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## **Psychiatric and Mental Health Report for Consent Decree**

**Date of Report: September 23, 2013**

**R.J., B.W., D.F., D.G., and M.D. on Behalf of Themselves and All Others Similarly Situated by Their Next Friend Jeffrey Shaman, Plaintiffs, v. Arthur D. Bishop, in His Official Capacity as Director of the Illinois Department of Juvenile Justice, Defendant.**

### **Introduction**

In September 2012, plaintiffs filed their class action complaint, challenging conditions, services, and treatment provided to youths confined by the Illinois Department of Juvenile Justice (IDJJ). In December 2012, the court entered and approved a consent decree. At that time, I was appointed as a court expert, and instructed to investigate and file a report regarding psychiatric and mental health issues at the IDJJ. After the report, the consent decree requires the preparation of a remedial plan that ensures:

the provision of adequate mental health services to all IDJJ youth, including but not limited to: screening and assessment upon reception; identification of youth whose mental health needs change; appropriate treatment planning; provision to each youth of the particular mental health services set forth in their individualized mental health treatment plan; appropriate, prompt, and confidential access to mental health professionals; appropriate suicide prevention; appropriate prescription and monitoring of psychotropic medications; appropriate and prompt hospitalization of youth when required; appropriate substance abuse diagnosis and treatment; appropriate juvenile sex offender treatment; and appropriate aftercare and discharge planning.

I investigated all of the foregoing mental health issues throughout the entire IDJJ. In April through August 2013, I conducted site visits at all six of the Illinois Youth Centers (IYCs) operated by the IDJJ, spending two to four days at each facility. I visually inspected all pertinent areas of each facility. I conducted confidential interviews with scores of IDJJ youth, comprising a cross-section of the various types of youths, and reviewed scores of individual youth mental health files. At each facility, I also interviewed top facility mental health and other administrators, and myriad mental health and other staff. Further, I interviewed top IDJJ leadership regarding mental health and other issues. Finally, I reviewed thousands of pages IDJJ policies, training documents, and other significant records.

### **Findings and recommendations**

#### **Overview**

It is difficult to fully assess the workings of mental health treatment at the IDJJ, because: 1) they do not have a full complement of services, and 2) even with the groups they have right now, a number of the facilities cannot function because of the paucity of security, and essentially are not getting youth to groups or are getting them there significantly late so they cannot run the program. No matter how many groups are described as evidence-based, and no matter how much support is being described for these groups, they are not actually functioning, consistently. The reality is that many of these youth are not getting the mental health support they need. It is very difficult to fully assess what is happening because of the paucity of groups, the vague variety of groups, and the lack of some youth being able to make groups and getting a sense of mental health stability. In my opinion, unless there is stronger support from the state to get the staff which is needed, these youth's basic mental health needs are not going to be met.

Although I have numerous areas of concern, I want to emphasize that the IDJJ and the youth which are in the facility are complicated. There has been tremendous growth and focus in trying to improve the programming by numerous administrative staff, including Jennifer Jaworski, PsyD, among others. I was quite impressed by the attempts by superintendents to balance some of the complexities of security and mental health, as well as some of the significant problems they have

had with the education system. However, there is still a significant amount of work to accomplish. In my opinion, there needs to be more support from the state to help these youth. The majority of these youth can be helped. However, if comprehensive programming is not put into place, they are going to be at much higher risk for recidivistic behavior.

Below, I separately address:

- Staffing issues, including the insufficient number of mental health professionals, the absence of a child and adolescent psychiatrist anywhere in the IDJJ, the failure of many mental health staff to hold necessary licenses, inadequate salaries for mental health professionals, and an insufficient number of security staff to bring youth to their mental health treatment.
- Mental health screening and assessment, including inadequate identification of youth with significant mental health needs, excessive idle time during the weeks youth spend in the reception and classification units, the need for improved psychiatric review, and the failure in the classification units to separate youth of significantly different ages.
- Solitary confinement, including the need to prohibit confinement for punitive purposes, and the improper use at some facilities of specialized treatment units that confine youth for 22 hours per day.
- The need to hospitalize certain youths outside the IDJJ.
- Psychotropic medication issues, including inadequate consent for medication, improper use of stimulant medications for youths with polysubstance use, and insufficient monitoring of medication consequences.
- Discharge issues, including inadequate discharge planning, improper continued IDJJ confinement of youth solely for lack of a community placement, improper months-long delay in release from IDJJ solely so youth can complete a unit of drug treatment, and insufficient use of Medicaid resources upon discharge.
- Other issues, including insufficient training regarding LGBT youths, the absence of specialized treatment in the specialized treatment units, the need

for the IDJJ to obtain outside accreditation, inadequate mental health training for security staff, the failure to obtain hospital records, deficient family therapy, and inadequate treatment for juvenile sex offenders.

