# An Association Report:

# Volunteer Visit
# to the
# Cook County Juvenile
# Temporary Detention Center
# 23 August 2006

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**This report** was written by Patricia Connell, J.D., and Malcolm C. Young for the John Howard Association of Illinois and is based upon observations reported by volunteer citizens who visited the Cook County Juvenile Detention Center on behalf of the Association under Ms. Connell's direction on 23 August 2006.

**The John Howard Association of Illinois** provides critical public oversight of the state's prisons, jails, and juvenile correctional facilities. As it has for more than a century, the Association promotes fair, humane, and effective sentencing and correctional policies, addresses inmate concerns, and provides Illinois citizens and decision-makers with information needed to improve criminal and juvenile justice.

**Volunteer citizen visits** to Illinois adult and juvenile correctional facilities are one means of providing public oversight of prisons, jails, and juvenile corrections facilities. These visits bring people from many walks of life into closed institutions where they can observe activities and conditions and speak with residents and employees.

Many volunteers who visit juvenile corrections facilities for the Association have professional backgrounds and experience in aspects of child and adolescent behaviors, but none are correctional professionals. Their observations do not substitute for professional accreditation or evaluations conducted by experts such as are on the Association's staff and among its consultants. They are, however, invaluable in providing a fresh view of how youth from the community are treated in juvenile facilities and, through published reports, in informing policymakers and the general public about the current state of youth corrections as seen through the volunteers' eyes. Consistent, periodic visits by teams of volunteers chronicle changes in an institution over time and permit comparisons between different facilities serving similar populations within the state.

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**John Howard Association of Illinois Report**
**Cook County Juvenile Temporary Detention Center**
Visit of 23 August 2006

## Introduction

The John Howard Association of Illinois conducted a regularly scheduled monitoring visit to the Cook County Juvenile Temporary Detention Center on Wednesday, August 23, 2006. Members of the team included John Howard Association Board Member Philip Carrigan, volunteers Barbara and Delbert Arsenault, Millie Juskevice and Sheila Merry, and John Howard Association staff Pat Connell and Malcolm Young. Team members focused on several issues that have been of concern for some time, including, most importantly, safety for children detained at the institution, leadership, training and staffing. Team members were as aware as anyone else involved with the Detention Center of recent evaluations and reports citing unsatisfactory conditions, staff behavior, and weaknesses in administration. Reports and evaluations include the John Howard Association's cumulative report based on five years' previous visits[1] and a "self evaluation" conducted in the last two months of 2005 under the auspices of the Juvenile Detention Alternatives Initiative by a specially-assembled team.[2] In addition, there had been several news reports and allegations of violence against children detained at the Center.[3]

These and other claims of poor management, violence against children, and other problems with leadership at the Detention Center helped attorneys for plaintiffs in the long-standing class action litigation on behalf of inmates in Doe v. Cook County, et al.[4] to persuade the Federal Court to compel renegotiation of a longstanding settlement agreement.[5] After negotiations, the parties agreed to the appointment of additional experts and advisors to assist the Detention Center's administrators. Four nationally-recognized experts, Michael Cohen, M.D., Louis Krause, M.D., David Rousch, Ph.D., and Carl Sanitti were retained to craft solutions for the problems at the facility. Ms. Brenda Welch was appointed as a "Compliance Administrator" to provide day-to-day, on site coordination. These persons were added to the two independent Court Appointed Monitors, Michael Mahoney and Charles Fasano, who were to continue to review and recommend changes which the experts might propose to the Federal Court having jurisdiction over the suit. These additions and changes in roles and overseeing personalities occurred in the months prior to the August 23 visit.

As significant as these changes were, equally transforming were the shifts in upper management at the Detention Center that were in taking place in August as an indirect result of

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[1] "An Association Report: Volunteer Visits to the Cook County Juvenile Temporary Detention Center 2001-2005."
[2] Juvenile Detention Alternative Initiative (JDAI) Self-Assessment Report (February 2006)
[3] See for example, "State probes claims of wrongdoing at juvenile center," Chicago Sun Times, December 20, 2005 p.20; "Cook County's House of Abuse," Chicago Tribune editorial, October 1, 2006.
[4] Doe v. Cook County, et al., No. 99 C 3945, before Judge Norderg, Federal District Court, Northern District of Illinois.
[5] Memorandum of Agreement Implementation Plan filed in Doe v. Cook County (2002).

misfortune to one of the County's political leaders. In February 2006, barely a week before the primary election in which he was a candidate for a new term, John Stroger, President of the Cook County Board of Commissioners and the county official most directly responsible for the Detention Center's operation and staffing, suffered a serious stroke. After several months of incapacitation, Mr. Stroger resigned the Presidency. In late July the Cook County Board of Commissioners elected Commissioner Mrs. Bobbie Steele to serve the remaining four months of Mr. Stroger's term. The Cook County Democratic Committee selected Todd Stroger, John Stroger's son, to run in the general election against the Republican candidate for County Board President.

Almost immediately upon her election by the Board, Ms. Steele expressed an interest in righting conditions at the Detention Center. Even before she was formally installed she paid a publicized visit to the Detention Center on July 27, 2006 [6]. In the days and weeks after her visit, there were sweeping changes in management at the Detention Center:

- On July 31 Superintendent Jerry Robinson resigned his position. On the next day President Steele replaced Mr. Robinson with J.W. Fairman, Jr., who was named Acting Superintendent. Mr. Fairman was no outsider. He had been serving as Director of Public Safety for Cook County a position in which he was responsible for supervising the operation of the Center.
- In early August, Carl Sanitti was named Assistant Superintendent. Mr. Sanitti had most recently been acting as a consultant to the parties in the Doe litigation, participating in the development of a modified implementation plan to rectify conditions at the Center. He came to Illinois after years of experience in the operation of juvenile detention facilities in other states including Georgia and Maryland.
- Shortly after our visit, Robert "Pete" Catchings was appointed as a second Assistant Superintendent. Catchings had over twenty years of experience working in the Illinois Department of Corrections, most of it in the Juvenile Division. Most recently he had been working with a community based agency that aids youthful offenders on the Westside of Chicago.
- Reid Paxson was named Chief Financial Officer.
- Some weeks before the John Howard Association visit, responsibility for health services at the Cook County Juvenile Temporary Detention Center was taken over by the Cook County Bureau of Health Services, under the supervision of Cermak Health Services, which provides health care at the Cook County Jail, a change long urged by the Court monitors. Cermak appointed a new Interim Health Care Administrator, Ms. Rose Lewis-Calvin, MSN, MBA.

