, Space, Supplies, and Equipment to Implement an Adequate Health Program: Paragraph #20

1. MOA Requirements

The Implementation Plan will include a description of the actions needed to maintain or procure sufficient staff, space, supplies and equipment to meet health program needs. The Plan will include:

(1) hiring and retaining a sufficient number of appropriately trained and qualified medical staff and administrative staff to provide adequate health, mental health, and dental services,

(2) Custodial staff to accommodate, move, and supervise detainees requiring care,

(3) acquisition and maintenance of appropriate equipment and supplies, and acquisition of designation of appropriate space for confidential treatment and counseling.

2. Solution/Plan

2.1 Hiring and retaining a sufficient number of appropriately trained and qualified health care providers and administrative staff to provide adequate health, mental health and dental services,

2.2 Custodial staff to accommodate move and supervise residents requiring care,

2.3 Acquisition and maintenance of appropriate equipment and supplies,

2.4 Acquisition or designation of appropriate space for confidential treatment and counseling.

3. Timeframe

These projects will be completed within six months of approval of the MOA. Development of therapeutic programs will be accomplished within six months. The process and specific sequence of events regarding the development of the more appropriate mental health program can be further discussed.

NN. Record Keeping: Paragraph #21

1. MOA Requirements

The Center will assure that adequate health and mental health records are kept for all detainees consistent with NCCHC Standards Y-60 and Y-61. To achieve this goal, the Implementation Plan will establish a system of keeping health records that:

(1) assures appropriate confidentiality;

(2) provides appropriately detailed health assessments, plans for care and progress notes for each detainee; and

(3) can, upon request of a parent, guardian, or detainee (when permitted or required by law), readily be transferred to new health care providers when a detainee is released or relocated.

2. Solution/Plan

2.1 A system of keeping health records must include provisions to:

(a) assure appropriate confidentiality;

(b) provide appropriately detailed health assessments, plans for care, and progress notes for each resident;

(c) can, upon request of a parent, guardian, or resident readily be transferred to new health care providers when a resident is released or relocated.

3. Timeframe

Within 120 days of approval of the MIP.

4. Measurement of Compliance/Performance Standards:

The following are the performance measures that will be used to accomplish the requirements of the MOA.

4.1 All health service positions will be filled. Salary levels for health staff should be adjusted as necessary, and appropriate advertising for vacant positions conducted to ensure that positions are filled with qualified persons in a timely fashion.

4.2 A quantitative assessment regarding the development of mental health programming needs to be developed.

4.3 Quantitative assessments regarding psychiatric development needs to be developed.

4.4 Further assessment regarding the development of the special need unit(s) should be conducted. Development of a substance abuse unit needs to be monitored and evaluated.

4.5 Continuing reaccredidation by the NCCHC needs to occur. Ongoing communication with the NCCHC regarding potential concerns pertaining to health service issues should occur.

4.6 There are numerous other specific mental health issues which need specific documentation and corrective action plans regarding how there is going to be clear improvement with specific dates and requirements for these improvements.

4.7 Continued clear documentation of youth who are placed in restraint, including security versus mental health restraint and continued correlation of clear demarcation of this, must occur.

4.8 Development of an appropriate Quality Assurance Program with appropriate corrective action plans needs to occur.

OO. Confidentiality of Health Information & Services: Paragraph #22

1. MOA Requirements

The Implementation Plan will require a system for maintaining confidential medical and mental health records consistent with NCCHC Standard Y-60 and Y-61. The Plan will also establish a system to allow detainees to request and receive health care and mental health services in a confidential manner without having to reveal information about their health care needs to non health care staff. However, in the event that dissemination of a detainee's medical information is necessary to protect the health of that detainee, release of medical alert information can be made to direct care staff with the approval of the Medical Department.

2. Solution/Plan

2.1 Policy and practice to ensure any information that JTDC creates or maintains regarding resident health or mental health will remain confidential.

2.2 Policy and practice to ensure that residents can access health and mental health care in a confidential manner.

2.3 Policy and practice to ensure the maintenance of confidential medical and mental health records.

2.4 Policy and practice to ensure a system to allow youth to request and receive health care and mental health services in a confidential manner without having to reveal information about their health care needs to non health care staff.

2.5 Policy and practice to ensure release of medical alert information necessary to protect the health of that resident is available and communicated to direct care staff with the approval of the Medical Department.

3. Timeframe

Within 90 days of approval of the MIP.

4. Performance Indicators:

The following indicators would document compliance with performance measurements and requirements of the MOA. Monthly summaries of all specific mental health issues should be prepared and reviewed and plans for the next month developed

4.1 Monthly statistics regarding the number of youth that are coming in and are referred to mental health and psychiatry. These reports shall be submitted to the Compliance Administrator and Court Monitors.

4.2 Clear documentation of youth that are placed in room confinement and who are placed in restraints.

4.3 Mental health logs and psychiatric records will continue to be assessed.

4.4 Quality improvement programs need to continue to be assessed with corrective action plans when necessary. Clear documentation, services and plans over the next six months need to be put into place.

4.5 The psychiatric assessments must be comprehensive covering key components including background history, prior psychiatric hospitalizations, family history, prior medications, current medications and a clear current history in regards to the present illness. All assessments must include, at a minimum, a clear, coherent mental status exam, a biopsychosocial formulation, and a clear treatment plan. All youth on psychotropic medication must be seen at least once per month. All youth who have psychiatric referrals must be seen within a 72-hour period. Any type of emergency psychiatric referral needs to be seen within a 24-hour period.

4.6 Approximately 6 to 8 assessments are discussed at some weekly treatment plan meetings. A review of several of the multidisciplinary treatment summaries revealed that they are relatively brief and superficial without clear treatment plans and goals; in addition, a relative paucity of time appeared to be given to completing these and as such the true purpose of doing a multidisciplinary plan was not reached. The experience of different professionals needs to be utilized in preparing a comprehensive treatment plan which focuses on the needs of the youth with the understanding of what those needs are; staff should develop a treatment plan which would be helpful for the youth in a variety of developmental, educational and mental health contexts. Staff were unable to explain the particular goals of these treatment plans or any long-term plans or any benefits of doing them. None of the psychologists could report how youth would be referred in the treatment plans. It was quite clear that not all youth have treatment plans and it is unclear how the determination for treatment plans was made.

PP. Standards for Prescribing, Storing, and Dispensing Medications: Paragraph #23

1. MOA Requirements

The Implementation Plan will include a description of the actions the defendants must take to prescribe, administer, store, and dispense medication in a manner that complies with legal and professional standards and security and accountability requirements of the CCJTDC, including appropriate protocol for respecting patients' rights to refuse medication and avoiding unnecessary use of psychoactive medications for disciplinary purposes or inappropriately to control behavior. The CCJTDC will follow NCCHC Standard Y-67 concerning the right to refuse treatment. Additional protocols will be developed to address the event that a refusal to take medication endangers the health of the patient and others.

2. Solution/Plan

2.1 All medications are prescribed, administered, stored, and dispensed according to applicable legal and professional standards.

2.2 Prescribe, administer, store, and dispense medication in manner that complies with legal and professional standards and security and accountability requirements.

2.3 Appropriate protocol for respecting patients rights to refuse medication.

2.4 Develop a policy to ensure that unnecessary use of psychoactive medications for disciplinary purposes or inappropriately to control behavior does not occur.

2.5 Adherence to NCCHC standard Y-67 concerning the right to refuse treatment.

2.6 Protocols shall be developed to address the event that a refusal to take medication endangers the health of the patient and others.

3. Timeframe

A plan approved by a registered pharmacist must be developed and implemented within 90 days of approval of the MIP.

QQ. Therapeutic Restraint and Room Confinement: Paragraph #27

1. MOA Requirements:

The Implementation Plan will include the actions defendants will take consistent with NCCHC Standards to assure the safe and appropriate use of restraint and room confinement for therapeutic purposes. The policies therein will include the following:

(1) Overview of therapeutic restraint and room confinement.

(2) In no case may mental health staff or any other staff use therapeutic restraint or therapeutic room confinement to discipline a detainee or as a convenience for staff.

(3) Medical and mental health staff will not make decisions about whether the behavior of any particular detainee warrants disciplinary action.

(4) Use of therapeutic restraint.

(5) Mechanical and fixed restraints.

(6) Therapeutic mechanical restraint will be employed only upon the order (either written or, if oral initially, later memorialized in writing) of a qualified mental health professional, who has clinically determined that the use of mechanical restraint is necessary to prevent the detainee from causing imminent physical harm to self or others, and that no other less restrictive intervention is appropriate. Such clinical determination shall be based on either (a) the personal observation or examination by the qualified mental health professional who issues the order or (b) the personal observation and examination of another qualified health professional that was communicated to the on-call physician, psychiatrist or psychologist who issued the order.

(7) The written order for therapeutic mechanical restraints will be distributed to appropriate supervisory personnel.

(8) The only permitted mechanical restrains are the same kind of restraints that would be appropriate for individuals treated in the community, (i.e. fleece-lined leather, rubber or canvas hand and leg restraints, and 2-point and 4-point ambulatory restraints as defined in NCCHC Standard Y-66). Metal or hard plastic restraints (such as handcuffs and leg shackles) will not be used for therapeutic restraint.

(9) Within ninety (90) days of the entry of an order by the Court approving this agreement, the CCJTDC will discontinue the use of metal and hard plastic restraints for therapeutic purposes.

(10) Detainees must not be restrained in any unnatural position (for example, hog-tied, face down, spread-eagle).

(11) Restraints being used for therapeutic purposes will not be affixed to furnishings other than restraint devices specifically designed and recognized by the mental health professionals as appropriate vehicles for achieving therapeutic goals.

(12) No detainee may be restrained for longer than 1 hour unless within that time period a qualified mental health professional confirms, in writing, following a personal examination of the detainee, that restraint for a longer period is medically necessary and that it does not pose an undue risk to the recipient's health in light of the recipient's physical and mental condition.

(13) The order shall state the events leading up to the need for restraint and the purposes for which restraint is employed. The order shall also state the length of time restraint is to be employed and the clinical justification for that length of time. Unless extraordinary circumstances are present, no order for therapeutic restraint will be valid for more than 2 hours, but in no case should it be applied for longer than is absolutely medically necessary.

(14) Once the restraint has been employed, it will not be used again on the same detainee during the next 48 hours without prior written authorization of a qualified mental health professional with the concurrence of the Medical Director or Medical Administrator. Such authorization is appropriate only when no less restrictive manner of preventing harm to a detainee or staff is available and it is not appropriate to transport the detainee to a mental health facility. In no case may the Medical Director or Medical Administrator authorize such restraint within six hours of a prior use of restraint absent, extraordinary circumstances. Copies of the authorization will be placed in the detainees' medical file and, within 24 hours of the authorization, excluding weekends and holidays, will be provided to the Monitor (s) and plaintiff's counsel, and made available to the attorney who is representing the detainee in juvenile court proceedings.

(15) Any detainee placed in mechanical restraint shall be examined by a qualified health care professional within fifteen minutes of being restrained, and every fifteen minutes thereafter. This medical monitoring will include a check for circulation, nerve damage, airway obstruction and psychological trauma. The qualified health care professional shall maintain a record of all relevant observations. In addition to the medical monitoring, a staff member must be in constant close proximity to the restrained detainee at all times.

(16) Unless there is an immediate danger that the recipient will physically harm himself or others, the restraint shall be applied in the least restrictive manner possible given the circumstances to prevent harm to the person restrained or others. The restraints must be timely adjusted, modified or removed, as medically appropriate, to allow meals to be eaten and prompt use of bathroom facilities.

(17) Within one hour after a detainee has been released from mechanical restraint, a qualified health care professional will evaluate the detainee thoroughly to assure that no physical or psychological injury has occurred, and will assure that appropriate actions are timely taken to prevent or respond to any injuries or needs. The examination will include complete vital signs, the level of consciousness, mental status exam, mood and signs of mental illness. The qualified health care professional performing the evaluation will when appropriate transfer the detainee to an emergency room, release the detainee from restraints, or arrange for examination by an appropriate specialist. Any injuries identified during this evaluation will be documented in writing and reported to the Superintendent, the Medical Director and the Monitors.

(18) Whoever orders restraint or restrains a detainee shall document the behavior that preceded the use of restraint, the efforts that were made to avoid the use of restraint and the reasons that restraint was deemed necessary and, within 24 hours, excluding weekends and holidays, place that documentation in the detainee's medical file and deliver a copy to the Medical Director or Medical Administrator. All use of restraints will be documented. The Medical Director or

Medical Administrator shall review all restraint orders daily and shall investigate to address any patterns of use of restraints that might be appropriate.

(19) Emergency mechanical restraint.

- *In the event there is an emergency requiring the immediate use of mechanical restraint to prevent imminent physical harm to a detainee or staff member, mechanical restraint may be temporarily ordered by a group services supervisor or floor manager only where a qualified health care professional is not immediately available, and no less restrictive method of preventing harm is available. In that event, an order by a qualified health care professional shall be obtained pursuant to the requirements in Sub-Paragraph (i) within fifteen minutes. In the event no such approval is obtained, the detainee shall be released from the restraint.*
- *A staff member must be in constant close proximity to the restrained detainee at all times. The restraint shall be applied in the least restrictive manner possible given the circumstances to prevent harm to their self or others. The restraints must be timely adjusted, modified or removed, as medically appropriate, to allow meals to be eaten and prompt use of bathroom facilities.*
- *Within one hour after a detainee has been released from emergency mechanical restraint, a qualified health care professional will evaluate thoroughly the detainee to assure that no physical or psychological injury has occurred, and will assure that appropriate actions are timely taken to prevent or respond to any injuries or needs. Any observations will be recorded and a written copy of those observations will be delivered to the medical Director or Medical Administrator.*
- *Whoever orders the restraint or restrains a detainee in an emergency situation shall document the behavior that preceded the use of restraint, the efforts that were made to avoid the use of restraint and the reasons that restraint was deemed necessary and, within 24 hours, excluding weekends and holidays, place that documentation in the detainee's medical file and deliver a copy to the Medical Director or Medical Administrator. All use of restraint, whether permissible or not, will be documented.*
- *The Medical Director or Medical Administrator shall review all emergency restraint orders daily and shall investigate to address any patterns of use of restraints that might be inappropriate.*

(20) Defendants will assure that the CCJTDC policies and practices adhere to NCCHC Standard Y-66 regarding the CCJTDC use of therapeutic restraints.