### **Staffing issues**

#### ***The number of mental health professionals***

Essentially every facility in IDJJ is deficient in regards to mental health professionals. It is unclear how well the programs might run if they had a full complement of mental health professionals.

There are no interdisciplinary meetings involving psychiatry at IYC St. Charles and none at IYC Kewanee.

#### ***Leadership and supervision***

Many of the youth within IDJJ have very complicated mental health and behavioral histories. I have a significant background in this area and continue to work with youth with significant behavioral and mental health issues within the community. I enjoyed my meetings with four of the psychiatrists within IDJJ.

But there are no child and adolescent psychiatrists in IDJJ. You must have at least one Board Certified Child and Adolescent Psychiatrist. One solution would be hiring a full time child and adolescent psychiatrist to be at IYC Kewanee. Their position could be two-fold: taking care of the complex youth at that facility; and overseeing any significant mental health concerns in any of the other facilities. The person in this position would assess potential issues at other facilities by visiting those facilities, by having the youth brought to them, or through tele-psychiatry and review of the records. In addition, they could be involved with didactics with the mental health staff in conjunction with others. IYC Kewanee needs additional psychiatric hours for the complex youth they have.

#### ***Mental health licensing***

No mental health program within an IDJJ facility should be supervised and run by a non-licensed mental health professional. They need to have not just the type of background that might fit into an IDJJ job description. Rather, they need to have mental health treatment experience, and they need to be licensed in regards to their profession, which must be a mental health profession. The director of an IDJJ

mental health facility or administrator should not only be responsible for organizing the mental health interventions, but when there is an acute youth or one whose diagnosis is unclear, they should have that fund of knowledge where they can assess the youth and assist in determining an appropriate intervention plan. IYC Harrisburg does not have this.

The issue of what is a competent mental health professional needs to be further discussed. There are all kinds of programs that have been put together, some of which look very good on paper. However, they are difficult to implement, in my opinion, without having well experienced, trained, and licensed mental health professionals. There is a reason that there are Master's programs, PhD program, and PsyD programs – for developing competencies so one can practice their mental health profession. In association with those base competencies there are state licensing requirements, which typically, among other things, require passing a test. Although I am sure there are reasonably good mental health professionals that are unlicensed, there is a reason there is a licensing boards and minimal licensing requirements. This offers a qualifying tool to assess competencies that an individual may have that cares for youth.

For example, in the IDJJ's definition of a psychology 2 position, it requires a Master's level professional who has a Master's degree in psychology who does not have to be licensed. When this position is hired, for example in the Wells program, they have two years to get their license. A typical salary in this position might be around \$35,000 a year. There was not a single psychology 2 professional who I talked to who thought this was a reasonable salary. Some of the psychology 2 professionals stated to me that they had no intention whatsoever of getting a license, but rather were going to stay in the program for two years, or as long as they could, and then leave. Others talked about using the program to get their license and once getting their license, finding a more reasonably paid position.

This lack of stability is not going to offer these youth the qualified mental health professionals they need. This is part of the reason why severe or even chronic mental health issues will be missed. This will be part of the reason why these mental health professionals will not know how to follow up regarding the

mental health issues with the youth, or how to report to the psychiatrist or others regarding the mental health condition of the youth. When speaking to the mental health professionals at IDJJ, the majority of what has been discussed has to do with anger control, stabilization, understanding what brought them to the facility, and release issues. When specific subtleties of mental health issues and potential impairment on behavior or emotions are discussed, there is a general lack of knowledge in many of these mental health professionals.

My recommendation is to have a comprehensive review of the definition of what a mental health professional is, as defined by the state. The IDJJ should call mental health professionals what they are, and not make up names that distort what the professional is.

### ***Mental health salaries***

Part of the difficulty in my opinion is not just the isolated nature of some of the facilities, but rather the salaries that are being paid. In general, if one salary's are too low, it is going to be far less likely that they are going to find qualified mental health professionals. This is not what these complicated youth need. I say this with the caveat that I do not want to minimize some fine mental health professionals who are involved with the programming. However, as it is not unusual, the best of the mental health professionals are in more administrative positions, whether within the facility or state.