[6] "Steele vows to aid juvenile site," Chicago Tribune, July 28, 2006, Metro section, p.2.

- During August, others in senior management at the Center were reassigned or allowed to resign, including long term Director of Training Erica Collins and Assistant Superintendents Sandra Jones, Aubrey Calloway, and Kevin Ford.

These appointments seemed to break the mold of political hiring for senior positions at the Detention Center. Although Sanitti had been recently engaged as a court-appointed expert to assist management at the Detention Center, most of his history of juvenile corrections leadership occurred outside Illinois. Nurse Calvin did not sound like an appointee dependent upon her position at any cost to the quality of her work. At her request, she received an "acting" appointment. She is on leave from her previous employer, and if the position at the Detention Center does not work out from Calvin's perspective, she is free to return to her former position. Even the appointment of J. W. Fairman, Jr., from Cook County government appears different from previous appointments. While Robinson as Superintendent was previously subordinate to Fairman as Director of Public Safety, Robinson also reported and was responsible directly to President Stroger who, it is reported, made or approved most other supervisory appointments. Fairman's autonomy as Superintendent was unclear to the John Howard Association team during our August visit, but the appointments that have occurred during his tenure seem to be taking the Detention Center in a different direction than those that occurred under his predecessor.

**Proposed Changes in the Detention Center's Approach to Intake, Behavior Management and Discipline**

On the day of the visit we met first with Mr. Sanitti, Monica Collier, a long time employee who now serves as a Floor Manager, Gwen Burrell, Case Work Supervisor, Tony Barone, who is in charge of Policies and Procedures, Belinda Watkins, a registered nurse who has worked at the Center for 15 years, and Rose Lewis-Calvin, the newly named Interim Health Care Administrator.

Mr. Sanitti described some immediate changes that have been made to increase the security and safety of the facility. Mr. Sanitti has had desks and chairs removed from the residents' rooms to eliminate youth placing contraband in the ceiling tiles or using the wires from which the tiles are suspended to hang themselves. Youth will also not be permitted to bring any of their own clothing or personal possessions into the institution or to wear their own clothing to court, again to reduce the introduction of contraband into the facility. Two-way radios are being placed on all living units so that staff members do not have to depend on telephones. Security officers are now being deployed on living unit floors of the building, so that they can be called for back-up quickly if a disturbance occurs. The movement and control officers are being issued keys to the living units and cut down tools to increase their usefulness. A key control system will be implemented in the near future.

Mr. Sanitti also discussed his plans for revamping the intake process at the Center. While in the Intake area in the basement all youth will be strip searched, showered and dressed in institutional clothing, including shoes, to eliminate the introduction of contraband into the

facility. Once the youth has undergone this preliminary screening he will be assigned to an Orientation Unit where he will have additional testing (MAISIE and SASE), and be introduced to the facility and rules through a handbook, video and discussion with staff. Youth will remain on an Orientation Unit for the first 72 hours in the facility or until the minor appears in court.

Further housing assignments will be based on behavior as well as traditional concerns of age, size and sophistication. Youth are to be assigned to color coded "levels." Generally youth will enter on the blue level, which is the second from the bottom of four increasingly positive levels. A youth earns his way to a higher level through good behavior and doing assigned tasks on time. For example, a child who has five "good days" during which he picks up no more than two "fines" and one "room restriction" moves from the blue to the green level. Seven days with similar behavior on the green level moves the youth to the gold level. Along with the change in color of Tee shirt, youth at the higher levels are given increased privileges like later bed times, a higher allowance of phone calls, commissary points, movies and extra and special visits.

In addition to earning points, a youth who misbehaves may be fined points, instead of simply being sent to his room. Room confinement may still be used for serious violations, but its use should decrease as the additional sanctions become available. The system contemplates a due process review that is available to a child who wishes to contest discipline or transfers to living areas with fewer privileges.

Sanitti explained the new system with enthusiasm and in detail, staying with us long past the time he had allotted to the task. During our meeting, John Howard Association visitors observed that the system of behavior modification Sanitti described seemed to emphasize a legalistic system of rewards and punishment and questioned whether the system encouraged efforts to reconcile or work out differences among children, with reference to the restorative justice principles and practices now recommended to the new Illinois Department of Juvenile Justice. Sanitti assured us that conflicts among children would be used as opportunities for counsel and learning. Alternative sanctions will be administered. The hearing officer could order a different response entirely. "The kid could write a paragraph" to explain an incident, Sanitti said, before he left our meeting.

Some of the John Howard Association team are concerned that in discussions of goals and of programming at the Detention Center, the previous and the current management have said very little about strategies to positively influence children as they return to their communities. One team member has asked if anything is being done to equip children with a personal "operating plan" as they leave the Detention Center. We think this an important question. Recognizing that many children remain in the Detention Center for a very short time, and that some others are sent to the Illinois Department of Juvenile Justice for more intensive and long term intervention, we recommend that this issue be added to those that are now before the new management.

After Sanitti's departure, our team asked the remaining staff questions, some of which they could not answer. At one point, staff observed that in reality a particular process was

different from the description Mr. Sanitti provided to us. But given the complexity of Sanitti's plans, the short time he had been on the job, and the near overwhelming number of equally important tasks in hand, the degree of shared understanding and support for Sanitti's plan was impressive to our team. The attitude seemed to be: "Yes, there are details to work out, and yes, we will work them out in short order." Upheaval among senior managers and supervisors almost inevitably leads to confusion, and what we heard indicated that this was certainly true at the Detention Center on the day of our visit. We felt, however, there was consensus among the senior administrative staff about goals, the need for change, and the strategies now being introduced to achieve positive change. We felt this far more important at this stage than that all the details have been worked out.