(21) Therapeutic room confinement.

- *Room confinement for therapeutic purposes will be employed only upon written order of a physician, licensed clinical psychologist, licensed clinical social worker, or licensed nurse upon consultation with a physician, who has personally observed and examined the detainee and has clinically determined that the use of room confinement is necessary to prevent the recipient from causing imminent physical harm to himself or others, and that no other less restrictive intervention is appropriate.*

- *No detainee may be placed in therapeutic room confinement for longer than 2 hours unless within that time period a qualified mental health professional confirms in writing, following a personal examination of the detainee, that the room confinement is medically necessary and does not pose an undue risk to the recipient's health in light of the recipient's physical and mental condition.*
- *The order shall state the events leading up to the need for the room confinement and the purposes for which the room confinement is employed. The order shall also state the maximum length of time room confinement is to be employed and the clinical justification for the length of time.*
- *Therapeutic room confinement will not be used for more than 24 consecutive hours, absent extraordinary circumstances.*
- *The completed order for therapeutic room confinement shall be disseminated to the Medical Director or Medical Administrator.*
- *Once room confinement for therapeutic purposes has been employed during one 24 hour period, it will not be used again on the same detainee during the next 48 hours, without prior written authorization of a physician, licensed clinical psychologist, licensed social worker, or nurse, upon consultation with a physician, licensed clinical psychologist or licensed social worker with concurrence of the Medical Director or Medical Administrator.*
- *Such authorization is appropriate only where no less restrictive manner of preventing harm to a detainee or staff member exists, and the detainee does not require treatment at a mental health facility.*
- *Copies of that authorization will be delivered to the Medical Director or Medical Administrator and placed in the detainees' medical file and, within 24 hours of the authorization, excluding weekends and holiday, and will be made available to the Monitor(s) and to plaintiffs' counsel, and upon request, to the attorney who is representing the detainee in juvenile court proceedings.*
- *Such room confinement shall not be authorized within six hours of a previous room confinement absent extraordinary circumstances.*
- *Whoever orders therapeutic room confinement shall document the behavior that preceded the use of room confinement, the efforts that were made to avoid the use of room confinement, and the reasons that restraint was deemed necessary and, within 24 hours, place that documentation in the detainee's medical file and deliver a copy to the Medical Director or Medical Administrator.*
- *All use of room confinement, whether permissible or not, will be documented.*
- *The Medical Director or Medical Administrator shall review all room confinement orders daily and shall investigate to detect and address any patterns of inappropriate use of therapeutic room confinement.*
- *Reasonable safety precautions shall be followed to prevent injuries to the detainee in room confinement. Room confinement rooms shall be adequately lighted, heated and furnished, and have immediate access to appropriate toilet facilities. If a door is locked, someone with a key shall be in constant attendance nearby.*
- *All detainees who are placed in therapeutic room confinement must be evaluated within three hours by a qualified health care professional. The health evaluation must include:*

- ✓ *Personal contact with the detainee, notation of bruises or other trauma markings, and*
- ✓ *An assessment of the detainee's mental status*

Note: Isolated non-systemic technical violations will not be an appropriate basis for a contempt citation.

- o *A copy of the health evaluation will be placed in the detainee's medial file. A juvenile detention counselor shall*

  - ✓ *Visually observe the confined detainee every 15 minutes, in addition to the visual checks.*
  - ✓ *A juvenile detention counselor will make personal contact with the detainee every hour while the detainee is awake.*
  - ✓ *A log must be kept of all interactions with the detainee while in room confinement.*

- o *Detainees in therapeutic room confinement must receive programming and educational opportunities, to the extent that their condition may allow.*

2. Solution/Plan:

2.1 The Center shall develop written eligibility criteria to specifically define the characteristics of the juvenile detainees who are appropriate for placement in the health care unit.

2.2 The Center will train staff in the implementation of these criteria.

2.3 The Center will designate supervisors with the responsibility of reviewing and approving requests for transfer to the health care services unit and for ensuring that data is entered into the DSI system on all such transfers. Approval of the transfer must be approved by designated health care providers specified by policy.

2.4 Therapeutic restraints and room confinement reports shall be submitted to the Compliance Administrator and Court Monitors on a daily basis (M-F).

3. Timeframe

3.1 The Center shall develop criteria within 45 days of the approval of the MIP. JTDC Staff will be trained within 90 days.

RR. Protocols to Prevent Unnecessary Assignment of Detainees to the Medical Unit: Paragraph #28

1. MOA Requirements

Detainees will not be confined to the medical unit unless medically appropriate. Detainees who must be confined in the medical unit will receive appropriate educational, recreational, and social programming to the extent that their medical conditions allow. The Implementation Plan will include criteria for determining whether confinement in the medical unit is medically necessary.

(1) The center will not assign detainees to the medical unit solely on the basis of the following factors: (a) detainees with casts, sutures, or who require the use of crutches; (b) detainees with chronic illness who can function safety in the general population; and (c) detainees who only require treatment a few times per day.

(2) The Implementation Plan will describe a process for responding to judicial placement in the medical unit of detainees who do not require assignment to the medical unit for medical reasons.

2. Solution/Plan

2.1 Protocols defining criteria for determining whether confinement in the medical unit is medically necessary need to be developed.

2.2 The facility will not assign youth to the medical unit solely on the basis of the following factors:

(a) youth with casts, sutures, or who require the use of crutches;
(b) youth with chronic illness who can function safely in the general population; and
(c) youth who only require treatment a few times per day.

2.3 Policy and practice needs to reflect that medical personnel specifically determine how much recreational and educational programming can be provided consistent with the resident's health and safety.

2.4 Development of special need unit(s), where youth requiring special attention or who may be at risk of harm from other residents will be housed.

3. Timeframe

Within sixty days of the approval of the MIP, the special needs unit(s) and criteria for admission will be established.

SS. Dental Care: Paragraph #29

1. MOA Requirements

The Implementation Plan will assure:

(1) a timely dental screening during the admission process to identify dental needs;

(2) immediate and appropriate care for pain, infection and significant dental injuries;

(3) a complete exam by a dentist within one month of admission, to identify oral pathology in need of care;

(4) cleaning and scaling as appropriate to treat gingivitis;

(5) appropriate treatment services to restore normal function and preserve teeth;

(6) an organized and appropriate program of routine restorative and preventative care for long-term detainees, including cleaning, scaling, sealants and, where appropriate, prosthetic dentistry; and

(7) sufficient staff, equipment, and administrative support to meet the dental needs of the population.

2. Solution/Plan

2.1 Policy and practice needs to ensure:

(a) timely dental screening upon admission to identify dental needs;

(b) immediate and appropriate care for pain, infection and significant dental injuries;

(c) a complete exam by a dentist within one month of admission, to identify oral pathology in need of care;

(d) cleaning and scaling as appropriate to treat gingivitis;

(e) appropriate treatment services to restore normal function and preserve teeth;

(f) an organized and appropriate program of routine restorative and preventative care for long term residents; and

(g) sufficient staff, equipment, and administrative support to meet the dental needs of the population;

(h) Long term youth are provided dental cleaning, prophylaxis and scheduled restorative services.

3. Timeframe

Within 6 months of approval of the MIP.

TT. Continuity of Care: Paragraph #30

1. MOA Requirements

The Implementation Plan will establish a process consistent with NCCHC Standard Y-45 that reasonably assures the timely identification of the medical, dental and mental health needs of detainees who enter the facility, including those who are currently receiving treatment for medical or mental health needs, who have previously received such treatment at the CCJTDC in the recent past or present a continuing need for treatment of an ongoing condition. The Plan will:

(1) describe the actions necessary to assure that the provision of continuing care, taking into account previous treatment plans, medication regimens, and other factors necessary to provide stability to detainees and appropriate continuity of care.

(2) assure that those who are receiving medical treatment at CCJTDC will receive referral to appropriate providers to continue treatment upon discharge, release, or transfer to another facility, and recommendations for diet, medications, and other appropriate regimens, for detainees who have received medical, mental health or dental treatment in the facility. In the event that a detainee is discharged or released directly from court, and does not return to the CCJTDC, the discharge plan will be sent to the last known address of the detainee within seventy-two hours.

(3) assure the preparation of a discharge plan that includes provisions for referral to appropriate providers.

2. Solution/Plan

2.1 Policy and practice needs to provide an appropriate continuity of physical and mental health care for all residents consistent with NCCHC Standard Y-45. Policy and practice will ensure:

(a) the timely identification of the medical, dental and mental health needs of youth who enter the facility, including those who are:

a. currently receiving treatment for medical or mental health needs, or

b. who have received such treatment in the recent past.

(b) provide for continuing care and take into account previous treatment plans, medication regimens, and other factors necessary to provide stability to youth and appropriate continuity of care;

(c) Those who are receiving medical treatment at JTDC will receive referrals to appropriate service providers to continue that treatment upon release or transfer;

(d) Discharge plan that includes provisions for referral to appropriate providers, and recommendations for diet, medications and other appropriate regimens.

3. Timeframe

Within 90 days of approval of the MIP.

APPENDIX A
Mental Health Narrative
Louis J. Kraus, MD

I. Introduction

Based on the Defendants Memorandum of Agreement Implementation Plan, Cook County agreed to follow the recommendations of the National Commission of Correctional Healthcare (NCCHC), regarding mental health services, suicide prevention program, juveniles with alcohol and other drug problems, procedures in the event of sexual assault, mental health screening and evaluation, and protocols for segregated juveniles at the Cook County Juvenile Temporary Detention Center (CCJTDC).

At the time of the assessments, there were approximately 400 children at the detention facility. Based on the February 2006 census, there were 445 juveniles at the beginning of the month. There were 95 (80 males and 15 females) held more than 30 days. Approximately 10 percent of these children were on psychotropic medication. Approximately 60 of these children were being followed on a regular basis which is every one to two weeks by a psychologist. Other than for intake or crisis, the LCPC does not see any children individually regarding treatment. The involvement of the mental health expert included prior assessment of youth and meetings with staff in January 2006, June 2006, and July 2006.

This evaluation of mental health services at CCJTDC relied on both implicit and explicit standards. The implicit standards were based on my educational background and experience as a forensic, child and adolescent psychiatrist, as prior head of the juvenile health section for the National Commission of Correctional Health Care, as a prior head of the American Psychiatric Commission on Juvenile Justice Issues Committee, as the current head of the American Academy of Child and Adolescent Psychiatry on juvenile justice reform, as an expert consultant to the correctional healthcare to the Department of Justice and the Arizona Department of Juvenile corrections, and my prior nine years as a psychiatrist at the Illinois Youth Center – Joliet, a maximum-security juvenile facility. In addition, I used explicit data, including published standards and documents from accreditation information from the NCCHC, peer reviewed journal articles and practice parameters from the American Academy of Child and Adolescent Psychiatry regarding psychiatric treatment of youth.

Areas reviewed included: 1) Initial intake screenings, 2) referral to appropriate mental health providers, 3) suicide training, assessment and interventions, 4) psychiatric care, 5) psychological/mental health treatment, 6) alcohol and substance abuse treatment, 7) discharge planning, 8) confidentiality issues and the overlap with the requests from juvenile court for forensic opinions, and clinical information to assist in a specific forensic opinion.

Following the submission of a draft version of this plan in July 2006, administrators from Cermak Health Services prepared a response that included a different staffing pattern for mental health providers. In an attempt to discuss the relative merits of both plans, a meeting was held on October 4, 2006. Dr. Kraus met with Sergio Rodriguez, M.D., Medical Director of Cermak,

Michael Puisis, D.O., who prepared the response, and Charles A. Fasano, one of the court monitors in this litigation. Appendix B now reflects changes in staffing that were agreed to by Dr. Kraus as a result of this meeting and other modifications designed to implement minimally adequate mental health services.

APPENDIX B
MENTAL HEALTH SERVICES
TOTAL STAFFING NEEDS

1. Psychiatry (2.5-3.0 FTE)

At least 2.5 FTE psychiatrists are needed initially, provided that funding is available to increase psychiatric staffing by 0.5 – 1.0 FTE if needed. There is still a need for a total of 3.0 FTE psychiatrists to meet the range of needs of the JTDC population. Psychiatric services should be reassessed in six months to determine whether adequate to meet needs of this clientele.

0.5 FTE for Intake
1.0 FTE for the 2 mental health units (1 male/1female)
1.0 FTE psychiatrist for the general population
(to be used with Nurse Practitioners or Advanced Practice Nurses)

2. Nurse Practitioners (Psychiatric)

There should be at least 2 full-time psychiatric nurse practitioners licensed to prescribe medication, to assist the psychiatrists.

3. Psychiatric Nurses

There should always be at least 1 psychiatric nurse per shift, for a minimum total of 4.2 FTE psychiatric nurses. At least one of these nurses should be an advanced practice nurse to assist with the complexity of issues which may arise. These nurses must have adolescent health training or experience.

4. Psychology

There is a need for nine (9) FTE psychologists. The increased psychologist staffing would make up for some of the deficits in social work services. Basis needs includes one psychologist (1.4 FTE) to oversee intake, two psychologists (2.8 FTE) to oversee the mental health units, and 4.2 FTE psychologists to oversee the general population. One of the psychologists should be the mental health administrator as described in item 7 below; these administrative duties should occupy no more than one-half (0.4 FTE) of his/her time. One least one psychologist assigned to general population should have specialty training in alcohol and substance abuse treatment.