In my opinion, based on some of the salaries which I reviewed, this is one of the limiting factors in being able to hire competent mental health professionals. One needs to look at what the current salaries are within the community and offer salaries at least comparable to this so they can hope to be competitive in hiring competent mental health professionals and have a full complement of staff. No matter what the programming is, it will not meet its goals until a full complement of staff is in place.

### ***Security staffing***

At IYC Kewanee, the chief of security reported they are having tremendous difficulty regarding transporting youth, and for that matter even allowing youth out of their rooms for free time, because of the lack of security staff. He informed me

that the full security staff on the day shift should be 32, on the second shift should be about 20, and on the third shift about 12. At the present time, they are down 20 security staff, approximately 30 percent of what they need to adequately offer security.

This is not just a safety issue. As with IYC St. Charles, when one is down this level of security, there are other basic rights that youth have which simply cannot occur. Youth will not have a right to treatment because security staff are not going to be able to get them consistently to groups and other interventions. Youth are not going to be able to get their basic educational needs met because staff would not be able to get them to school. Also, staff cannot give youth time outside, or recreation time. Youth are spending excessive amounts of time in their cells, which leads to greater levels of frustration, higher levels of fighting, lower tolerance levels for working with staff, and not surprising greater conflicts with security and staff.

### **Mental health screening and assessment**

#### ***Identifying youth with mental health needs***

I had a difficult time in looking at exactly how IDJJ staff identify youth for mental health levels 1 (the fewest needs) through 4 (the highest needs). It seemed that youth are identified more in regards to the staffing the IDJJ had, and how frequently the youth could be seen, than what the youth's mental health needs actually were. The best example was a youth that I interviewed at IYC Harrisburg who was overtly psychotic. I was told he would be in his fecal smelling room about 22 out of 24 hours a day, was not on any psychotropic medication, and no one had a clear sense of what his diagnosis was. He was a mental health Level 2.

Any youth where there is concern over a possible mental health issue or is on a psychotropic medication should be evaluated by a psychiatrist.

#### ***Screening and assessment tools***

On the positive side, IDJJ is following up with different organizations regarding some of their valid rating scales, such as the MAYSI-2. Tom Grisso, PhD, who created the MAYSI, is coming back in to work with the IDJJ. Their use of the MAYSI-2 in my opinion has been helpful in regards to assessing youth in a variety of contexts. Other assessment tools such as the GAIN and CANS have also been helpful

in assessing the youth. Comprehensive clinical assessments in association with these scales need to then be implemented.

In my opinion, the IDJJ also has done a reasonable job in assessing suicide risk and doing initial screenings in a time efficient way.

***Idle time in the reception and classification units***

There are difficulties in the amount of time that youth have to stay in the reception and classification units, and with that the paucity of staff in these units. These difficulties require youth to remain in their rooms/cells, sometimes for weeks at a time if not longer, with only minimal breaks, and without significant activities, until they are placed into a dorm.

In my opinion, this would be an ideal setting for groups. This would allow staff to begin to get a better understanding of youth, not just from how the youth describe their history in different forms, but by what staff directly observe. Thus, if some youth are not being completely forthright in their forms regarding issues at hand, they can be observed by staff in groups prior to their placement. In short, the weeks that youth spend on the reception and classification units can be used in a more functional and useful way. Staff at the largest of these units, at IYC St. Charles, have expressed significant concern regarding this issue. This needs to be addressed.

In my opinion, it is a good idea to keep youth on Intake for a reasonable period of time, whether two or three weeks. However, this should only be done if there is reasonable programming that can be put into place, including recreational time, and a variety of additional diagnostic and treatment groups in assessing the youth. In association with evidence-based assessment tools which are being used consistently, this will allow staff to better understand the youth and their underlying mental health issues. In turn, this will help staff to make the appropriate recommendations for Cottages, and treatment, prior to release from the reception and classification unit.

***Classification by age within the classification units***

I have strong concern over having young youth, age 13 and 14, in the same environment as 20 or 21-year-old youth. This is essentially like putting a sixth or

seventh grader with a junior or senior in college. It is simply a potentially dangerous thing to do.

### **Solitary confinement**

The United Nations (UN) has established minimum standards for juveniles in correction facilities. The UN resolution was approved by the General Assembly in 1990 and supported by the United States. They specifically prohibit the solitary confinement of juvenile offenders. Specifically, Section 67 states: "All disciplinary measure constituting cruel, inhuman, or degrading treatment shall be strictly prohibited, including corporal punishment, placement in a dark cell, closed or solitary confinement or any other punishment that may compromise the physical or mental health of the juveniles concerned."

The American Academy of Child and Adolescent Psychiatry concurs with the UN position and opposes the use of solitary confinement in correctional facilities for juveniles.