We found reason for optimism: if the new leadership is able to develop and propose to management changes as extensive as is Sanitti's approach to discipline and behavior management, and if management absorbs the details and endorses the proposals as quickly as seems to be the case, then the prospects for carrying the changes forward with staff ought to be good. This was the sense among the John Howard Association visiting team, and it is an improvement over the impressions John Howard Association visitors have had at the close of their visits to the Detention Center in prior years.

A cautionary note lies in concerns about whether, and how quickly and thoroughly, the new direction and orientation described with much energy by Mr. Sanitti and the new senior staff seeps down to the Detention Counselors and Caseworkers who implement policies and have contact with the children held at the Detention Center. Sanitti's enthusiasm and his staff's apparent endorsement made the proposed plan seem very real, as if it had been in place for some months. It has not. For the new direction and orientation to take hold and make a difference to the children at the Center, the leadership at the Detention Center must train Detention Counselors and obtain their buy-in to Sanitti's approach to discipline and behavior management. Staff have frustrated reforms at the Detention Center in the past, and could do so again.[7]

## Staffing: in an Environment of Hiring Freezes and Budget Cuts, Shortages and Quality are a Concern

The John Howard Association visitors inquired about the current level of staffing at the Center. To our knowledge there is no actual staffing roster which describes the number of individuals to be assigned to each position in the Center.[8] Our inquiries were framed to elicit the

[7] Brenda Welch, appointed to oversee operations at the Detention Center, is reported to have characterized staff as "resistive to new ideas," writing in July that, "Basic safety, sanitation and security procedures are not currently enforced. The lack of security creates a dangerous environment for staff and residents." "Monitor says juvenile center reforms aren't being implemented", Chicago Tribune online edition, July 26, 2006, www.chicagotribune.com/news/local/illinois/chi-ap-il-juvenilecenter,1,5722818.story.

[8] The Implementation Plan agreed to in 2002 called for development of a "roster management system" and for a staffing analysis that would "identify the minimum number of staff required to maintain security and effectively provide services to detainees." MOA Implementation Plan, op. cit., "Staffing: Paragraph #36, sec. 4, at p.29. Apparently this was not accomplished, and the Detention Center lacks any formal staffing plan.

number of people currently employed and the number of positions that, in the opinion of management, need to be filled to provide something better than minimal and closer to optimal services for children. From supervisory positions downward, our understanding of the current staffing levels at the Detention Center is as follows:

Floor Managers

The title is a misnomer because it implies that the person filling the position supervises the work on one of the four floors on which children live and attend school. The responsibilities are much broader, and the position would be more accurately titled "Shift Supervisor." The person filling it is responsible for operations, material and supply needs on all four floors during his or her shift, as well as assisting in hiring, supervising the case work staff, being the liaison between departments, and overseeing the grievance procedure.

There are currently four floor managers, only enough to cover each of the day's three regular shifts, with the fourth to fill in so that weekends, holidays, and the other Floor Manager's vacation and sick days can be covered. Currently, one of the Floor Managers is also filling the position of a facility Operations Manager. It appears that four Floor Managers may be insufficient to the task of covering all three shifts seven days per week, as well as vacation and sick days.

Supervisors

This is the position that is immediately over the Detention Counselors who have immediate contact with children at the Detention Center. Supervisors are to enforce policies and assure that staff act in accordance with professional standards. To the extent people in this position are themselves poorly motivated, inadequately trained, or lax in attitude toward staff, the Detention Counselors who are responsible for the day-to-day activities and oversight of children will lack the oversight and support necessary to assure that their work at the Detention Center is of the quality necessary to meet the Detention Center's institutional goals.

The Supervisor's job is described as "stressful." A capable, qualified Supervisor may have to contend with poorly performing staff who, at least in the past, are said to feel secure in their position without regard to performance. A capable, qualified Supervisor may also have had to contend with Floor Managers or other management staff who were themselves poorly qualified. We were not able to assess the qualifications of, or demands upon, Supervisors. We did feel that the new management team will attempt to address shortcomings and build on strengths among Supervisors at the Detention Center.

There are now only a sufficient number of Supervisors to permit only one excused absence per shift. We were told that, knowing that they are likely to be denied requests for time off, Supervisors frequently call in sick, which leaves the Center short-staffed at this critical level with little or no notice. It was suggested to us that there should be a Supervisor on each of the four floors for each of the three daily shifts, but, we were told, as things now stand, Supervisors must frequently "cover" two floors during one shift.

Currently there are only 18 Supervisor positions, of which 12 are filled. With weekend duty, leave and sick time, the optimal number approaches 24.

Detention Counselors

The most numerous of staff working with children, Detention Counselors are the first line of authority which children at the Detention Center encounter and the staff with whom they have almost constant contact while at the Detention Center. Only teachers have more contact with children, and that comes during school hours. At the Detention Center, Detention Counselors are the "security" staff as that term is applied in a correctional setting: they deal with safety, discipline, order, movement of youth within the institution, meal service and exercise. Detention Counselors are responsible for discipline, both as it has been administered and as it will be administered under new management.

The most frequent complaints of violence or abuse are against Detention Counselors. In fact, we were told that following repeated allegations of mistreatment of youth, several Detention Counselors have been reported to the Department of Children and Family Services and some of these have been suspended or discharged following investigations of allegations of abuse. If Detention Counselors are the source of problems in the discipline of children, one should anticipate that under new management these same Detention Counselors will be disciplined or discharged, increasing the need for new staff above and beyond that which is now apparent. Filling empty positions and replacing suspended or discharged Detention Counselors will have salutary benefits for the children. Well trained and familiar with rewritten policies, new Detention Counselor staff may be expected to improve the quality of care for children at the Detention Center. First, however, they have to be hired. Until qualified persons are hired and trained, the John Howard Association has a continuing concern for children's safety.