5. Social Workers and Master's Level Therapists

All social workers and Master's level therapists must be licensed as therapists within the State of Illinois. It is difficult to determine the definitive number of therapists who will be needed, but this can be more clearly accessed during the periodic reviews within the implementation period delineated above.

Each special needs unit that houses youth with mental health needs will need coverage by a therapist, either a psychologist or social worker. Assuming that 60-70% of the general population has significant mental health issues, there will need to be significant mental health coverage for each unit. At present, six social workers, with the additional psychologists staffing specified above may be sufficient.

This will need to be reassessed within a six-month period, once all staff has been hired to see whether or not this is the case. As many as six additional social workers may be required depending on the need. In additional, there should be at least one to two social workers with additional alcohol and substance abuse experience and certification (CADC).

There also will be a need for an additional 5 FTE Social Workers (MSW level) to assist and to help with verifying demographic information gathered at intake, establishing and maintaining family contacts, and participating in other clinical activities.

6. Psychometricians

Psychometricians must possess, at a minimum, a Bachelor's degree, preferably with training in psychology and testing. Based on approximately 150 admissions weekly, at least three psychometritions per intake unit (2 make, 1 female) are needed, for a total of nine psychometritions.

In the event that Cermack Health Services or a contract mental health service provider operating under its auspices can demonstrate and implement an alternative method of performing cognitive or psychometric testing or otherwise obtaining such data in an appropriately timely manner, this requirement may be renegotiated by mediation.

7. Mental Health Administration

There is a need for a mental health administrator, who should be a licensed psychologist with juvenile correctional and adolescent forensic experience. The Mental Health Administrator may be included as one (1) of the nine (9) required psychologists referenced in item # 4 above. The Mental Health Administrator may perform clinical duties as deemed appropriate with staffing levels and resident needs.

These are minimal staffing levels, which have been revised from the initial recommendations of the mental health expert with the hope that these could be implemented as soon as possible. However, as stated in these modifications, the mental health expert remains concerned whether or not this would be sufficient staff to care for youth at the facility. It would be very important to continue to assess this and modify the staffing needs. Particular areas of concern include not having enough staffing in the initial intake process. There is a specific need for a comprehensive intake for all youth admitted to the facility. It is unclear whether this can be accomplished with the staffing at hand or what was recommended by Cermak administrators. In addition, additional social work services and psychiatric services will be needed. Hopefully these minimal staffing requirements will be able to meet the need of the youth at CCJTDC.

A modified time table for implementation of the various tasks specified in the MIP relating to mental health services originally developed by Cermak Health Care Administrators has been incorporated below. In addition, initial efforts to increase mental health staffing shall result in staffing levels for the various positions listed below within 60 days of the approval of the MIP.

2.0 FTE Psychiatrists
1.0 FTE Psychiatric Nurse Practitioner
2.0 FTE Psychiatric Nurses
7.0 FTE Psychologists (including one who will be designated as the mental health Administrator)
5.0 FTE MSW'S/Therapists
2.0 FTE Psychometricans

IMPLEMENTATION SCHEDULE

Mental Health Program Timelines			
	Item	Responsibility	Time to Complete
Intake Screening			
	Determine who will perform MAYSI-2 and SASSI testing at detention intake		2 weeks
	Develop questionnaire for nursing to identify urgent mental health referral		2 weeks
	Develop questionnaire for mental health specialist to use for mental health screening in addition to MAYSI		2 weeks
	Develop policy, procedure and rules for who is referred to see a psychiatrist based on intake screening		2 weeks
	Develop policy, procedure and rules for who is referred to see a psychologist based on intake screening		2 weeks
	Determine information sharing system for MAYSI test results between JTDC, Cermak mental health staff, and Probations with rules for using aged test results, means of test administration, and test information data storage and access		3 weeks

	Determine rules for use of MAYSI-2 and SASSI in referral and classification relative to special housing. This includes development of classification rules as they pertain to mental health patients.		6 weeks
	Develop policy and procedure to describe intake mental health screening		1 months
	Develop policy and procedure to describe rules for sending youths to acute mental health hospitals		3 months
	Develop policy, procedure and rules for special housing assignments based on behavior or special mental health conditions		3 months
Ongoing Management of Mental Health Conditions			
	Develop suicide prevention protocol and practice that ensures compliance with MIP.		2 weeks
	Develop mental health related seclusion policies and procedures related to housing related issues for mental health patients.		4 weeks
	Develop policies, procedures and put into practice processes of a means of communication with Courts related to transfer of need-to-know information that is consistent with privacy concerns and consistent with ensuring the safe management of the patient.		3 months
	Develop an acuity/severity of illness scale that describes acute (requiring hospitalization), chronic serious, and chronic but not serious mental health conditions. This scale is used to guide referral and housing decisions		2 months
	Develop a policy and procedure for addressing the mental health management needs of all persons with mental health conditions		2 weeks

	based on acuity/ severity of illness		
	Develop policy and procedure and put into practice medication management of youths with chronic serious mental health conditions		3 weeks
	Develop policy and procedure and put into practice a means of addressing mental health conditions that are identified after intake screening.		2 weeks
	Develop policy and procedure and put into practice a program of treatment team meetings related to management of persons with mental health conditions.		4 weeks
	Develop policy and procedure and put into practice a means of providing group and other programming for youths on special living units and in general population units that utilizes existing case management staff to the fullest extent possible.		3 months
	Develop policy, procedure and put into practice a structure for psychology follow up of persons with mental health conditions as well as referral mechanisms to a psychiatrist.		2 weeks
Special Housing for Youths with Mental Health Conditions			
	Develop with custody a policy and procedure to house youths with behavioral and serious mental health conditions in special units and develop procedures to provide mental health services to these youths.		2 months
	Develop with custody a procedure for provision of mental health services to units that are not expressly mental health units but which require mental health services (e.g. units for aggressive youths).		2 months

	Assist custody in developing a classification instrument to assist in housing assignments		3 months
Linkage of Youths with Mental Health Conditions			
	Identify screening mechanism to identify long-term from short term mental health patients.		3 weeks
	Work with MHJJ, JPD, and other community provider's policy and procedures to ensure that those youths with mental health conditions have a discharge linkage plan that enhances the probability of placement into the community.		3 months
Adherence to MOA and MIP			
	Ensure NCCHC accreditation		On going
	Work with Chicago Public school psychologist to ensure patients with cognitive problems are referred for testing		3 weeks
	Assist with and collaborate on information system management at the center in order to facilitate medical record keeping and reporting requirements.		continuous
	Provide quarterly reporting (monthly for the first six months) on progress in adhering to MIP and MOA.		1 month
	Develop performance indicators and CQI indicators that meet approval of Cermak and result in measurement of items addressed in MOA and MIP.		1 month
	Develop CQI program to measure, discuss and report on performance and CQI indicators.		1 month
	Assist as requested in educational measures and training measures to assist custody staff in understanding behavioral components in addressing interactions with youths.		6 months

	Review and revise the mental health policy and procedure manual covering all aspects required by the MOA and MIP, including requirements of the NCCHC.		3 months
	Report statistical information as required relative to MIP, MOA and Cermak requirements.		1 month
	Working with base staff, produce a report to Cermak regarding how the mental health program with collaborate and utilize County and other employees in meeting program goals		3 months
	Produce audits measuring compliance with all elements of this work plan as specified.		4 months 6 months

APPENDIX C

MODIFIED IMPLEMENTATION PLAN NARRATIVE

David Rouse, Ph.D and Carl Sanniti

We offer to the court and the monitors a new implementation plan because the Cook County Juvenile Temporary Detention Center (CCJTDC) has not made satisfactory progress toward acceptable conditions of confinement. We, therefore, assume that what is wanted from us is something different to resolve the issues and obstacles that have prevented acceptable outcomes. To meet this task, we have analyzed (a) previous plans, (b) previous consultant reports, (c) many existing facility documents, (d) official court documents, including the Memorandum of Agreement (MOA) and the Agreed Supplemental Order (ASO), (e) interviews with residents and staff, (f) the organizational structure, and (g) notes from direct observations of daily operations.

We offer a somewhat different perspective on the way to achieve compliance with the MOA. Our perspective will be two-fold, addressing the content of a plan (the goals, the technical skills required to move from a goal to a practice, and sufficient resources), particularly in comparison with previous plans, and addressing the process of a plan (leadership, will, and capacity), elevating to a priority the elements of plan implementation. As a result, considerable text explores the obstacles to achieving acceptable conditions of confinement. We hope that this "content and process" approach provides the court and the monitors with the quality of information and direction to achieve compliance with the MOA.

We start with several assumptions:

- There are preconditions that must be resolved before substantial change can occur. To discount the list of preconditions will reduce the likelihood that this ASO plan will succeed.
- The current organizational structure cannot support the level of change outlined in the MOA.
- Previous attempts to comply with the MOA appear to have failed because of missing or omitted factors, most notably leadership, and not because of the competency of the plans.

Despite some success, CCJTDC administration has demonstrated limited ability to implement fully and satisfactorily all of the requirements of the MOA. It is not the intent here to diminish the efforts of those who have been removed from their positions at CCJTDC as a result of the recent change in the County Board Presidency. Rather, we want to establish that some of these efforts, while good and positive in some regards, were not good enough to satisfy the expectations of the court. Furthermore, we understand the importance of acknowledging the hard work of many staff who remains at the Center and who are as concerned and invested in the return of CCJTDC to a position of excellence as any of the parties in this litigation. There is staff with the skills and motivation to be leaders, even at the best detention centers. These individuals will be the cornerstone of change once an administration can be assembled that understands how to improve conditions in juvenile detention. Conversely, there are many on staff that are troubling and who have brought this litigation on the Center as a result of their misconduct, and their removal from the staff will be an important element in achieving acceptable conditions of confinement. Finally, our

perspective is best practices, but our mission is acceptable practices. Improvement is incremental, so the question is not how to move from here to a best practice. The question is how to establish a system to move from here to an acceptable practice, knowing that the system can, over time, progress to a best practice.

CCJTDC staff members are myopic. Their definition and understanding of juvenile detention is based on CCJTDC alone, meaning that the depth and breadth of detention operations knowledge and experience are limited by a narrowed perspective. Therefore, as much as staff wants to contribute to the change process, their range of problem-solving abilities is constrained. Furthermore, staff has not been able to turn to administration (the superintendent and assistant superintendents) for advice and guidance because their range of detention experience has been even narrower.

This report contains two parts. Part 1 discusses an implementation plan, the issues required for implementation, the missing variables that need to be added to the implementation equation, and the barriers that need to be resolved before a successful implementation of the plan can be accomplished. In other words, Part 1 contains the pre-conditions or prerequisites that need to be resolved before the parties in this action expend additional resources on the implementation of any more implementation plans. If there is no resolve to act on the issues presented in Part 1, there is little need to proceed to Part 2.

II. PART 1

A. Change Models[1]

The MOA implementation plans developed by consultants represent models for change. Social scientists build models to explain and predict in a more simplistic form a variety of complex relationships. The effective operation of a juvenile detention facility would be an example of a set of complex and interrelated variables. When properly constructed and implemented, a model will explain a sufficiently large enough amount of the variance in outcomes so that the social scientist can predict with confidence that certain changes (in key variables) will produce certain outcomes. Given this premise, the court has solicited yet another plan for achieving acceptable conditions of confinement at CCJTDC. This means that for some reason(s), the previous plans did not work to the satisfaction of both parties.

We offer the following conceptual model as the foundation of this plan: Acceptable Conditions of Confinement (CoC) at the Cook County Juvenile Temporary Detention Center (CCJTDC) are a function (f) of the interaction and implementation of key variables, issues, and factors associated with successful detention operations. The diagram below shows how

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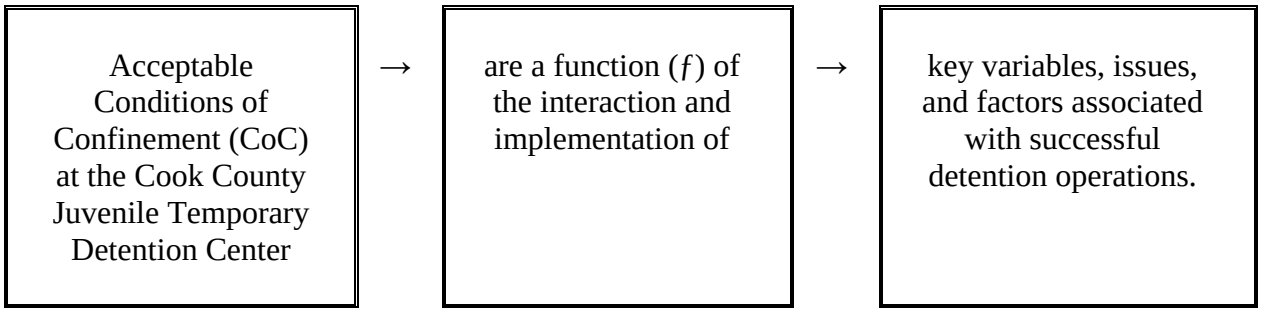
[1] A model is a simplified description or explanation to predict the essential actions and interactions of a set of complex variables and relationships. A model is an easier way to use and understand the complex reality from which it is derived and patterned (Bohigian, 1977:15).

the plan works. The MOA represents the court's definition of acceptable conditions of confinement.



Each previous MOA implementation plan (MIP) represents a plan constructed by experts that explains and directs the necessary changes in the CCJTDC operations in order to achieve acceptable conditions of confinement or to get the facility in compliance with the MOA. Each MIP details a list of key variables that must change in order to achieve the goals of the MOA.