#### Confinement at the IDJJ for punitive purposes must stop.

Measures to avoid confinement should be implemented, including appropriate behavioral plans, consistent de-escalation techniques, alternatives to confinement, and other interventional plans.

In my opinion, IDJJ has done a reasonable job in differentiating solitary confinement from "time outs." Essentially time outs within the facilities can be initiated either by youth or by staff, and is described as being less than a 1-hour period of time. If this is not a statewide definition, it is a reasonable one that should be implemented.

In addition, if any youth is confined for more than 24 hours on the grounds that they are in crisis and they are an immediate threat to themselves or others, they must be evaluated by a mental health professional, such as a child and adolescent psychiatrist when one is available. The facilities in IDJJ have done a good job in having youth that are on confinement for more than 24 hours evaluated by a mental health professional. However, the evaluations that I reviewed have been quite cursory. A structured format for the evaluation, and expectations of the evaluations, has not occurred. Assessment as to whether or not the youth is at an acute risk to

self or others seems to be made. Typically it is determined that a youth is not an acute risk to self or others, yet they remain on confinement. The concern here is that confinement is being used by the IDJJ a punitive measure, and not one of protection of either the youth or others.

The only facility at the beginning of the summer of 2013 that has essentially eliminated confinement is IYC Pere Marquette. They developed a 5-day program where youth are not removed from the general population, and they continue with programming, but they still must work with different staff and ultimately with senior security before they can go back to their base status.

IYC Kewanee and IYC Harrisburg have specialized treatment units for behaviorally problematic youth. These youth can end up being in their rooms for as much as 22 out of 24 hours a day. They are being segregated from the general population and this is confinement, regardless of what staff attempt to call it.

At IYC Kewanee, the confinement rooms were noticeably dirty. There was chipped paint, food and other debris on the floor. I spoke with security about this. They stated that essentially they don't have enough staff to clean the rooms. Security would not give the youth a broom to clean the rooms.

### **Hospitalization**

There needs to be better IDJJ assessment of youth that are acute and potentially in need of hospitalization. For example, one particular youth I recently met at IYC Kewanee was acutely psychotic, and in my opinion needed immediate hospitalization. The longer a person stays in a psychotic state, the higher the likelihood of long term and irreversible cognitive deficits, among other risks and difficulties, including violent behavior both to the youth and others. Hospitalization can be avoided if appropriate treatment is put into place and supported at the IDJJ. If not possible, it is necessary to hospitalize such youth. Hospitalizations are extremely rare. It is my opinion that use of hospitalization for those youth who are in need of such treatment should be put into place.

## **Psychotropic medication issues**

### ***Consent for medications***

Appropriate consents are not being obtained for psychotropic medications. The consents do not clearly spell out major side effects, or even specific goals. On occasion they will define the diagnosis, but not always. As such, there is no sense that there are options, and certainly not a clear sense of what the potential side effects and goals are, so the guardian or parent can make informed consent. This is something that is consistent in all of the IDJJ facilities and must be corrected.

### ***Stimulant medications for youth with polysubstance use***

Stimulant medications are being given to youth who have a history of polysubstance use. Although there is research to support that appropriate treatment of ADHD symptoms can decrease polysubstance and alcohol use in youth, it is generally not an accepted practice to use stimulants in youth with a history of polysubstance abuse. There are three different nonstimulant medications that are FDA approved for different types of ADHD symptomatology which should strongly be considered.

### ***Monitoring medications***

I was not impressed with the IDJJ follow up in regards to how treatment is impacting the youth. Most information given to the psychiatrist in follow up is from the youth. Occasionally there is an acute acting out behavior that is shared, but other symptomatology, which might be more subtle, is clearly not.

The use of rating scales, such as the Connors or Vanderbilt scales for ADHD symptoms, should be completed by teachers and potentially other mental health staff and security staff in regards to how the youth is doing. This will give the psychiatrist a much better picture of how the youth is doing. I would also use rating scales to further assess anxiety and mood symptomatology, in particular major depressive symptomatology. In addition, the use of involuntary movement scales needs to be used with all youth in a consistent fashion. This appeared to be used in some facilities, but not all. There are many youth on neuroleptic medications which among other things can cause Parkinsonian (extrapyramidal) side effects, and on rare occasions more significant movement disorders such as tardive dyskinesia,

which potentially is irreversible. I did not find, in the clinical follow up, assessment of these issues.