Our visitors were, as in the past, concerned about the dedication, interest and suitability of some of the line staff they observed in the facility. During our visits to living units, line staff members were seen eating and doing paper work but rarely interacting with residents. We saw youth playing basketball in the outside recreation area, and it is worth noting that this was the first time that many team members had seen the exercise area in use. But their Detention Counselors were seated together on the sidelines, watching but not participating or actively supervising or communicating with the children. In interviews, children complained to us that many Detention Counselors won't let them talk or otherwise socialize. Two girls who had been in the Center previously, complained that they felt their ability to interact had been severely restricted lately. When the visitor asked why, the girls responded that the staff "needed to get their power back." The residents reported that when they are not in school (and they have two weeks out of school three times per year) they spend virtually all their time in front of the TV. One girl described watching "Lean on Me" five times in the past few weeks.

On most every unit there is at least one staff member who is described as "good." Girls talked about a staff member who provides regular recreation for them on the unit. Another girl

described one of the nurses as being "really good." On a boys unit on the fifth floor we observed a list of vocabulary words written on a blackboard. When we asked about the words a youth told us that anytime the boys don't have school, one staff member posts such a list and has the boys work out the definitions to expand their vocabularies. Although one might expect that boys might find this a tedious exercise, they instead pointed with pride to their accomplishments.

It is clear that senior management share our concern about staff performance. Some acknowledged that staff members have been abusing sick time because of stress or the inability to get wanted time off. There seemed to be a consensus among the managers with whom we spoke that the training and orientation offered Detention Counselors, security and perhaps other employees does not equip staff to do their jobs. When asked about staff morale Ms. Collier responded that she thinks staff members are ambivalent. Because of the frequent changes that have occurred over the past months staff members are skeptical that real changes such as are now proposed to them will last past the inauguration of a new County Board President in December.

While on the living units one visitor spoke with a staff member at some length. She expressed concern about the frequent changes in administration and frankly thought things would change again after the elections in November. She complained of not feeling supported by the administration. "The Caseworkers are here for the kids; the Superintendent is here for the kids. But no one offers support for the Detention Counselors." She complained about being evaluated by a person who had little contact with her. She also offered that the school doesn't teach the boys anything and the teachers don't have control of the boys.

The adequacy of the Detention Counselor staff is a major concern. There should be a sufficient number of Detention Counselors with appropriate training and personalities to spend time with children, take them to outdoor recreation, help them with behavior problems and conflicts, and see to it that children are engaged and that their time is spent productively. In the past, an absence of youth from outdoor recreation areas has been attributed to recreation staff and Detention Counselor shortages. If shortages of Detention Counselors were ever a bar to getting children off the unit and out for exercise, those shortages should not be permitted to continue. But shortages cannot explain the lack of interaction we have too often observed between Detention Counselors and children.

Members of the visiting team recommend that Detention Counselor's role should emphasize participation in programming for youth as opposed to merely keeping order. Positive interactions with children through casual conversation, structured recreation and programs should be a part of every detention counselors' day. Detention Counselors should be trained in these behaviors.

We want to emphasize that some Detention Counselors need only encouragement, for we have seen Detention Counselors who do engage youth in their care, and we have heard from youth who appreciate their counselor's efforts to engage them. We recommend that the new management make every effort to recognize those Counselors who are working well with children.

We were told that there are approximately 250 positions filled and 64 positions in need of filling, either to replace Detention Counselors who are not coming to work, ought to be laid off, or to expand to a sufficient staff level. Our observations drove home a simple fact: having an adequate number of Detention Counselors who are motivated, properly qualified and trained, and emotionally equipped to engage troubled children is essential to the safe and effective operation of the Detention Center.

Caseworkers

Caseworkers are involved directly with children on several levels and are basically the non-security staff who handle program issues and otherwise take on the responsibility of matching up services and programs to the children who need them. They handle all grievances, which are the complaints submitted by youth at the Detention Center. Caseworkers also oversee visits by family and friends, telephone calls children are allowed to make, and intake, where children enter the Detention Center. Their role at Intake includes assessing children who are brought to the Center for indications of abuse or mental health issues, and serving as a liaison with children's parents or guardians during the Intake process, which is to say they must often seek background, medical or behavioral information from people who know or are responsible for the children who are being admitted to the Detention Center.

There are currently only 24 case workers to work seven days per week on two shifts (6 a.m. to 2 p.m. and 2 to 10 p.m.) The managing staff would like to have two caseworkers per floor per shift on the day and afternoon shifts, or a total of 16 assigned each day. Currently, due to leave, sickness and other absences, there is more likely to be one caseworker for each floor during the day. The Detention Center is currently "down" three caseworkers from recent higher levels, and supervisory staff members feel that a total of 6-7 more would be required to provide optimal service.

Some change in responsibilities has been suggested: the Detention Center is considering substituting clerical staff for the Caseworkers now assigned to Intake. This would free time for Caseworkers on the floors, and staff supervising Caseworkers favor having them assigned to the floors instead of Intake for that reason. The John Howard Association visiting team inquired into the wisdom of this change. It was not clear to us that clerical workers could conduct satisfactory assessments of youth. It was suggested that assessments might be conducted by mental health staff who would be made available at Intake for that purpose. Caseworkers exercise screening authority at Intake, including rejecting children who should be sent to a hospital or mental health facility, and their exercise of this authority can help reduce inappropriate detention. The John Howard Association visitors wondered whether mental health staff would be as well suited for this task. Staff we spoke with acknowledged that before being able to assume the Caseworker's responsibilities at Intake, mental health or other employees would "definitely have to be trained." In the end, we were unable to judge the appropriateness of the suggested change in staffing.