Using this conceptual model as the format for articulating the key variables to predict acceptable conditions of confinement, we are forced to conclude that Cook County's ongoing failures to achieve acceptable conditions should focus our attention first on the designation, selection, or specification of the key variables and then on the manner of plan implementation. Therefore, two questions arise.

Question 1: Is the failure of previous MIP plans attributable to a failure by the model-builders (consultants) to specify the proper combination of key variables?

Question 2: Is the failure of previous MIP plans attributable to an inability of the system (its organization and resources) to implement the key variables effectively, assuming an adequate specification of variables?

These two questions (Is the plan adequately specified, and is the plan adequately implemented?) permit the use of a 2 x 2 matrix to explain the interactions between specification and implementation.

1. Specification-Implementation Matrix

	Adequate Implementation	Inadequate Implementation
Adequately Specified List of Variables	1: Successful Outcomes	2: Marginal Unacceptable Outcomes
Inadequately Specified List of Variables	3: Marginally Acceptable Outcomes	4: Failure; Unacceptable Outcomes

With adequate implementation, adequately specified plans yield successful outcomes (Cell 1) and less than adequately specified plans still yield marginally acceptable outcomes (Cell 3). Since implementation is a function of leadership, will, and capacity, then these variables can produce positive changes even when important variables are missing from the plan.

Inadequate implementation (poor leadership, lack of political will, and inadequate capacity) yields less than acceptable results regardless of quality the plan (Cell 2). When inadequate implementation combines with an inadequately specified list of important variables for change, the result is failure (Cell 4).

If the existence of the ASO represents each party's acknowledgment that previous efforts have not worked, i.e. previous efforts have failed, and then the specification-implementation matrix draws attention to Cell 4 or how to develop both an expanded list of variables and an improved implementation of the plan.

2. Key Variables from Previous MOA Implementation Plans

Five categories of important variables appear in all of the implementation plans, and they constitute more than enough information to have provided effective pathways for change. These categories of variables are: organizational structure, physical plant, programs, resident management, and staff development.

CoC	*f*	Key Variables
	1.	Organizational structure (the administrative orthodoxy): policy and procedure, organizational chart, data collection and management information system, classification and housing, safety and security, and resident and staff rights.
	2.	Physical Plant: Sanitation, maintenance, custodial, and space requirements.
	3.	Programs: resident activities and recreation (programs that combat idleness and boredom), and education services.
	4.	Residents: resident discipline and behavior management (including confinement and physical restraints), assessment, classification, and housing; medical and mental health services.
	5.	Staff: adequate numbers; adequate training and development programs.

- The organizational structure variable is the administrative orthodoxy[2] that is a standard part of public administration. The important components are competent policies and procedures, formalization and standardization of policy and procedures, development of an organizational hierarchy with clear lines of authority and accountability, competent management information systems to collect accurate and reliable data for decision-making and quality assurance, and adequate structures to maintain a safe and secure environment for residents and staff.

- The physical plant variable includes environmental issues such as sanitation, cleanliness, custodial services, and maintenance. Because many of these are contractual services, it is important that CCJTDC and Cook County administration re-examine contracts so that the terms of the contract are compatible with the components of the implementation plan.

- The program variables include activities, recreation, and education.[3]

- Resident management includes assessment and classification, behavior management and discipline, and medical and mental health services.

- The staffing variable includes the recruitment, selection, training, development, and retention of CCJTDC staff. Again, important elements of this variable (recruitment, selection, retention) are not under the control of CCJTDC administration nor this litigation.

B. Expanded Implementation Plan for the ASO

Previous plans have identified the proper concerns, but these past several years of less than successful implementation have provided valuable information and outcome data not available to previous consultants. Access to this information allows, even compels, us to expand upon previous plans and to offer what we hope is an improved plan for change.

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[2] Administrative orthodoxy is the set of rules about how agencies should be organized and managed. However, administrative orthodoxy can best be described through its characteristics: a hierarchical structure, a series of official positions, formal rules, and technically qualified personnel (Knott & Miller, 1987:6). This definition stresses the importance of rules and hierarchy:

> The basic tenet of this orthodoxy is that efficiency requires clean lines of authority from top to bottom in an organization. The central responsibility of the superior is the faithful implementation of policy sent from above and the accountability to his superiors; the key responsibility of the subordinate is obedience. (Warwick, 1975:69)

In response to constitutional challenges and personal liability, the issues of formalization and standardization were added to the correctional orthodoxy (Lund, 1988), i.e., for detention practice to withstand a legal challenge, it must also be documented or written. Formalization expresses the degree to which policies and procedures are written and roles are defined, while standardization reflects the extent to which these formalized policies have become a consistent and uniform part of the daily routine (James & Jones, 1976). It is this link between the formalization and standardization within the correctional orthodoxy that reflects the adoption and execution constructs.

[3] Since education is the most important component of programs offered to youth in a juvenile detention facility, it is unusual that the organization that controls the education program is not named as a defendant in the litigation.

For example, one factor associated with the failure of the previous plans is that the litigation and its MOA have not provided CCJTDC administration with sufficient control over important variables. These omissions have constrained the capability of all parties, especially the monitors, to implement change. We will refer to these omitted variables as "barriers to change," and they are discussed below. The importance of the identification of the barriers is their link to the organizational structure in which CCJTDC finds itself. If the removal of these barriers is important to the success of this ASO (and we believe it is very important), then the power to address these barriers has to come from the County Board President. In other words, the main issues facing the County Board must not be seen so narrowly as to include only the removal of political appointees, it must also include these barriers.

Previous plans have followed the C.H.A.P.T.E.R.S. strategy.[4] Each component of C.H.A.P.T.E.R.S. is distributed throughout the five categories of variables contained in previous MOA implementation plans. The previous implementation plans address what we will call "internal" variables. From this perspective, and based on the previous comments, we believe there are three categories of variables that need to be added to the previous plans for change. These variables are leadership, capacity, and organizational uniqueness. Our expanded model is as follows:

CoC	***f***	**Key Variables**
		Internal Variables
	1.	Organizational structure (the administrative orthodoxy): policy and procedure, organizational chart, data collection and management information system, classification and housing, safety and security, and resident and staff rights.
	2.	Physical Plant: Sanitation, maintenance, custodial, and space requirements.
	3.	Programs: resident activities and recreation (programs that combat idleness and boredom), and education services.
	4.	Residents: resident discipline and behavior management (including confinement and physical restraints), assessment, classification, and housing; medical and mental health services.

[4] This assessment used Mark Soler's C.H.A.P.T.E.R.S. model. Soler, president of the Youth Law Center and a nationally recognized expert on conditions of confinement in juvenile institutions, and several of his associates identified eight important areas related to litigation (Soler et al., 1990). He created the acronym C.H.A.P.T.E.R.S. to identify the eight central themes of conditions of confinement litigation:

Classification and separation issues; **H**ealth and mental health care; **A**ccess to counsel, the courts and family; **P**rogramming, education, exercise and recreation; **T**raining and supervision of institutional staff; **E**nvironment, sanitation, overcrowding; **R**estraints, isolation, due process in discipline, and grievances; and **S**afety issues for staff and confined children.

5.	Staff: adequate numbers; adequate training and development programs.
6.	Leadership: The capacity and ability to lead, plan, guide, direct, and inspire the work of others; to clearly and accurately plot the right course of action.
7.	Capacity: Development of competent goals and plans; technical skills to implement goals and plans (how-to skills); and sufficient resources.
8.	Organizational Uniqueness: Management of size and complexity.
	External Variable
9.	Political will: Ability to provide the components of "capacity" in a timely fashion, i.e., the will to make things happen.

1. Additional Internal Variables in the ASO Plan

The ASO plan incorporates the first five variables derived from previous MIPs. The additional variables are leadership, capacity, and organizational uniqueness.

a. Leadership

Leadership is essential. Previous MIPs are examples of how some things go unspoken, hence not really stated at all, but somehow communicated with particular power. While the inclusion of the administrative orthodoxy is essential in any organizational reform model, leadership is equally, if not more, important as the administrative orthodoxy.[5] There must be an emphasis on leadership qualities and capabilities of the one or two top leadership positions at CTJTDC. In the absence of direct juvenile detention experience, outstanding leadership skills must be present. This is not to confuse leadership with management, for we are using Bennis and Drucker's distinction that leadership is doing the right thing, management is doing things right.[6]

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[5] Barton, W. H. (1994). Implementing detention policy changes. In I. M. Schwartz & W. H. Barton (Eds.), Reforming juvenile detention: No more hidden closets. Columbus: Ohio State University Press.

Christy, J. (1994). Toward a model secure detention program: Lessons from Shuman Center. In I. M. Schwartz & W. Barton, (Eds.), Reforming juvenile detention: No more hidden closets. Columbus: Ohio State University Press.

[6] Former Superintendent Robinson, typical many who are placed in positions outside their experience and expertise, gave the impression of confusion. For example, Compliance Monitor Brenda Welch, Status Report, July 15, 2006, reported:

"I met with Supt. Robinson on July 6, 2006 regarding the failure to re-assign selected direct care staff according to the MOA. Supt. Robinson stated that it had simply 'slipped his mind.' There was also a discussion regarding the letter issued to the selected staff. When I asked about the counseling and mentoring requirements for selected staff, Supt. Robinson did not know the specifics of the requirement and stated he did not know who would make the determination that the requirement had been met and the employees could return to their normal duties."

"He then called Supt. Robinson who stated there were 4 counts per day. The Supt. was unaware that the midnight and 6 am counts had been discontinued."

b. Capacity

In a seminal book on juvenile detention reform, Schwartz and Barton[7] lay out a plan for improving juvenile detention services substantially, including conditions of confinement. This systemic approach builds on the concepts derived from the Annie E. Casey Foundation (AECF) intervention in the reform of the Broward County juvenile detention system, and many of the concepts identified by Schwartz and Barton have been expanded and improved as part of the Casey Foundation's Juvenile Detention Alternatives Initiative (JDAI)[8] movement. The efficacy of these principles is evident in the JDAI detention reform outcomes implemented by the Cook County Juvenile Probation Department.

"The Supt. was unaware that the facility did not launder resident's personal undergarments." It was also confusion between perception and meaning. Many can understand events and phenomena, but the meaning of these events can be elusive. Many assume without sufficient corroborating evidence that experience in one aspect of the justice system automatically translates into the ability to understand and draw meaning from the events in juvenile detention. One quality of exceptional leadership is the ability to draw the inferences that support meaning, but it is also a rare quality. So, confusion comes to represent answers in camouflage, not because they are vague, but because they are allusory. If one thinks of confusion as an administrative style, or as a camouflage instead of an expression, then Robinson's style was not so much to resist the scrutiny of the court, as some would mistakenly conclude [cf, Editorial. (2006, July 30). Will another adult fail the kids? Chicago Tribune, Casillas, O., & Ciokajilo, M. (2006, August 1). Juvenile center's chief gets forced out. Chicago Tribune Update], as it was to obscure his inability to know the meaning of troubling events and hence to solve them. Again, Compliance Monitor Brenda Welch, Status Report, June 30, 2006 reports:

"Room Searches were conducted on the 4th floor living units on June 17, 2006. Contraband included a charged cell phone, a large amount of marijuana, home made pipes, shanks, pornography, US currency, cigarette lighters, etc.) Although administrative staff did not mention this "operation," a copy of the report had been placed under the door of my office. The report indicated that the AOD was contacted. In discussions with unit managers, neither Mr. Farmer nor the AOD reported to the facility. Caseworkers were instructed per policy to interview residents and conduct hearings. Caseworkers lack the skills and expertise to conduct investigations of this type. Law Enforcement was not contacted until June 18, 2006. Three residents were charged. On June 22 and June 23, Mr. Sanniti and Dr. Roush asked administration why the facility was not locked down and the entire facility searched. They were told that extra staff was required to conduct room searches. It should be noted that per facility policy, room searches are to be conducted on a daily basis."

Superintendent Robinson had the opportunity to use the contraband incident to address issues affecting supervision, accountability, investigations, personnel discipline, and resident safety. These issues were not investigated.

There are no guarantees that this confusion will disappear with Robinson's departure, especially since his successor possesses no greater experience and expertise in juvenile detention. Meaning is the key; and when the leader grasps the meaning of events and circumstances, then it is much quicker and easier to make the right decisions and choose the right course of action. If the leader does not possess this quality, then it is incumbent on the County to surround the leader with individuals who understand juvenile detention.

[7] Schwartz, I. M., & Barton, W. H. (Eds.). (1994). Reforming juvenile detention: No more hidden closets. Columbus: Ohio State University Press.

[8] Lubow, B. (1999, December). Successful strategies for reforming juvenile detention. Federal Probation, 63, 16-24.

Lubow, B., & Barron, D. (2000, November). Resources for juvenile detention reform. Fact Sheet (#18). Washington, D.C.: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

Within this compilation of reliable and trustworthy strategies, Barton supplies powerful yet simple variables that he argues are at the heart of any model's ability to predict or produce system and institutional reform. These two variables are will and capacity. Barton defines will and capacity within an effective change plan as follows:

> the implementation of policy change requires developing the political "will" to initiate the changes and the technical "way" (*capacity*) to carry them out…goals (what to do), causal theory (how to do it), and resources (with what to do it). (p. 148). (insert of "capacity" added)

The National Partnership for Juvenile Services (NPJS) states that will and capacity are the most important variables in predicting an agency or organization's success at institutional reform.[9] Again, we found no references to either of these variables in any of the previous court-ordered documents or implementation plans provided for our review.