### **Discharge issues**

#### ***Discharge planning***

A clinician's involvement should include treatment, reassessing a youth's underlying mental health, the need for modification of treatment plans, and reintegration into the community. Yet, when talking to IDJJ clinicians, they expressed a vagueness in regards to community reintegration and a lack of full understanding of what is done. At some point in the near future, a new program for reintegrating youth which is being implemented in Cook County and hopefully statewide, will help with this process. Based on conversations with clinicians in IDJJ facilities, there seems to be a paucity of understanding of how this plan will be implemented and ultimately beneficial to the youth.

#### ***Continued confinement for lack of a community placement***

There continues to be a multitude of youth that are forced to stay at the IDJJ past their Administrative Review Date (ARD). Based on the information which I have reviewed, this is often caused by a lack of community based placements. There continues to be work in regards to this area. This is something that cannot be tolerated. There needs to be designs for community based programming to avoid youth staying longer than their ARD. This type of continued IDJJ confinement, against their will and after they have been rehabilitated, is simply a violation of their human rights.

#### ***Delayed discharge to complete drug treatment***

In my opinion, a youth should not be given additional time within the IDJJ solely to have a certain type of treatment program, such as a substance abuse program. This is particularly true if the youth is refusing the program. Within the community, when a youth is refusing substance abuse treatment, it is not continued. It may not be best for the youth that they don't continue it, but it is not continued because essentially it will fail. To force a youth to enter into a substance abuse program that they are opposed to, and to force on them additional set time in IDJJ for this purpose, violates their rights to refuse treatment.

### ***Medicaid upon discharge***

When youth entitled to Medicaid benefits are placed in IDJJ, they are dropped from their Medicaid. All services are provided through IDJJ. On the other hand, when such children and adolescents are placed in residential facilities in the state of Illinois, their Medicaid is not dropped. In fact, the funding through Medicaid can often be used to assist in funding a variety of medical and mental health services. When the youth leave residential programs, their Medicaid is in place and they are able to set up aftercare appointments. But youth in IDJJ have their Medicaid stopped.

I couldn't be given any examples of IDJJ youth having their Medicaid in place when they were discharged. Some of the rationale included difficulties connecting with families and other logistical concerns. In addition, nobody was able to discuss the questionable aftercare that youth have had in regards to medical health and interventions following release from IDJJ, and whether or not the lack of Medicaid coverage, even if brief, could have impacted this.

### **Other issues**

#### ***LGBT youth***

A mental health and developmental area which consistently occurs within IDJJ is a paucity of understanding of LGBT youth by staff, whether mental health, security or others. There needs to be better training in regards to issues dealing with Gender Identity Disorders. In association with this, a clear plan needs to be put into place which addresses treatment of such youth. I observed some of the difficulties with these youth within the facilities. Yet, their treatment plans are somewhat fragmented and piecemeal, and not clearly understood. A treatment plan can easily be put into place in the timeframe that the youth is in the reception and classification unit.

#### ***Specialized treatment units***

At present there is a special treatment unit at IYC Kewanee and IYC St. Charles. The units at the time of my assessment had no special treatment associated with them. The groups were no different than any groups being offered within the facility.

### ***IDJJ accreditation***

IDJJ has been quite proud about using Performance-Based Standards in trying to improve a variety of interventions for youth and the operations of the facility. However, there continues to be significant deficits. In my opinion, there should be an outside organization such as the National Commission of Correctional Health Care (NCCHC) or the American Correctional Agency (ACA) that accredits the IDJJ facilities and follows up with them.

### ***Mental health training for security staff***

There are youth at IDJJ facilities with significant mental health issues. Security has to have a better understanding of the mental health concerns and how to best address these youth. These are longstanding issues and complex ones, but ones that need to be addressed. When one has a youth that is depressed or with ADHD, and inappropriate comments are made to them, they will have a proclivity for impulsive acting out of self-defeating behaviors which can, among other things, result in violent actions. Additional training for security regarding mental health needs must be put into place.

### ***Hospital records***

There was a need to better attempt to get hospital records for youth who are placed in the juvenile system. This will greatly assist assessment and knowledge of prior medications, psychosocial concerns, and prior mental health diagnoses.

### ***Family therapy***

Mental health staff reported there is a paucity of family therapy. They reported that families rarely come to the facility and that they have no teletherapy capabilities.

### ***Juvenile sex offenders***

There did not seem to be any specific differences in regards to sex offender treatment approaches with the youth within the program, even though there was tremendous variability of psychiatric disorders.

Different staff worked in the juvenile sex offender program felt that not only are they using outdated materials, but that they have not been able to get new

material in regards to treatment. They felt the major difficulty with being able to do this is the lack of funding.

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