We were also told of a proposal to employ Caseworkers on only one shift, starting at noon. This suggestion did not impress the John Howard Association visiting team, as it would leave the Center without Caseworkers at the time when children are quite commonly being admitted and when they are going to and from court and school. There is an argument to the extent that Caseworkers are not needed during the day as most children are in school. But it was also pointed out that Caseworkers are supposed to speak with teachers and deal with school issues, that not all youth are in school each day, that no youths are in school on the weekends, and that Caseworkers are responsible for record keeping and reviewing information about children which they can best do when children are in school and away from the living units.

Ms. Burrell told us there are 27 slots for Case workers. There are currently only 24 Caseworkers to work seven days per week on two shifts (6 a.m. to 2 p.m. and 2 to 10 p.m.). There is currently a problem with absenteeism which Ms. Burrell believes is partially due to a feeling of being overloaded. Many youth complain that they do not get their weekly phone calls and that their visits are frequently cut short. Whether this is because Caseworkers are not doing their jobs or because there are not enough Caseworkers is not clear. In all Ms Burrell felt that not only should all 27 Caseworker positions be filled, but that there should be an additional 6 or 7 more positions.

The John Howard Association strongly recommends that, given its troubled history and as a necessary step in ending concerns about children's safety, the Detention Center should obtain a full compliment of capable, qualified Caseworkers as soon as possible.

Summary of Staff Levels

The following chart summarizes current and optimal staffing for non-school and non-medical employees who have direct contact with children at the Detention Center, as the visiting team understands it to be:

| Position | No. Current Staff | Optimal No. Staff | Shortfall | Percentage Shortfall |
|---|---|---|---|---|
| "Floor" Managers | 4 | 5 | 1 | 20% |
| Supervisors | 12 | 24 | 12 | 50% |
| Detention Counselors | 250 | 314 | 64 | 20.4% |
| Case Workers | 24 | 33 | 9 | 27.3% |
| **Total** | **290** | **376** | **86** | **22.9%** |

**Safety for Children at the Cook County Temporary Juvenile Detention Center**

The dynamic change that is occurring at the Detention Center is at this point most evident at the top. It has yet to work its way down the chain of command to the staff that are most frequently in contact with the children. It could well be that the new management will send a clear message forcefully enough to put an end to the kind of behavior that has resulted, in the past months and even years, of significant allegations of physical abuse against children detained at the Center.

The new management has corrected some potentially dangerous conditions that existed even under the watchful eye of court monitors, during involvement of attorneys in the operation of the Center, during the ongoing visits by John Howard Association teams, and after the single "Self Inspection" visit conducted by the Juvenile Detention Alternatives Initiative team of lay people and experts in late 2005.

For example, Assistant Superintendent Sanitti ordered desks and tables removed from the individual rooms in the housing units. The reason, he pointed out, is that children could reach the acoustical tile ceiling by placing chairs on tables and climbing onto the chair. They could then place contraband, including drugs and weapons, in the ceiling on top of the suspended acoustical tiles. They could, he claimed, even hang themselves from the wires from which the tiles are suspended. Fortunately ---and as Sanitti points out, as one benefit of the lack of privacy that results from overcrowding --- no such tragedy occurred.

Also by way of example, the new management has improved the manner in which supervising staff handles complaints of abuse. In Illinois, professionals who become aware of evidence or complaints of abuse against children are obligated to report them to the Department of Children and Family Services (DCFS). Neither the Detention Center nor the DCFS had taken this requirement seriously until fairly recently, and then, under pressure from the Court Monitors. The John Howard Association visiting team inquired at length into current practice. Supervisory staff persons were adamant that reports of any suggestion of abuse were made to DCFS after investigation which might last an hour or so at most. Detention Center staff do not filter these complaints, leaving the responsibility to do so to DCFS. The Caseworker cannot conclude his or her shift or leave the building before making the report to DCFS.[9] Just in the past month, we were told, there have been two or three referrals to DCFS. At least one was accepted for investigation. We were told that in the last year, three or four cases that were referred to DCFS went to findings, and of those, two or three resulted in dismissal or sanctions against staff.

Eliminating physical abuse and violence by staff against children at the Detention Center requires a change in behavior by Detention Counselors, to whom most reported incidents of physical abuse or harassment are attributed.[10] Detention Counselors are, after all, the staff who

[9] One concern about the proposal to limit Case Workers to one shift each day lies in the decreased opportunity for Caseworkers to hear from children any allegation of neglect, abuse of or injury that might have occurred during the previous night.

[10] Not all incidents of alleged violence against children were attributed to Detention Counselors. While the John Howard Association team looked closely at only one month's reports of injury to children, one team member observed a report of a child's complaint of having been struck by a teacher in the previous month, with injuries

must first deal with a child who refuses to comply with a request or who is emotionally upset. Their contacts with children frequently go unwitnessed by other adults or by supervisory staff. An incident reported in the Chicago Tribune serves as an illustration: a child was allegedly physically assaulted in his room by a Detention Counselor when the room and the child were being secured for the evening. No Supervisor was on the floor at the time, and the alleged incident of violence concluded at the moment that a Supervisor returned to the floor from another duty.[11] Clearly, despite the best intentions from the new management, problems that are due to intemperate, inappropriate, or reflexive behavior by Detention Counselors will be most immediately resolved by placing all Detention Counselors under continuous supervision --- requiring more supervisors on the floors --- while they are provided needed training, or as marginal Detention Counselors are replaced. Adding to the number of skilled and well-trained Detention Counselors will also improve the overall level of conduct. Until these things happen, some of the risk that has been present for children is likely to continue.

To obtain some idea of the nature of currently reported abuse or violence against children, John Howard Association staff reviewed one set of logs and one set of reports maintained by the medical unit. The set of logs is used to report injuries from any source or cause. We observed reports of incidents going back several months. We looked in detail at the logs for 30 July – 22 August 2006. Of approximately[12] 59 incidents of injuries from any source which were logged in the comprehensive log, 41 reportedly involved other residents, 11 seemed to have involved accidentally self-inflicted or athletic injuries, and 4 referenced staff in some way. Of the four log entries reporting injuries by staff:

1. One entry states that the child said "he hit his head on the floor while being restrained and nose was bleeding"
2. Similarly, another entry reads "contusion of forehead …being restrained by staff."
3. One entry records a child's "report [that] female staff scratched his chest…. incident happened … at 10:30 p"
4. And yet another entry records that a child said he was "struck accidentally by staff" when the staff was "breaking up a fight."