Line staff demonstrates some will to change the detention system. In November, the National Partnership for Juvenile Services (NPJS) conducted a strategic planning event (a Storyboarding workshop) to address the needs and issues facing staff from the MOA. Fifteen staff from a cross-section of job positions and job assignments participated in the two-day event and produced quality recommendations regarding the changes that needed to occur in order to implement the MOA. With the exception of the participants from this Storyboarding group, CCJTDC staff neither individually nor collectively has demonstrated sufficient capacity to implement changes in the daily operations that are consistent with the issues in the MOA.

c. Organizational Uniqueness

An organization is defined as a system of interrelated behaviors of people who are performing tasks that have been differentiated into several distinct subsystems, each subsystem performing a portion of the tasks, and the efforts of each being integrated to achieve effective performance of the system.

CCJTDC is unique in its complexity and size. Our underlying assumption is that the CCJTDC complexity has meant that experts and litigants have had no extraordinary plans for institutional change except to expand and strengthen the administrative orthodoxy, believing that strengthened structural elements will produce certain outcomes. Therefore, the focus on MIP compliance has been to scrutinize the formalization and standardization of policy and procedure, thereby displacing the goals of MOA compliance from substantive outcomes to completing the means and minutiae of the orthodoxy. This is bureaucratic dysfunction through goal displacement, and it describes the current situation at CCJTDC. To recommend more orthodoxy

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[9] Earl Dunlap is the Executive Director of NPJS and is generally considered one of the nation's most effective juvenile detention practitioners. At all of his intervention sites, the facility became know for the development and maintenance of acceptable, often exemplary, conditions of confinement. His work will be referenced later in this report, but the relevance to this section has to do with an understanding of Dunlap's detention reform plan. Dunlap starts with an assessment of will and capacity. Dunlap will not engage a juvenile justice or juvenile detention services system without a clear indication that it possesses or intends to develop the will to change.

is to miss the meaning in the present circumstance. The issue is not better orthodoxy; it is less complexity.

Complexity of juvenile detention and its organizational concomitant, uncertainty,[10] may have dwarfed the scope of the solutions presented to the court, especially if the best solutions were not fully specified. Today, complexity and uncertainty remain, and they serve as the fuel for the perpetuation of failed solutions and inadequate practices.

As organizations increase in size, complexity also increases, and the combination of size and complexity frequently adds to the impersonalization of staff and residents.[11] Public agencies characterized by complexity and excessive size, such as CCJTDC, are frequently described as fragmented, lacking in accountability, and guided by ambiguous or imprecise goals. Within this type of organization, change efforts invariably reflect a movement toward administrative orthodoxy. While the structure associated with orthodoxy has become commonplace in the management strategy of detention administrators,[12] the popularity of this approach resonates with those inside the organization who want more clarity, rules, and hierarchy. When job complexity increases (as it does with each successive implementation strategy through the redefinition and expansion of staff's roles), the staff and residents will seek out the structure and control associated with an administrative orthodoxy.

Administrative orthodoxy becomes the structure to moderate or stabilize the rate of institutional change. This is particularly important when judicial intervention is involved. Within a juvenile institution, sweeping changes in detention practice emanating the MIPs can be moderated by the use of administrative orthodoxy. During times of change, one function of the CBA is to slow the pace of change or to slow the expansion of complexity and uncertainty associated with the proposed new way of operating detention. The best example of how this occurs is through the necessity of the orthodoxy to spell out and inform all organizational participants about what is going to happen, where its going to happen, who will be affected, and why it is occurring. Communication theorists and psychologists demonstrated years ago that increased clarity in communications reduces the anxiety and threat value of the message.[13] Orthodox principles require a level of clarity that stabilizes the change process.

Not all court interventions prove successful. Court interventions run the risk of creating a new bureaucracy characterized by an ever-expanding re-writing of policy and procedure. Emphasis gets placed on means-oriented control mechanisms. The key issues become documentation, residents' rights, and policy and procedures. The legalistic style of the means-orientation will appear too many staff as taking precedence over the actual effects or outcomes of

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[10] Knott, J. H., & Miller, G. J. (1987). Reforming bureaucracy: The politics of institutional choice. Englewood Cliffs, NJ: Prentice-Hall.

[11] Present, P. E. (1979:7). People & public administration: Case studies and perspectives. Pacific Palisades, CA: Palisades Publishing.

[12] Christy, J. T. (1987, Summer). Managing juvenile detention: An organizational perspective. The Rader Papers: A Journal of Juvenile Detention Services, 3, 3-6.

[13] Goldstein, A. P., Heller, K., & Sechrest, L. B. (1966:172). Psychotherapy and the psychology of behavior change. New York: Wiley.

the reform efforts. The danger is when the organizational structure is not concerned with resident well-being. Instead, the primary objective of the orthodoxy is to formalize and standardize the requirements of a court-defined acceptable institutional practice.

Organizational structures, taken to excess, have a negative effect on staff. Litigation, MOA's, case law, emphasis on documentation, policies and procedures, and union contracts all combine to create additional responsibilities for juvenile detention personnel. The addition of extra rules and regulations helps to create an attitude where staff tries to reach compliance through the easiest method possible. The search for expediency in the face of being overworked promotes the adoption of a means-orientation.[14] A means-oriented strategy for problem-solving places greater emphasis on compliance with requirements of the rules and regulations versus the intent of the rules and regulations or their outcomes.

More organizational structure will not help. Clarification and simplification are more important. The CCJTDC policies and procedures need to be re-written to enhance consistency and accountability, not to expand structure, rules, or hierarchy. The size and scope of the rules and regulations contained in the MOA and MIPs are fine. Expanding the orthodoxy is counterproductive. First, a qualified detention expert will know exactly what needs to happen to implement well-written policy and procedure. Second, the monitors do not need second opinions for them know when the facility has formalized and standardized acceptable practice.

The elimination of excessive and irrelevant complexity and uncertainty along with the control and regulation of the inherent complexity and uncertainty are the essential prerequisites for the development of a viable solution. The CCJTDC system often appears too ponderous to be effective. What is missing is Weick's understanding of small wins, that major change is probably incremental in nature and contingent upon small successes to build momentum.[15] We

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[14] Marquart, J. W., & Crouch, B. M. (1985). Judicial reform and prison control: The impact of Ruiz v. Estelle on a Texas penitentiary. Law and Society Review, 19, 447-586.

[15] Several decades ago, social psychologist Karl Weick (1984) argued that the reason for government's inability to solve most of its social problems had more to do with the approach to problem-solving than the competency of the recommended solutions. In other words, Professor Weick believed that even the right solutions will prove ineffective if implemented incorrectly. From Weick's perspective society and bureaucracies continue to fail at problem-solving because the size or complexity of the problem is larger than the capacity to implement a solution. Through his research, Professor Weick argued that effective solutions to large and complex problems were a function of what he called "small wins." In other words, effective problem-solvers were able to break a large and complex issue into small and manageable challenges. By resolving the small challenge, or by solving a piece of the puzzle, the reform effort gathered momentum, gathered information about the nature of the problem and its solution, expanded its understanding of "what works," and increased its effectiveness.

Professor Weick was very clear in his description of how problem-solving efforts fail when they do not adopt his small wins strategy. He described the frustration that occurs when solutions are inadequate to produce demonstrable change, when systems and bureaucracies are slow to move, and when the time required for change to occur exceeds the amount of time available for a pre-determined definition of success. A social psychologist would likely find many of the same factors and forces at work at the CCJTDC. In fact, one hypothesis is that the failure to reach a resolution to this lawsuit is as much a function of the failure to embrace Weick's small wins psychology as it is the controversies about political patronage, understaffing, or lack of training.

Evidence from juvenile detention practice involving the transformation of troubled facilities into successful facilities for the implementations of program strategies throughout a large facility support Weick's psychology of

propose to address complexity and uncertainty by making the tasks more manageable (reducing the size) and by streamlining the organizational structure to increase accountability (an enemy of uncertainty).

2. Political Will: The External Variable

Political will is (a) the ability to get things done (or the ability to make the right things happen) (b) in a timely fashion. In a place where government is often referred to as "the machine," it is difficult to explain why such a highly political environment seems to lack the political will to address the plight of its troubled youth.

Does political will exist within the Cook County Board of Commissioners? The information, actions, and findings from a review of the organizational and administrative structures at and around CCJTDC do not present a compelling argument that the political will exists under the current arrangement. If this conclusion remains true, it is unlikely that any implementation plan will succeed.

Political will has existed in Cook County regarding juvenile detention. There was a time when CCJTDC was a leader in juvenile detention services. Under the leadership of the late James M. Jordan, CCJTDC was one of the first juvenile detention facilities to receive accreditation from the American Correctional Association, a process repeated on multiple occasions. These achievements required political will in the form of support from county government, agency administration, and line staff. During the focus groups and in individual staff interviews, staff described numerous programs that used to be provided by the facility, the community, and volunteers. Remnants of these programs continued following Jordan's retirement, but largely disappeared after Jesse Doyle's departure as superintendent, according to staff. It may be coincidental, but staff suggests that the demise of programs is directly related to the hiring of leadership with no juvenile detention experience or credentials.

Little evidence of political will exists since the filing of this lawsuit by ACLU. Several examples serve as proof of this assertion. They are:

Management hiring practices are problematic and do not move CCJTDC closer to MOA compliance.[16] This takes several forms.

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small wins. Institutional transformation in Washington, D.C., Atlanta, GA, Detroit, MI, Albuquerque, NM, to name a few, all began by breaking the institution into small, discreet parts (usually starting with a pod, unit, or residential wing) and implementing the change within that context. The success of the transformation occurred through the replication of the new program in selected and subsequent units of the institution. Replications continued until the critical mass of the institution and its culture "tipped" in the positive direction. While there have been numerous competent and quality recommendations surrounding implementation of the Memorandum of Agreement, what has been missing is a strategy that incorporates Weick's psychology of small wins. [cf, Weick, K. E. (1984, January). Small wins: Redefining the scale of social problems. American Psychologist, 39, 40-49.]

[16] The recent spate of resignations and transfers among the CCJTDC top leadership is an indicator of growing political will, but this is only half of the issue. Adequate personnel management means two things: hiring the right people and removing the wrong people. To the degree that the interim County Board President is removing

- Juvenile detention is a unique profession, fundamentally different from adult corrections and law enforcement. Failure to recognize these differences is inherently demoralizing to all juvenile detention staff (supervisors, juvenile detention caseworkers, and juvenile detention counselors). It is equally discouraging to other juvenile justice practitioners and juvenile detention experts when, on the surface, the appointments of CCJTDC leadership are not based on qualifications or credentials directly related to juvenile detention. Furthermore, the appointment of superintendents with no juvenile detention experience has not been mitigated by the appointment of a juvenile detention specialist to assist them.

- The delay in getting things done is excessive.

a. Delay Is the Strongest Indicator of the Absence of Political Will

More than anything else, bureaucracy slows the pace of change; however, highly political bureaucracies with fluid hierarchies and rules like Cook County have been able to make things happen almost instantaneously. In a situation with an ASO that places the change process on the fast track, this plan addresses critical variables that will affect the pace of change. The following statements apply to all forms of social interactions, and their impact is not lost on CCJTDC employees despite the fact that there has been little formal attention to them.

Truism One: Justice delayed is justice denied. Nowhere is this more evident than in the prolonged period of time to resolve a disciplinary action against a CCJTDC employee for child abuse. The time it takes for each system to do its job is a concern. Delay weakens the administration's case, strengthens the employee's and the union's case, increases overtime expenditures, weakens staff scheduling options, constrains hiring practices because of the excessive amount of time required to resolve the employee's status, lowers staff morale, allows an increase in resident misbehavior due to staff fears of confrontations, reduces resident safety, and does little to bring closure and healing to the abused juvenile.

Truism Two: Delay is the deadliest form of denial.[17] Many examples exist where bureaucrats have expressed their intentions to cooperate with the MOA and have been "working the issue through the system" only to have CCJTDC suffer through extensive delays while waiting for a decision or an action. Organizational and bureaucratic slowness to the extent of excessive delay[18] is a well-established way of not cooperating, or giving the false impression that one is actively trying to cooperate.

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some of the political appointees is only half of the challenge; and while solving half of a problem is good, encouraging, and hopeful, like the progress staff have made with programs and accountability, half is good but not good enough. Political will does not accrue until the task is complete and that means hiring competent administrators.

[17] This is one of C. Northcote Parkinson's laws of bureaucracy that seems to have held true for decades. His first law of bureaucracy is that work expands to fill the time allotted for its completion.

[18] Consider the need for an independent inspector to investigate allegations of child abuse. Former Superintendent Robinson, a veteran of law enforcement and internal affairs investigations, correctly determined that the CCJTDC superintendent needed a professionally trained and experienced investigator to handle the internal

C. External Obstacles to Change

CCJTDC does not exist in a vacuum, and its effective operations depend upon its association with other external organizations. In light of the court-ordered change process, there are four external variables missing from previous MOA implementation plans. They are the Chicago Public Schools, staff unions, the Cook County and State of Illinois personnel review and appeals systems, and the Cook County Human Relations Department.

1. Cook County Human Relations Department

CCJTDC administration exercises very little control or influence over the quality of non-exempt staff coming into CCJTDC. Personnel management is a simple concept in public agencies for juvenile delinquents. The first goal is to get the right people on staff, and the second goal is to get the wrong people off staff. Not all new staff is sufficiently qualified for work at the Center. It is unfair that CCJTDC will be evaluated on an issue (quality of staff) that it cannot adequately control.

Cook County is surrounded by Illinois, generally viewed as a leader in juvenile detention staff hiring guidelines. All other Illinois detention facilities are under the Administrative Office of the Illinois Courts (AOIC), which requires the same entry level education and experience requirements as probation officers, i. e., a bachelor's degree. Juvenile detention officers in Illinois also participate in a nationally recognized 40-hour detention training program delivered under the auspices of AOIC through the Center for Legal Studies at the University of Illinois at Springfield (UIS).[19]

Oversight is needed with the Cook County Human Relations Department to bring the juvenile detention counselor pre-employment qualifications in line with the rest of juvenile detention practice in Illinois. The irony is that experts point to a national best practice that can be found in DuPage, Kane, Lake, and Will Counties. Furthermore, the County should consider the implementation of the video-based screening tool, IMPACT, by Ergometrics to supplement the existing selection process.