The medical unit also maintains a set of Resident Injury Reports. These reports provide slightly more detailed descriptions of the nature of the injury and other information associated with injuries that are alleged to have been caused by staff. There were four reports from the 30

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resulting. As in each incident reported, we only viewed the allegations of the child as reported by the medical staff and do not assume accuracy.

[11] Allegations reported in "Teen tells of juvenile center beating," Chicago Tribune, February 14, 2006, Metro section, p.4. The matter was referred by the then administration of the Detention Center to the Cook County Inspector General's office, which has not released a report. Staff of the John Howard Association reviewed an investigative report provided to the Association by then-Superintendent Robinson and independently spoke with the child and his attorney, Jeffrey Granid, to obtain an account of the child's allegations.

[12] Names did not show on some forms and on others were obscured at our request so as not to disclose identify. As a result it was impossible to determine the number of separate incidents in two cases.

July – 22 August 2006 period covered by the logs we reviewed. None of the reports matched up to the fourth log entry noted above, which may reflect a conclusion that any staff involvement was accidental. Three readily matched up to the first three log entries noted above. The fourth appears to match up with a fifth log entry which did not on its face reflect staff involvement:

1. In a Resident Injury Report that matched up to the incident reported in the first log entry noted above, a nurse documented dried blood under the child's nose and swelling and redness on the child's upper back and under the chin. A doctor observed the exam, and photographs were taken at the supervisor's request. No details about allegations are reported, but the name of the Detention Counselor who was allegedly involved is recorded.
2. A Resident Injury Report that matched to the second log entry noted above, provides details on the nature of the injury as "blunt head trauma, liniea ecchymatatu, …[13] skin abrasions, neck with neck pain, subhematoma forehead" and names two female Detention Counselors as allegedly involved in the incident.
3. A Residential Injury Report parallels the third log entry noted above, and notes in greater detail an absence of scratches on the chest, "no open skin, no stinging sensation. No other injury reported." A female Detention Counselor was named. The form also reported that the Supervisor instructed staff to have the child brought to the nurse.
4. A fourth Resident Injury Report describes an event that allegedly occurred at about 9:00 pm, resulting in facial injury to a girl who reported she "fell on her face on concrete, staff 'threw me down' left side of face, swelling. Denies loss of consciousness." The girl was sent to the emergency room. The only identification provided for staff is: "male staff." This incident becomes recognizable in the log entries for the same date which notes "facial injury/face slammed on concrete" and "to ER," but the log entry gives no indication that staff were allegedly involved.

We thus have reports from two sources of five incidents in which it is claimed that staff had some involvement in injuries to children during an approximately three week period. Two reports involved injuries of some significance that occurred while a child was being restrained by Detention Counselors. Another involved an alleged injury by a Detention Counselor that was not medically confirmed. A fourth involved minor injuries that the child, apparently, attributed as an accident that occurred while a Detention Counselor was breaking up a fight. The fifth incident, rather obliquely reported in the log, resulted in a trip to the emergency room after an unidentified staff person allegedly "threw" the girl down.

The logging and reporting of injuries could be tightened up and more formally retained. At present, however, the logs and medical reports reflect a sustained effort to record claims of injury to a youth by staff, albeit with some inconsistency in reporting. The number of incidents

[13] The notation was unintelligible to the reader who viewed the report.

seems in line with the number of incidents we were told had been reported to DCFS in the last month, although we did not try to match up the DCFS reports to the incidents noted above. We cannot conclude that any of the incidents reported above necessarily reflected error or physical abuse by Detention Counselors, although the allegation of an injury to a girl at 9:00 pm is suspicious at the least. But we can conclude that the Detention Center's medical unit records show continuing allegations by children of injuries caused by staff, with some injuries verified by medical observation.

The Detention Center has a history of attempting to conceal, or appearing to conceal, evidence of injury at the hands of staff. At one point, the Detention Center administration claimed to refer all complaints about physical injury at the hands of staff to Cook County's Inspector General. Referrals to the Inspector General seemed never to result in a report, or at least a public report; rather they seemed to end up in a black hole, with no report and no action taken by supervising staff.[14] The DCFS does not, apparently, release reports of its investigations.

As a step toward trying to assure safety for children at the Detention Center, Court Monitor Charles Fasano made arrangements to have a "hot line" telephone installed and to post the hot line phone number, with instructions, by which any staff, family member, or child could have contacted the Court-appointed monitors with a claim of staff misconduct of any kind. The Court Monitor had notices printed, provided copies to Supervisor Robinson, and requested that he post the notices approximately February 2006. At the time of our visit on 23 August, 2006, no notices were posted. The failure of the Superintendent who was then in charge to take a simple step by which anyone with information about abuse of or injury to a child at the Detention Center could report that information, anonymously if desired, reflects a willingness to thwart, or at least ignore, a simple plan that would have gone some way to verify that the children confined at the Detention Center were safe.

The new administration has to be continuously concerned about the safety of children at the Center. Safety for children will remain an issue until the culture, standard of care, and lack of professionalism that prevailed among some staff for a number of years is completely eliminated.

The John Howard Association of Illinois recommends the following additional steps be added to the many that the new Detention Center administration is taking to improve safety for youth inside its walls:

1. That to the extent that the John Howard Association has correctly noted shortages in staffing, we recommend that positions be filled with qualified, trained individuals as rapidly as is possible.
2. That the new Management Team recognize and encourage Supervisors and Detention Counselors who have been engaging children at the center, and who are performing well

[14] The practice of referring claims of injury to youth by staff to the Inspector General has been discussed in court in conjunction with the Doe v. Cook County litigation, specifically on May 18, 2006.

by all accounts. We are concerned that widespread criticism will obscure good work by many staff at the Detention Center.

3. That the Detention Center should institute the "telephone hot line" service which had been requested by Court Appointed monitor Charles Fasano by posting signs describing how complaints can be made.
4. That the Management Team insure that any and all reports of mistreatment from any source, including the "hot line" requested by the Court Monitor, attorneys for plaintiffs, grievances filed by youth, or statements made to medical staff, be investigated promptly and thoroughly.
5. That senior staff continue to report any credible information of injury or abuse caused by staff to the outside authority responsible for investigating such complaints, which appears to be DCFS.
6. That in the interest of transparency, any investigation of injury or abuse by staff and that investigation's results should be submitted to counsel and Court appointed monitors in the Doe litigation and, in addition, should be made publicly available without revealing the identity of children involved. Staff who are involved in mistreatment of youth should be disciplined or discharged when merited, and that information made publicly available without, however, revealing the identity of persons involved. There should be some kind of tracking of these investigations so that in becomes possible at any time to determine the timeliness of investigations and of their conclusion.

In addition, the John Howard Association of Illinois respectfully recommends that Cook County leadership publicly commit to retaining the new management team, or, perhaps more to the point, to the changes which the new management is instituting. We make this recommendation because it is our impression that the belief among some staff that things will go back the way they were after the fall election undermines the management team. In our opinion, this is the time for county leadership, including candidates for the position of County Board President, to dispel the notion that after the election there will be a new, politically-appointed leadership at the Detention Center who will permit a return to past practices and steer a different course than that now being set by new management. In the interest of safety for children and the future of the Detention Center, now is the time for the County to fully commit to a Detention Center that hires staff on the merits, trains them, and demands professional and child-appropriate conduct from employees at all times.

## Grievances

Youth may file written grievances to protest any conditions within the institution or particular actions taken against them. These complaints are to be placed in boxes located on each living unit from which they are collected each day, and referred to an appropriate department head or floor manager for investigation and resolution. This process is to be resolved within three days. If the youth is not satisfied with the decision, they may appeal the grievance

to an Assistant Superintendent at the Center. Staff estimates that approximately 100 to 120 grievances are filed each month.

We requested copies of all grievances filed in the month of July 2006. We were given 97 grievances, almost all of which appeared to have been written between the 21st and 31st of July. From this we assumed that we were probably only given a portion of the complaints filed during the month. It would also seem to indicate that the actual number of grievances filed each month far exceeds the staff estimates.

Many of the grievances which we reviewed were duplicative. Either a number of youth on a particular housing unit complained about the same problem on the same day or one individual filed numerous complaints about the same problem within minutes of a previous complaint. (One such complainant admitted on the form that he was really upset so he wrote a "bunch of grievances to get his anger out.")

The most common complaints included food (not enough, too cold, menu choice), lack of barber (he was apparently out sick and no one replaced him for a week or two), missing phone calls, the quality of soap and lotion provided to residents, and having the lights on long after youth are put in their rooms for bed. A smaller but not insignificant number complained about staff behavior towards youth (disrespect, cursing, and "attitude").

Many responses to grievances appeared to be appropriate on their face, but it would take more investigation to know if the issues were actually resolved. For example, the response to complaints about enough food was to tell the youth that the Detention Counselors needed to contact dietary to request more food; however, it is not clear that the Detention Counselors convey the children's complaints about food. In fact, residents on the units that we visited were still making exactly the same complaint recorded in grievances to our visitors.

Another incidence of such "non-resolution" was in response to the complaint of being forced to go to bed at 8:30, an hour and a half before the lights are turned off. The response was uniformly that "state law requires that the lights stay on until 10 p.m," a nonsensical requirement if it exists.

Conversely, in a number of cases the resolution indicates that the problems had been taken care of ("you did receive your phone call", "I brought you a different kind of soap") before the grievance was received by management.

The two living units we visited both had grievance boxes and forms available. Youth we spoke with indicated that they knew how to file a grievance and had done so in the past. The youth expressed less confidence about having their complaints resolved. Two girls said that "you wait two weeks for anyone to get back to you, and then the answer is no." Other girls on the same unit mentioned that Ms. Collier had brought them a different kind of deodorant because the facility's brand is "horrible."

We recommend that management investigate the efficacy of the grievance procedure, particularly with respect to complaints about staff. In all instances the response we observed to complaints about staff was that someone will "speak with staff" or "monitor" the staff. For any complaint raised by a child in detention, it is critical to know if the problem exists and if so, whether it has been corrected in a timely fashion, not just whether someone had been "spoken to."

## Discipline

The team requested copies of five of the last disciplinary hearing records. We were actually provided ten hearing records for incidents which occurred between August 15th and August 21st. Half of the incidents involved fights or threats, while the other half involved insubordination to staff. Numerous times the resident spoke of being provoked by staff or other residents. In all instances the charges against the resident were sustained. And in all instances the punishment was 24 to 36 hours of room confinement. Some of the records indicated the hearing officer spoke to witnesses, but generally this only included the resident and the staff member who had filed the discipline report. Such a small sample does not allow us to draw general conclusions, but the John Howard Association visiting team believes it would be prudent for management to increase scrutiny of the discipline process and the actual consequences meted out in the name of discipline.

## Physical Condition of Living Units

The design of the Detention Center is unfortunate. The common areas of the units in which children are housed face inward. Light which reaches them is reflected from the walls of the central core of the building and passes through two sets of windows. The building seems as if it has a light-absorbing quality. Little short of a miracle would make the institution appear "bright and cheery." Yet we would encourage a second look by the new administration at the potential of introducing color and light into the facility. Juvenile Probation, located in the same building contends with a similar basic building design and yet children's art, posters, photographs and awards posted in hallways and offices make the area more human, warm and colorful.

The team visited one girl's unit (3D) and one boy's unit (5B). Both units appeared reasonably clean and odor free, except for the bathroom areas which while not filthy, had soap scum in tubs and basins. The boys' bathroom smelled of urine, and had one toilet which was not flushed. The showers were not clean. The floor drain in the area of the sinks was backed up.