2. Union

Some argue that the union is cooperative, others that it is ineffective; but regardless of which may be the case, there are inherent union challenges whenever an institution is in a reform mode, especially in response to issues involving the safety of youth. Unions and collective bargaining agreements (CBAs) are often associated with adversarial relations between administration and staff, and the CBAs frequently become a sticking point for changes necessary to the reform efforts. For example, despite more than five years of recommendations that

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investigations of staff abuse allegations. He discussed this position in September 2005, yet, the position is not filled.

[19] Some of the training materials currently in use at CCJTDC derive from the detention officer training program at UIS, specifically from former CCJTDC training coordinator Dr. Erica Collins' consultation with Tom Ambrose, the UIS detention training specialist.

juvenile detention counselors adopt a standard three shift schedule, the multi-shift scheduling process persists. Staffing issues normally considered to be administrative responsibilities, such as shift bidding, position assignments, and continuous direct supervision, sometimes become bargaining elements in contract negotiations.[20] Staffing and supervision run the risk of being compromised, increasing the likelihood of harm and problems to youth. If juvenile detention is a unique work environment, then negotiations with unions like the Teamsters appear to need oversight so that the safety and well-being of detained youth receives adequate representation at the bargaining table.

3. Cook County and State of Illinois Personnel Review and Appeals Systems

The Illinois Personnel Review Board recently determined that a CCJTDC juvenile detention counselor terminated for child abuse (twice punching a CCJTDC resident in the face) will be returned to work with full back pay. The situation warrants careful and thorough investigation. The circumstances where personnel review boards and appeal processes overturn administrative terminations create an obstacle for change. The concern on the part of both parties for the protection of the safety and well-being of detained youth means it is counter-productive to overlook the employee disciplinary and appeals processes as a target of investigation.

There are many reasons why county and state personnel review hearings should be of concern to the monitors and to the court. First, in a system characterized by highly politicized approaches to decision-making, it is difficult to believe that only CCJTDC is susceptible to unconventional practices.

Second, it is unfair to CCJTDC administration to place high expectations on it to maintain accountability, to protect the safety of incarcerated youth, and to terminate the employment of staff members who represent a danger to incarcerated youth, if there is no reliable mechanism to remove the barriers to implementing this accountability. This is not to fault the review process in the two recent cases where the termination decisions were overturned; however, our review of the available documents raises procedural questions that a reasonable person would want answered.[21]

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[20] Unconfirmed reports on the recent contract negotiations indicate that juvenile detention counselors may have won two 15-minute breaks per shift or a reduction of on-site supervision of 6.25% per employee per waking hour shift. Based on the staffing recommendations in this report, this CBA stipulation could require 31 additional hours of supervision per waking hour shift or the equivalent of four additional juvenile detention counselor positions per shift or 13.8 full time equivalencies on an annual basis. It is unlikely that the County will add the needed staff coverage to avoid employee grievances.

[21] The rationale of the arbitrator for overturning the termination in one case was based on the union's allegation that the youth had created a sophisticated web of lies against the employee in direct contradiction to the independent investigations by staff and the Inspector General's office. If youth are not credible witnesses in hearings, then substantiation of abuse will require an adult witness for successful terminations, a situation that has substantially impeded the removal of abusive staff from California detention centers.

"Unsubstantiated allegations" of child abuse (allegations lacking an adult witness) lay the foundation for additional child abuse by establishing the "rules" for abusive behavior, i.e., abuse is permissible if it is not witnessed by another staff member or if some staff members agree, by collusion or intimidation, not to testify against one another.

California seems to be the state with the strongest employee rights in personnel actions. In one large county, a review of personnel records over a two year period indicated that the administration of an executive-branch-operated juvenile detention center terminated eleven employees for serious staff misconduct, and three were subsequently overturned by the personnel review process.[22] In other words in one of the most challenging environments toward administration (and antagonistic to the well-being and safety of incarcerated youth who are abused by these staff), the probation department had a 73% success rate for terminations. Comparable Cook County data from 2005 reveal that CCJTDC terminated seven employees for abuse, and two have been reinstated. This yields a success rate of 71% for terminations, a rate remarkably similar to the situation in California, which should be cause for concern. Again, if it is the goal of both parties to eliminate abuse, then (a) attention must be given to the quality and soundness of all abuse investigation processes and (b) the monitors should be empowered to review these processes and to present corrective action plans to remedy all errors or problems associated with its review.

4. Chicago Public Schools

Education is the most important program component of detention; and even in the best facilities, education is an ongoing challenge to detention administrators because it is provided by an agency independent of detention.[23]

This situation applies to CCJTDC where the Nancy B. Jefferson School is operated by the Chicago Public Schools (CPS). The current arrangement is aggravated by the fact that different guidelines exist for what constitutes adequate educational services. Most public school systems do not have regulations for detention, so a variety of guidelines apply (e.g., alternative school, homebound instruction, special education, to name a few); whereas, the ACA standards set clear minima.[24] When detention is under external pressure to improve programs and services, it must depend on the good will of the public schools to accommodate voluntarily the changes recommended by the external pressure.[25] Since most of these changes have powerful budget implications, school systems are rarely cooperative unless other forms of external pressures are brought to bear on it. Assuming that the public schools will follow along is a mistake.

In a time when the court is considering greater intervention if there is not an adequate response to the ASO implementation plan, the CPS plans to reduce the number of teachers at the

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[22] Roush, D. W. et al. (2003, August). A response to the issues identified by the U.S. Department of Justice Investigation of the Santa Clara County Juvenile Hall: Report of findings and recommendations. San Jose, CA: Office of the County Counsel.

[23] Roush, D. W. (1996, October). Desktop guide to good juvenile detention practice. Washington, D.C.: U. S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[24] American Correctional Association (1991) standards call for one certified teacher for every 15 youth in residence.

[25] Good will exists at the local level because resolution of the problems facing CCJTDC will also resolve some of the problems occurring in the Nancy Jefferson School. Additionally, Principal Judith Adams is cooperative in efforts to improve the working relationships between teachers and juvenile detention counselors, c.f., Brenda Welch letter to Judith Adams, August 7, 2006.

Nancy B. Jefferson School.[26] By excusing the CPS from the litigation, no compelling reason exists for CPS to incorporate the ASO implementation plan into the operations of the Jefferson School. Others (County administration, CCJTDC administration, and the monitors) will have to begin negotiations with CPS to address the role of education in the development of acceptable conditions of confinement. (See the recommendation is Part 2 about the establishment of an interagency agreement.)

D. Organizational Change

Evidence-based practice calls for integrated outcomes or "products" that reflect the major goals of an organization. For example, some outcomes of CCJTDC are (a) creation of a safe environment in each living unit, (b) keeping youth safe and secure while awaiting court hearings, and (c) addressing the immediate needs of youth for health and well-being. "Functions" are a description of the tasks performed by the organization to achieve the outcomes. For example, functions include programs (recreation and school), social services (casework), transportation, security, group living, and medical and mental health, to name a few.

Efficiency increases when the organization has an outcome orientation. This means that the functions align under and are subordinate to the outcomes as opposed to the high degree of specialization and complexity that occurs when the tasks are organized according to functions. The current CCJTDC organizational chart reflects an organization-by-function approach.

The size and complexity of CCJTDC combine with the inability of past administrations to affect a sufficient amount of change in the daily operations to warrant consideration of the more vertical and integrated[27] organization-by-outcomes approach. A shift to an outcomes-oriented organizational structure would be compatible with a unit management approach. One suggested option would include the following:

1. Reconceptualize juvenile detention by considering CCJTDC as three distinct detention facilities under one organizational structure and under one roof. This would mean the creation of three detention facilities, one per floor, even renaming the floors. The name of the entire complex could remain the same by simply adding an "s" to the end of the title, i.e., the Cook County Juvenile Temporary Detention Centers.

2. Create a new personnel structure, moving away from job classifications including the title of superintendent. Move instead to a position hierarchy based on directors. Hence, the superintendent would become the executive director, and assistant superintendents would become directors. (Depending on who the top person is, it may be necessary to supplement the leadership with an assistant executive director who serves the function of director of operations and who has an extensive background in juvenile detention.)

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[26] Judith Adams Memo to Dr. Erica Collins, May 12, 2006

[27] Lane, M., Becker, K., Hardyman, P., Platt, J., Blakemore, G., & Orr, B. (2002). An assessment of conditions at the Cook County Juvenile Temporary Detention Center: A continuing process of improvement, 2002 (p. 130). Chicago: John Howard Association.

3. Designate three individuals to serve as directors of the floor-based juvenile detention centers, assigning one each per floor. Create a job description for this position similar to that of a juvenile detention superintendent, placing administrative, organizational, and operational powers for that floor under the director's authority and supervision.

4. At the director level, appoint one individual as the Director of Support Services who will coordinate, supervise, and implement all support services such as security, transportation, food services, personnel management, purchasing, etc.

5. Appoint a Director of Quality Assurance. Empower this individual to implement a quality assurance program consistent with the MOA and the concerns of the monitors.

6. Assign an Assistant Director to each floor-based facility along with the appropriate number of case workers, teachers, recreational specialists, and juvenile detention counselors. This would be a good opportunity to change the name of juvenile detention line workers from juvenile detention counselors to juvenile detention specialists or juvenile detention officers or group leaders.

The unit management approach also addresses size-related complexity by reducing the scope of the MOA into three smaller and more manageable organizations. Furthermore, unit management creates a structure that supports, as opposed to hinders, a classification system.

Two strategies for organizational change are a top-down approach and a bottom-up approach. The top-down approach is where the system is changed by external forces or top management, and then the changes are communicated down the organizational hierarchy until they appear in the daily operations. In the absence of a participative process whereby line staff contributes ideas and perspectives on the nature of the change, resistance is very likely to occur. The circumstances over the past several years have generated substantial resistance from line staff (juvenile detention counselors, caseworkers, and recreation specialists). On multiple occasions, staff members have commented defiantly that they were here before Superintendent Robinson was appointed, and they will be here after Superintendent Robinson is gone. (Evidently, they were correct, and Superintendent Robinson's departure reinforces the notion of instability in CCJTDC leadership and that staff can wait out the change process.) This sort of attitude underlies a lack of confidence in the system and in the change process. Therefore, an equally important strategy is a "bottom-up" approach.

A bottom-up approach starts with the assumption that the identification of good people will result in the emergence of (a) good ideas regarding the real nature of problems within the agency and (b) an insider perspective on the viability of change strategies. Through the support of the Annie E. Casey Foundation, several bottom-up strategies occurred over the past six months, producing some encouraging results. One of the first interventions was a two-day Storyboarding event, a strategic planning program consisting of lead staff identified by CCJTDC administration that focused on the implementation of the requirements of the MOA. The enthusiasm, commitment, and capabilities of this group of staff members, ranging from the superintendent to juvenile detention counselors, were impressive. The quality of problem-solving ideas and materials was excellent. One of the monitors participated in the process.

Following this meeting, a subgroup from the Storyboard group met three times to work on the challenge of reducing room confinement by 50%. The group pilot-tested a data collection form, made corrections to the form, and is ready to implement an improved tracking system for room confinement.

Second, the group discussed a strategic approach to addressing issues regarding room confinement by expanding the range of program development. The outcomes from the bottom-up approach indicate that, with the addition of will and capacity, there are many existing staff members who can be relied upon to produce quality changes in the conditions of confinement. At this time, the number of employees that fit this category is unknown. The media's reporting on the problems at CCJTDC, while not inaccurate, has been primarily negative. This discourages those good staff who wants to see and support positive changes. The bottom-up strategy has been one means of identifying and strengthening a group of staff that will be vitally important to any successful reform effort. Any effective implementation plan should have a bottom-up component.

Sometimes when problems become intractable, many practitioners and policy-makers wish they could simply do away with the current system and start over. One documented model exists to accomplish this goal. The transformation of the Jefferson County (Kentucky) Juvenile Detention Center from one of the nation's most troubled and dangerous institutions[28] to exemplary status as a national resource center includes one frequently overlooked but significant component of change. Prior to embarking upon a new direction with a new program, all staff was fired (laid off indefinitely). Leadership re-hired approximately 35% of the previous staff and hired new staff to complete its roster. Whether this radical strategy can be duplicated remains to be seen; however, it exists as proof that a bold approach can be successful despite initial appearances of impossibility.[29]

1. Parallels with Jerry M

The Department of Youth Rehabilitative Services, the agency responsible for implementing the federal court consent decree on the Jerry M lawsuit, reports substantial improvements in the conditions of confinement for detained youth in the District of Columbia. Federal monitor Grace Lopes agrees with some of the claims of improvement, particularly those attributed to the coaching intervention at the Youth Services Center (YSC), the new secure detention facility.[30] Lopes recommends the YSC coaching model for jurisdictions and agencies that find themselves in a similar situation, i.e., the need to find a reliable way to improve expeditiously conditions of confinement in juvenile detention. Many of the elements of the coaching strategy parallel the recommendations in this report. For example, Lopes lists the following factors as contributing to the positive changes at YSC:

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[28] Kihm, R. C. (1981). Juvenile detention administration: Managing a political time bomb. Federal Probation, 45 (1), 9-13.

[29] Roush, D. W. (1996). Chapter 3 -- A juvenile justice perspective. In C. M. Nelson, R. B. Rutherford & B. I. Wolford, (Eds.), Comprehensive and collaborative systems that work for troubled youth: A national agenda. Richmond, KY: National Coalition of Juvenile Justice Services.

[30] Personal communication, July 20, 2006.

a) Injecting political will and identifying the political and bureaucratic obstacles to reform that had been previously assumed to be taboo.
b) Enhancing capacity by setting forth clear and usable program concepts, policy and procedure, and staff training.
c) Restructuring the organization by establishing discreet teams of staff and supervisors for each living unit.
d) Improving accountability by expecting staff behaviors to be consistent with new policy and procedure and by confronting, sanctioning, or rewarding all instances of exceptional staff behavior, both appropriate and inappropriate.
e) Strengthening credibility and trust among staff because of immediate improvements associated with the coaching intervention and improved personnel decisions, e.g., promotions and new hires.

The coaching model currently in place at YSC involves the designation of a detention specialist who serves as a coach for the YSC superintendent. The meaning of the word coach has numerous definitions and connotations as applied to professional development [n 1: (sports) someone in charge of training or directing an athlete or a team (syn: manager, handler) 2: a person who gives private instruction (as in singing or acting) (syn: private instructor, tutor)]. Too often, the contemporary understanding of a coach is synonymous with teacher, advisor, mentor, counselor, friend or cheerleader. This configuration of coaching is flawed because the coach has only influence and no power or control over getting recommendations implemented.

In the YSC situation, the coaching is more like that of a professional football coach. Unlike other situations, the coach (Earl Dunlap) has the authority to "bench" the superintendent for poor performance. In other words, the YSC coach has power and control over the change process, including the authority to rewrite policy and procedure, to restructure the YSC organizational chart, to redefine job responsibilities and duties, and to select the training programs to be implemented. The YSC coach also spends three full days on-site per two-week pay period (30% time). In this particular instance, Dunlap actually lives in the detention center, making himself present and available 24-hours a day during his on-site visits. This level of accessibility allows Dunlap to know the staff on all shifts and to know the residents.

With a proven and nationally-respected detention expert as the coach for a facility one-sixth the size of CCJTDC, substantial progress toward achieving the goal of acceptable conditions of confinement has taken more than one year; and all parties agree that while substantial progress has been made, the change process is far from complete. To date, Dunlap's YSC coaching model appears to be the most viable option for changing conditions of confinement in troubled juvenile detention facilities.

2. Data Collection

Data collection remains a significant problem. Current systems are so poor and out-dated that much of the important data are collected by hand and archived in bulk folders in various storerooms before the information can be entered into an aggregate form. The system is so bad that CCJTDC cannot say with certainty how many youth are detained at any point and cannot

prove it is doing what it says it is doing. One promising event is the offer by the Annie E. Casey Foundation to support the work of Drs. Butts and Schwartz to develop a plan for the implementation of a competent data collection and management information system. This offer should be approved and implemented as soon as possible.

The technology available to staff for data collection, including the electronic filing of incident reports, is poor.[31] There were personal computers (PCs) on the units, but they are used no longer. About 75% of Illinois juvenile detention facilities use computers to collect basic information about daily operations, especially incident reports; however, CCJTDC staff have very little professional interaction with other facility staff, and they are not exposed to other detention facilities that have kept pace with technology. CCJTDC is woefully behind the times.

Several conscientious staff has been logging incident report data on an Excel spreadsheet. While we were unable to determine the accuracy of the numbers, nonetheless Table 1 contains incident report data for CCJTDC for the months of April, May, and June 2006. Information from the spreadsheets allows some disaggregating, particularly by offense category and floor. No information was available about which staff member(s) was involved in the incident. These data permit the establishment of a rate for certain categories of incident type that can be compared to the findings of the Congressionally-mandated study of conditions of confinement in juvenile detention facilities.[32] The study provides rates for several types of incidents based on the number of incidents per 100 juveniles per month. These rates appear in the "OJJDP" column of Table 1. Through information supplied by Ron Oldaker regarding monthly population figures for April-June 2006, the CCJTDC rates for each category of incident types appears in the "Rate" column in Table 1.

Direct comparisons of rates occur for suicide attempts, physical restraints, and mechanical restraints. In no comparison is the CCJTDC rate close to the national rate. For suicide attempts, the CCJTDC rate is more than 10 times lower than the national rate.[33] For mechanical restraints, the CCJTDC rate is 11 times lower than the national rate. Staff explanations indicate that physical restraints rarely escalate to mechanical restraints. Finally, for physical restraints, the CCJTDC rate is 36.8% higher than the national rate, meaning that physical restraints are used more frequently at CCJTDC. Another way to look at the rate is that there is a physical restraint on about one out of every five detained youth per month. These data project an annual total of 956 physical restraints for 2006. This rate is too high.

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[31] Lane, M., Becker, K., Hardyman, P., Platt, J., Blakemore, G., & Orr, B. (2002). An assessment of conditions at the Cook County Juvenile Temporary Detention Center: A continuing process of improvement, 2002 (p. 16). Chicago: John Howard Association.

[32] Parent, D., Leiter, V., Kennedy, S., Livens, L., Wentworth, D., & Wilcox, S. (1994, August). Conditions of confinement: Juvenile detention and correctional facilities (Research report). Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

[33] Skeptics have already said that CCJTDC suicide attempts are underreported due to the desire to keep such information out of the press and out of investigation by DCFS. Yet, other institutions in the national study had and continue to have the same pressures to underreport controversial data. Other factors may be involved. For example, in a recent national study of suicide in juvenile detention facilities, the National Center on Institutions and Alternatives (NCIA) noted that African-American youth were underrepresented in all aspects of suicide behavior.

One staff member, who is a certified Handle With Care instructor, reviewed these numbers and thought they were consistent with his experiences on the 5th Floor. He indicated that of the 92 physical restraints on the 5th Floor during this period, he thought he was involved in about 80% of them. [Discussions about a first response team consisting of specially trained staff to handle possible crisis and physical situations (See Part 2) have raised concerns about pay, status, training, insurance, and scheduling. The concept appears to be happening informally.]

Table 1. Incident Data for April through June 2006

Incident Type	Apr to June Totals	Monthly Average	Proj. Annual Totals	3rd Floor	4th Floor	5th Floor	Rate	OJJDP
Attempt Suicide	1	0.3	4.0				0.23	2.48
Battery/Assault on Peer	73	24.3	292.0	10	36	27	5.57	
Battery/Assault on Staff	10	3.3	40.0	3	5	2	0.76	
Battery/Assault on Teacher	3	1.0	12.0	0	2	1	0.23	
Group Disturbance	36	12.0	144.0	0	15	21	2.75	
Fights	335	111.7	1340.0	51	147	137	25.56	
Sex Offense	0	0.0	0.0					
Total Incident Reports	494	164.7	1976.0	77	219	198	37.69	
Alleged Abuse	12	4.0	48.0	3	4	5	0.92	
Physical Restraint (P.R.T.)	239	79.7	956.0	35	112	92	18.2	13.3
Mechanical Restraints	5	1.7	20.0	2	2	1	0.4	4.4

3. Staffing

The late John Sheridan, retired Air Force Colonel and a decorated war veteran, served as New Hampshire's director of juvenile corrections for many years. His comment to his colleagues at the American Correctional Association several years ago still resonates today. Sheridan defined the essence of effective juvenile institutions as three things -- a sufficient number of well-trained and good people. There are many factors that contribute to good institutional conditions of confinement; and while the particular combination of these variables may change for each particular institution, Sheridan's staff-related triad seems to play an important role in all good institutions. His axiom generates three questions for this implementation plan: Are there sufficient numbers of staff to provide adequate supervision? Are there adequate amounts of relevant training to prepare workers to supervise competently? Are there competent mechanisms to screen into the profession good people and to screen out of the profession those adults who want to work with troubled and vulnerable youth for the wrong reasons?

a. Sufficient Numbers of Staff

The question of a sufficient number of CCJTDC staff has been asked many times over the past decade. As schedules, job assignments, and job duties have evolved in a variety of directions, the line staff position of juvenile detention counselor became more difficult to understand. The complexity of scheduling, the control of absenteeism, the inability to get individuals to report to work on time, and the inability to control the number of staff on special duty created a situation where the number of staff on the roster did not appear to be sufficient to operate the program. This report represents a fourth external study of staffing needs.

There are many strategies that can be used to project staffing, most of which are derived from adult correctional practice. As a result, these strategies are not as sensitive to the demands for staff generated by a juvenile detention facility. Therefore, the NPJS strategy is an adaptation of the Program Specific Model (PSM)[34] specifically designed for juvenile institutions. Using concepts and principles adopted by the National Institute of Corrections,[35] the PSM incorporates a profiling of the facility to determine how its particular configuration creates an increased or decreased demand for staff, the establishment of the direct care staff ratio,[36] and the computation of the institution's replacement factor.[37] This information permits comparisons between (a) existing staffing patterns and (b) staffing projections based on requirements derived from professional standards, guidelines, and best practices. By using standards and empirical calculations to estimate various staff scheduling strategies, PSM supplies a constant and uniform estimate of the numbers of staff needed to accommodate each strategy.

Juvenile Detention Counselor. The PSM model predicts the need for 315 juvenile detention counselors. This estimate is the same as the 2005 John Howard Association staffing report,[38] except for the strengthening of the juvenile counselor presence at Intake. Table 2 presents the juvenile detention counselor projections from each of the external studies. All are remarkably similar in their projections. These projections differ somewhat from the internal staffing analysis done by CCJTDC staff which placed the need for juvenile detention counselors at 335. The CCJTDC projection implies that some important components of the staffing projections have not been included in the outside staff estimates. CCJTDC administration maintained that the number of staff who are not available to work in a direct supervision capacity, i.e., staff on disciplinary leave, administrative leave, workers comp, sick leave, light

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[34] Roush, D. W. (1997). How to estimate staffing requirements in juvenile detention and correctional facilities: A computation workbook. East Lansing, MI: National Juvenile Detention Association.

[35] Miller, R., & Liebert, D. (1988, January). Staffing analysis workbook for jails. Washington, D.C.: National Institute of Corrections.

[36] Practice indicates that two juvenile detention counselors are on duty during waking hours, yielding a staff ratio of 1:8 and 1:9, which is compatible with the ratio recommended in the OJJDP study of conditions of confinement (Parent et al., 1994).

[37] This staffing estimate adopted the 1.72 relief factor established by the 2005 John Howard Association staffing report (John Howard Association, 2005:35). The relief factor estimates appeared thorough and competent.

[38] John Howard Association. (2005, June 30). Cook County Juvenile Temporary Detention Center: Staffing and roster management (Draft). Chicago: Author.

duty, intermittent FMLA, and non-supervisory duty, exceeds of the non-working calculations included in the relief factors in the outside staffing projections.[39] Even though a relief factor of 1.72 is very high, CCJTDC administration maintains it still underestimates the actual need for relief staff.

In some ways, the amount of time that juvenile detention counselors spend away from work assignments reflects the bureaucratic challenges within the Cook County system. Staff at every level of CCJTDC complains about delays related to staffing issues. Given the size of the system and the size of the problems, the standard relief factor may be inadequate to compensate for the complexity and delay associated with the inefficiencies linked to staffing. Without an adequate number of staff, a new implementation plan will experience similar delays and inconsistencies. Training will be delayed until new staff members can move through the hiring process; development of new teams within a unit management structure will be delayed; and additional numbers of staff will find their way onto special duty rosters as a way of expressing their resistance to change. Therefore, the need exists for a "transition" adjustment to the staffing projection.

Given the fluid nature of the numbers of staff on inactive status, the numbers of staff requiring special assignment, and the likely upheaval to occur among disgruntled and troubled staff with the installation of a competent administration, we recommend that the County hire juvenile detention counselor positions at 107% of the recommended level for a two year period of time to account for the transitions that will occur at that juvenile detention counselor level. Therefore, the adjusted staffing recommendation for juvenile detention counselors should be 337 through July 2008. Natural attrition will allow the number to return to 315 by early 2009, provided an additional staffing analysis also projects the juvenile detention counselor needs at or about 310.

Recreation Specialists. The move to a unit management structure will expand the responsibilities of recreational specialists and place them under the supervision of the unit manager. Likewise, the number of recreational specialists needs to be expanded, so that there are 10 recreation specialists working each day. In order to have a recreation specialist on-duty in the afternoons and evenings (1:00 to 9:00 pm) on weekdays and for the majority of the day (10:00 am to 6:00 pm) on the weekend, the number of recreation specialists should be set at 17.

Caseworkers. Caseworkers will play an important role in a unit management structure. The American Correctional Association[40] recommends one caseworker for every 25 residents. This projects a minimum number of 20 caseworkers based on the CCJTDC capacity. The unit management concept for casework services projects a seven-day a week caseworker function. Therefore, to staff casework functions on a seven-day schedule requires a total of 34 caseworkers.

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[39] A review of the staff roster provided by Superintendent Robinson for May 15, 2006 revealed 288 juvenile detention counselors on the payroll, but 14 (5.11%) were on inactive status. This did not include the juvenile counselors on special assignment or the proportion of staff who call in sick, which can be as high as half of the shift on weekends (Lane et al., 2002:164).

[40] American Correctional Association. (1991, May). Standards for juvenile detention facilities (3rd ed.). Laurel, MD: Author.