In the rooms themselves, lighting and furnishings are barely adequate and very institutional. Many mattresses were badly cracked and had no sheets. The desks and chairs removed from the sleeping rooms have been piled up in one area of the living unit. On the girls unit there were a few plants. The boys unit contained a number of completed jig-saw puzzles

which had been shellacked and hung on the walls as decoration. Much more could have been done to make the living area pleasant, bright and clean.

Rules of the institution are posted on each unit. There is no poster describing the grievance procedure, but there are locked boxes to put them in. Youth indicate they are familiar with the procedure, whether or not they have any confidence in it. The boys unit had additional items on the wall, including a Mission Statement, Basic Behavioral Expectations, Rights and Responsibilities, Social Skills Calendar, Level Reward System, and Daily and School Schedules. The "Schedules," however, are very general in nature and do not actually indicate what types of activities a unit will participate in at any given time.

On the boys' unit we observed a mop sitting by a sink in full view of the residents. A visitor thought it might pose a safety risk if a resident tried to use it as a weapon. Likewise a "staff only" closet containing wood and metal hangers was left open, offering another potential array of weapons.

**Health Services**

With the departure of the previous Health Care Administrator from the Center in summer of 2005, the John Howard Association has expressed concern that the advances made in past years in this area would be lost. We were pleased to learn that Cook County Bureau of Health has officially assumed oversight for the medical unit and to meet the new Interim Health Care Administrator, Rose Calvin, MSN, and MBA. Ms. Calvin, from Cermak Health Care, impressed team members as being familiar with the problems of delivery of adequate medical care in a correctional setting.

At present the medical unit suffers staffing shortages. There are three full-time doctors, a full-time dentist and hygienist, twelve RNs, one LPN and one advanced practice nurse. The Mental health Unit is staffed with a full-time mental health coordinator, two full-time and one part-time psychologist, for a total of 112 hours per week, and there are 42 hours of psychiatric coverage per week. The level of mental health care seems inadequate given the ample evidence of significant mental health needs in the population.

The population at the Center is described by staff as basically healthy. The most common illnesses occurring in the population include substance abuse, STDs, Diabetes I, asthma and sickle cell anemia. They center sees a youngster who is HIV positive every couple of years. HIV and STD screening is available and almost all youth are screened. As many as 1/3 to ½ of the population tests positive for STDs. Those who do are treated while at the Center.

Health care is accessed after Intake by filling out a sick call slip and putting it in boxes on the living units or at the school. Nurses routinely pass medications on the living floors three times per day, and additional requests can be made of them during these contacts. Nurses can also be called by staff if acute care seems necessary at any time.

While touring individual living units we observed a place for sick call slips on each unit, however, on one unit the "box" was merely an open manila folder, affording no privacy to the resident seeking medical care. We also spoke with seven residents about their experience in requesting medical care. Each resident knew how to request medical care and all but one was satisfied with the care they received. That girl said that "nothing happened" when you filled out a sick call form. She then said that when you finally got to see a nurse they just told you that everything wrong – headache, stomach ache, etc. – is "because of your weight."

The John Howard Association remains concerned about medical and mental health services at the Detention Center. At this time, our principal recommendation is that Nurse Calvin be given staff and resources to develop services to the level she appears to aspire to attain.

## Conclusion: The Visiting Team's Overall Impressions

All of our visitors have been to the Center numerous times and have seen a variety of different leadership. Their concerns have echoed those expressed publicly by the professional monitors, consulting experts and the recent JDAI self-assessment team

Foremost and of continuing concern to all of us, and to the public, County officials, and the new leadership team is the safety of the children. For the first time in more than five years, a John Howard Association team felt that management at the Detention Center has the professional background, orientation, and apparent independence to reorganize the Detention Center, improve operations, install new procedures and guide staff at all levels toward a standard of care that could, in time, assure safety for children as well as staff members.

The new management team has its work cut out for it. Changes at the top do not automatically result in change in the same and equal directions at middle and lower staff levels. As we noted above, there are deficiencies in numbers and in the quality of mid- and line-level staff which can best be remedied by hiring sufficiently qualified and highly-motivated staff and by providing all staff with training, instructive supervision, and guidance. But as others have noted, and as the history of the Detention Center demonstrates, curing these deficiencies is not easy even with the best of leadership. Our recommendations in the interest of safety for children at the Detention Center articulate considerable demands upon the management team at the Detention Center and upon County officials.

In other areas, we are pleased to note that the John Howard Association visitors tallied a number of improvements in previously-observed deficiencies. Residents were observed outside the facility playing basketball on the third floor athletic court. In the past this area was rarely used. There was an urban gardening project in evidence in the same area, with corn, tomatoes, squash and flowers growing in containers. In contrast to our November 2005 visit to the Center, when we were told that residents could not view videos because the Center would have to get a commercial license to show video movies, on this visit we saw stocks of videos that residents

regularly watched on the units. There continue to be a number of smaller issues which, if resolved, team members thought might well have a positive impact on the children in the Detention Center:

- Youth complain, and managers acknowledge, that dinner is served between 4 and 4:30 p.m. At the same time the evening snack is delivered to the unit. In most instances residents are required to eat both dinner and snack at the same time, so that vermin are not attracted to food sitting on the unit. Unfortunately, that means that the residents do not have anything to eat again until the next morning when breakfast is served around 7 a.m.
- Depending on behavior level, youth are required to go to bed at 8:30, 9, or 9:30 p.m. Despite these relatively early bedtimes, all lights stay on until 10 p.m. Surely pursuant to a resident's request, the facility should be able to provide a darkened atmosphere for those who wish to sleep or are required to go to their bed.
- At 1:30 p.m. Detention Counselors on the girls unit still had no idea when they would be able to take their girls to recreation. They were waiting for someone from the recreation department to call them. It seems reasonable that the facility would have a regular, published recreation schedule around which Detention Counselors could plan.

We are eager to return to the Detention Center, to observe continued improvements and to monitor and report on progress in the areas of concern to all of us.

John Howard Association of Illinois
17 October 2006