Table 2. Juvenile Detention Counselor Staffing Level Projections

Staffing Reports	No.
2002 John Howard Association Staffing Study[41]	306
Cook County Bureau of Administration Study[42]	300
2005 John Howard Association Staffing Study[43]	311
2006 Agreed Supplemental Order Staffing Analysis	**315**
Average	308
107% of ASO Projection	337

Note: The organizational structure influences staffing estimates, and these figures correspond to a unit or team organizational structure as recommended above (see p. 18). If CCJTDC determines that the unit management approach is not its preference, then the same organizational structure changes the assumptions used in these predictions; and a new staffing estimate should be conducted.

b. Adequate Amounts of Relevant Training

A decade ago the training department at CCJTDC was recognized as one of the best juvenile detention training programs in the country.[44] With the departure of then training director Myra Vucicnovic, the staff training function deteriorated. Training remains an important function and an essential piece of staff development, but the training department has been understaffed and underfunded for years. To address the lack of resources, the most recent former training director, Dr. Erica Collins, saw the National Juvenile Detention Association's staff training standards[45] as the foundation for the development of a training academy. She contacted the NPJS Center for Research & Professional Development to strengthen and expand the internal training capacity. With assistance from the Office of Juvenile Justice and Delinquency Prevention (OJJDP), CRPD conducted a training needs assessment, curriculum development, and a 40-hour training-for-trainers workshop. These training interventions represent the current best training practices for juvenile detention. The review of the training department revealed the following improvements: a schedule for line staff training, development of a basic line staff curriculum, development of an orientation curriculum, improvement in

[41] Lane, M., Becker, K., Hardyman, P., Platt, J., Blakemore, G., & Orr, B. (2002). An assessment of conditions at the Cook County Juvenile Temporary Detention Center: A continuing process of improvement, 2002. Chicago: John Howard Association.

[42] Eldridge, J. L., Jr. (2004, November 22). Juvenile temporary payroll and overtime analysis (Memorandum to James L. Whigham and J. W. Fairman, Jr.). Chicago: Bureau of Administration.

[43] John Howard Association. (2005, June 30). Cook County Juvenile Temporary Detention Center: Staffing and roster management (Draft). Chicago: Author.

[44] Roush, D. W. (1997). Conditions of confinement at the Cook County Juvenile Temporary Juvenile Detention Center (unpublished manuscript). Richmond, KY: National Juvenile Detention Association.

[45] Roush, D. W. (1996, April). Juvenile detention training needs assessment: Research report. Washington, D.C.: U. S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

training content, and development of a group of staff who can work as staff trainers. A solid foundation exists once more to build a good staff training program.

Dr. Collins also assembled a group of talented staff from various job descriptions to serve as her staff trainers. Because of inadequate training support and an inadequate number of trainers, Dr. Collins moved the training department in the direction of strengthening internal training capacity. As a result, she had several staff members who provided the bulk of staff training programs. This strengthened the credibility of the training and built a better link between the concepts presented in training and the likelihood that supervisors would reinforce these concepts when the training participant was working the floor. In addition to the development of (a) a pre-service orientation program, (b) a 40-hour basic skills program, and (c) a strategy for expanding the use of trainers from other agencies (including the re-establishing of training cooperatives with the Probation Department), the training department has been working on the development of lesson plans, PowerPoint presentations, and participant hand-outs. Staff continues to modify the CRPD training materials to fit the specific issues at CCJTDC. These modifications have not altered the quality of the training content.

The biggest challenge facing the training department is understaffing. Currently, the emphasis has been on the delivery of training, so the completion of the written materials (lesson plans and handouts) remains only partially finished. This underscores the need for an expansion of the training department through the assignment of additional full-time trainers and clerical support. Given the size of CCJTDC, there should be a full-time trainer for each floor (three additional full-time trainers), and one additional clerical support person added to the training department. The new trainers, along with the new training director, should have experience in staff training and a certificate of completion from a recognized training-for-trainers workshop.

c. ASO Special Training

One part of the ASO calls for the development and implementation of a special training curriculum for those staff members who have multiple abuse allegations. The initial recommendation for the intensive training curriculum included the following courses: effective communication, conflict resolution, anger management, responding to anger, stress management, problem solving strategies, residence discipline, juvenile right, cultural diversity, juvenile supervision, report writing, the escalation techniques, and physical restraint techniques. In addition to these topics, the curriculum is supposed to have a pre- and posttest for measuring participant learning.

The list of curriculum topics still should be strengthened through the inclusion of lessons on adolescent development, working with youth with mental health problems, ethics, and a review of the principles of behavior management.

Outcome measures that indicate compliance with the training recommendations include the following:

1. The trainers, whether line staff trainers or trainers from outside CCJTDC, have evidence of successful completion of a training foundation skills course sometimes refer to as a training-for-trainers (T4T) course.

2. The training lesson plans contain appropriate content and process information. Lesson plans follow the guidelines developed by Hunter in her Instructional Theory Into Practice (ITIP) model. In addition to specifying the training objectives, the lesson plan includes the following categories of information: anticipatory set, instructional input, guided practice, and independent practice.

3. Trainers supplement the training through the use of PowerPoint slides and participant handouts or manuals.

4. There is a training evaluation process that includes an evaluation of the training and a test to gauge learning. The test should be a pre-test and posttest, enabling trainers to determine participant knowledge and skill deficits before the training session and to determine how much learning occurred in each of the key content areas.

5. A recognized juvenile justice training organization should review these training materials and give its approval or endorsement that the materials meet minimum standards of acceptability based on current practices. Two organizations that can provide this review and approval are the Center for Research & Professional Development at Michigan State University (the training division of the National Partnership for Juvenile Services) or the Juvenile Justice Trainers Association (JJTA), a partner organization within NPJS.

A review of the special training conducted on July 27, 2006 revealed the following:

1. The special training was provided on one occasion by competent trainers.

2. The content of the special training did not reflect agreed upon modifications to the list of training topics. There are no lesson plans that address adolescent development, mental health issues, ethics, and principles of behavior management.

3. Of the original topics listed above, lesson plans and PowerPoint presentations existed for effective communications and conflict resolution.

4. Hargrove provides training for anger management and stress management; and while PowerPoint presentations were available, there were no lesson plans on file for anger management and stress management.

5. PowerPoint files existed, but lesson plans did not exist, for problems solving strategies, resident discipline, juvenile rights, cultural diversity, juvenile supervision, report writing.

6. PowerPoint presentation and the materials from Handle With Care (HWC) regarding de-escalation techniques existed for this lesson plan, and the same applied to physical restraint techniques. These materials meet the expectations of the ASO for competent and remedial training on de-escalation techniques.

7. There was no pre- or posttest for this training.

Based on these deficiencies (with the exception of the HWC de-escalation training), the special training does not comply with the recommendation in ASO paragraph ten that "staff with more than one allegation of abuse will receive intensive training."

c. Mechanisms

The mechanisms to get good people on staff and to get the wrong people off of staff appear ponderous. CCJTDC staff complains that the low pre-employment qualifications for juvenile detention counselor's means that many of the candidates referred for interviews share the same values and behaviors as the residents in the facility. Many applicants and several current employees hold gang affiliations, according to numerous staff reports. Staff also complains that the hiring is done from a list returned to Human Relations following an interview of a group of candidates. In other words, the CCJTDC does not have a final say over the hiring process.

Recent reports indicate that very little is done to discipline staff for a wide range of inappropriate behaviors, including absenteeism and tardiness. In fact, our assessment leads us to believe that the entire system is tainted. Until there is a competent, reliable, and just system for employee discipline, correction, or termination, CCJTDC will continue to have a group of negative and trouble-making staff that will resist change and contaminate staff morale.

There is innocence in assuming that a detention operation can make significant changes (including the addition and removal of staff) when a different agency controls personnel actions.[46] Even the most competent juvenile detention administrator will have to expend excessive amounts of time and energy to resolve personnel issues of this nature. The failure to put personnel mechanisms under the authority of the monitors places an additional burden on the leadership in Cook County government to make personnel department changes. For that reason, there needs to be some accommodation to assist the CCJTDC in bringing greater pressure to bear on the process of getting the right people on to staff and to getting the wrong people off of staff in a quick, efficient, and equitable manner.

[46] Under the terms of the Jerry M. consent decree in Washington D.C., the District appointed a child advocate Vincent Shiraldi as the director of Youth Rehabilitation Services. Shiraldi noted that institution's dependence on the larger system or organization. The failure to include these organizational variables permits them to become organizational obstacles, and they contribute to situations where court-ordered remedies are slow to produce much, if any, of the desired change. For example, the inability to get the human relations department to hire an adequate number of staff or to support the removal of dangerous staff degrades other reform efforts.

E. Pre-Requisites for Change

Part 1 identifies issues that should be addressed before the implementation of the ASO MIP. There are five pre-conditions.

1. Develop Political Will and Strengthen Capacity

a) Reduce the delay in getting things done. Cook County government should send a message to its various departments requiring an increase in the level of cooperation and a reduction in the amount of delay on each department's part in the implementation of the ASO.

2. Change the Organizational Structure

b) Write a comprehensive set of policies and procedures using the ACA standards as guidelines. This may require contracted services with a juvenile detention operations specialist. The standards should be prepared, reviewed, and approved within 60 days.

c) Change the organizational structure and organizational chart to reflect an organization-by-outcome approach, making the organization more vertical through the implementation of a unit management system.

d) Divide the facility into three institutions; assign different populations of youth to the living units in accordance with a new classification system; develop a team of staff for each living unit, including juvenile detention counselors, caseworkers, and recreation specialists; assign staff to various units; designate a leader or director for each floor; and parcel support services to each floor.

3. Hire a Sufficient Number of Qualified Staff

e) Hire qualified leaders in accordance with a revised organizational chart and a unit management organizational structure.

f) Bring staffing to the recommended levels: juvenile detention counselors at 337, juvenile caseworkers at 34, recreation specialists at 17, and full time staff trainers at three (3) (not including the training director).

g) Achieve 90% of these figures within three months following the implementation of the ASO plan; achieve 100% of these numbers within six months.

4. Data Collection

h) Implement the data collection contract with Butts and Schwartz within ten days of the implementation of the ASO plan. Implement the recommendations of the plan to improve data collection. Install the recommended technology including the installation

of personal computers (PCs) with access on the living units consistent with the recommendations from the Butts and Schwartz report.

5. Create Ad Hoc Committees to Investigate Obstacles to Implementation

There should be four ad hoc committees to investigate the concerns and issues raised in this report about obstacles to successful implementation found in the external environment and to prepare plan of action to remedy any problems verified by the committee that adversely affect of the implementation of the MOA. Each of the named committees listed below should consist of three members, one each appointed by the plaintiff, defendant, and monitors.

The ad hoc committees should be:

a) The Employee Discipline committee should investigate (a) the CCJTDC personnel discipline policies and practices and (b) the personnel review and appeals processes within Cook County and the State of Illinois. The goal should be to identify issues that require improvement at all phases of the employee investigation, disciplinary, grievance, and appeals processes.

b) The Human Relations committee should investigate the Cook County Human Relations Department regarding recruitment, selection, and efficiency in hiring practices related to CCJTDC.

c) The Union committee should investigate collective bargaining agreements and union policy and practices to determine areas of incompatibility with the MOA.

d) Chicago Public Schools committee should investigate the nature and extent of an acceptable detention education program within the context on the MOA and national best practices to determine areas of discrepancy between current practices and the Nancy B. Jefferson School. This committee should provide information for the interagency agreement outlined in Part 2.

The monitors should identify the individuals in charge of each of these agencies or organizations and, through a letter, invite them to participate fully in a review of how their practices affect the ability of CCJTDC to comply with the MOA. The same invitation should be extended to the Cook County Board President as some of these committees relate to operations under her control.

Reports of findings for each committee should be submitted within 90 days of the implementation of the ASO. Refusal to cooperate with the work of the committees should result in a petition to the court to amend the list of defendants to include the non-cooperating agency.

F. Summary

The capacity exists to implement the ASO quickly and effectively. There are a series of good plans (MIPs) that outline the goals and objectives for establishing acceptable conditions of

confinement very clearly. Technical know-how exists through some competent CCJTDC staff and through numerous technical assistance providers, outside experts, concerned foundations, and members of the JDAI inspection committee. Finally, the court and the media have created sufficient pressure that the County might supply the resources needed to implement these plans.

The missing piece is leadership.

The selection of the right people to fill the vacancies, the organizational restructuring, and the expanded staff roster should result in successful implementation of the ASO. Part 2 is offered as a roadmap for the new leadership.

Appendix D
On-going Reports to C/A and Court Monitor Schedule

Report/Documents	Paragraph	Daily (M-F)	Weekly	Twice a Month	Monthly	Quarterly
Child Abuse Allegation Packets	12, 13	X				
Incident Reports (including Detention Standards Incident Reports)	65	X				
All reports regarding Extraordinary Circumstances	65	X				
Room Confinement for Protective Custody Reports	59	X				
Room Confinement for Institutional Emergencies Reports	58	X				
Therapeutic Restraint and Room Confinement Documentation	27	X				
Copies of new or revised policy, procedures or operational memos	ASO 9	X	X			
Daily "rated capacity" and population reports	39		X			
Daily residents not attending school reports	10		X			
Daily list of resident's not allowed to participate in recreation	33		X			
Daily list of resident's not allowed to participate in one hour of structured large muscle exercise.	51		X			
Use of Force Reports	25, 57		X			
Weekly Fire and Safety Inspections	44		X			
Daily Sanitation Reports	45		X			
Weekly Maintenance Log	46		X			
Injury Reports and Logs	17		X			
Report/Documents						
Bi-monthly Sanitation Reports	45			X		
Copies of completed grievances	54			X		
Copies of original resident grievances	54				X	
Disciplinary Rule Committee Summaries	52				X	

Report/Documents	Paragraph	Daily (M-F)	Weekly	Twice a Month	Monthly	Quarterly
Performance Measures Progress Report	32, 34, 47, 55, 64				X	
Staff meeting minutes or summaries	12, 13				X	
Progress report on % of staff completing training	12, 13				X	
Staffing Report	36				X	
"Systems Check" Forms	56				X	
Monthly Fire and Safety Inspections	44				X	
Monthly Statistics on Mental Health	22				X	
Contract Monitoring	33, 45					X
Employee Disciplinary Reports	12,13				X	
Youth Denied Recreation Report	50				X	