COOK COUNTY HEALTH

Behavioral Health Quarterly Report
December 2021 – February 2022

- **Departments of Behavioral Health & Psychiatry**
- **Cermak Health Services**
- **Juvenile Temporary Detention Center Health Services**
- **Cook County Department of Public Health**

March 4, 2022

Department of Behavioral Health & Psychiatry

This BH quarterly report will provide some end of the year data that were not available when the previous report was due. This report provides updates to services rendered from end 2021 to the current date. The data below highlights the types of services delivered as well as the growing needs in the delivery of mental health services.

The Department of Psychiatry 's "no show rate" has never been at its lowest volumes in over 10 years. The shift from the concept of "mental illness" to "mental wellness" has permeated throughout the Department and has manifested within the service lines delivery. This allows for a greater investment from the patient perspective in navigating wellness and the responsibilities inherent to its maintenance. The patients essentially become ambassadors for their own mental health needs. This is reflected in the improvement in the "no show rate" and "LWBS" rate (left without being seen)-data presented in the previous report. This is also seen in the medication management numbers -especially those under the category of Injections- which are the long acting injectables (LAI), aka the long-acting psychotropic medications (given 1 injection every 30 days).

While the Department of Psychiatry continues to perform at a high level and volume of patient care, they did so despite the issues the Delta/Omicron pandemic brought such as staff attrition, lack of applicants to hire for BH positions, as well as management issues encountered within the hiring process through our Human Resource Department. Currently the Department has 5 staff vacancies that will be are required to sustain the level of services provided to our patients. We are currently forging ahead to fill all Psychiatry and BH open staff positions.

We will also be assessing the volume and need for adding LAI clinics to some ACHN clinics or to embed the clinic within our community partners services as a pilot. Utilizing some of our APRN's to support this level of care would be ideal.

ADULT OUTPATIENT PSYCHIATRIC SERVICES

SERVICE TYPE	2015	2016	2017	2018	2019	2020	2021	Completed to date 2021
INJECTION	208	289	253	323	733	872	584	864
THERAPY	3,826	3,804	3,885	2,310	2,494	2,523	1,281	4,815**
ADHD	466	491	558	464	450	497	376	608
MEDICATION MANAGEMENT	16,392	18,702	18,671	21,147	21,649	16,488	11,546	21,274

*Child & Adolescent Services not included

* *Included Neuropsychiatry

* January 1, 2021 – December 20, 2021

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In this report we will also highlight the major services delivered for our SUD/MAT patients. While the SUD/MAT population continues to grow, and we are not keeping up with the staff required to perform and sustain treatment modalities for this very vulnerable population. Currently we have 12 positions for recovery coaches and were only able to hire 2 due to the hiring difficulties at CCH and around the country. The Recovery coaches are the "glue of the SUD/MAT patient care needs and without them the services would not be sustainable and have impactful results. We have experienced a shrinkage of our service deliverables due to lack of staffing of Recovery Coaches. This is reflective in the graph presented below. If CCH commitment to provide services the SUD/MAT population, then solid staffing from hires as FTEs at CCH will be necessary to meet the demand of our SUD/MAT ever changing demographics.

See summary of the 2021 demographics for our SUD/MAT patients below:

2021 SUD/MAT intake summary

Demographics: 65% identify as African American, 73% as male

Health: 47% endorse a diagnosed mental health condition, 41% experienced violence or trauma

Social determinants: 33% with food insecurity, 30% with housing insecurity

Justice involvement: 1 in 8 patients are on probation or parole (13%)

Substance use: 79% endorsed commencing opioid use with heroin (21% with pain pills), 51% have experienced an opioid overdose

Data source: Business intelligence. MAT intake and SUD intakes completed 1/1/21-12/31/21. N varies from 595 to 706, pending the question. These data represent new referrals and are not necessarily representative of engaged patients.

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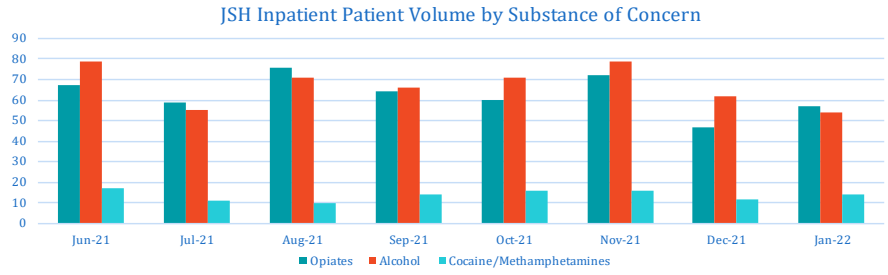
In addition, not only has the outpatient SUD/MAT population grown, but we have also seen a high uptick in Inpatient SUD/MAT services that are required during inpatient hospitalizations for comprehensive patient care for medical and SUD/ MAT care. The graph below which is reflective of the number of patients receiving services while hospitalized for a medical, surgical, or OB/GYN inpatient days.



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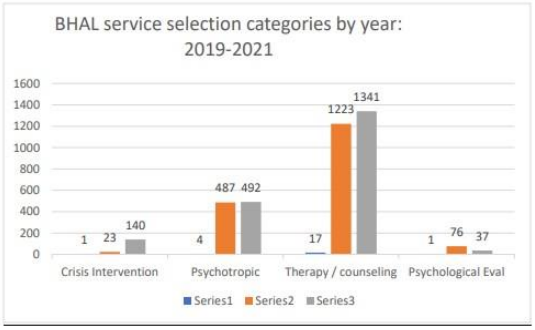
Overall alcohol continues to be highest subsatnce of usage, however, limited resources for program stafffing exists. We tend to lump all SUD togther and call it “polysubstane use” but a more comprehensive mode/approach is traditionally more successful. We are working to build more models that center around self help and group therapies to support their neeeds.

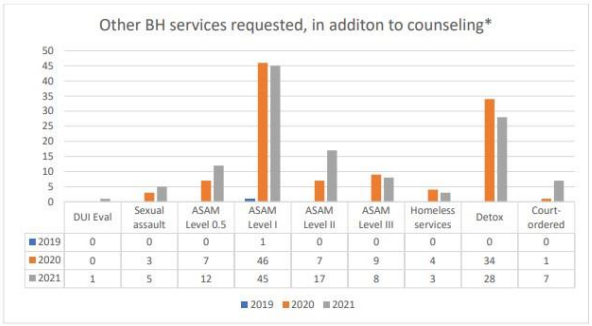
Over the last year we have made a concerted effort to reboot, improve and expand our BHAL (Behavioral Health Access Line) services. While COVID caused a higher than normal call volumes over the last 2 years, our frequency of "crisis calls" was magnified three-fold. The crisis calls take a longer period of time to triage for the appropriate disposition and level of care. By adding personnel for "crisis management" we will be able to adequately provide emergency services often requested. One process inprovement that we are seeeking is hire more staff to manage the lines weekly and during the weekends and to focus some personnel on the "crisis caller". This addition of staff will be dependent on budgetary allottment to support these part-time or full-time contractors to improve this process.

The first graph shows data that reflects the types of calls received from the BHAL and second graph shows the number of referrals made via the BHAL to our BH community preferred partners. This line is heavily accessed by all within CCHand beyond-anyone can call the lne and request referrals for BH services.

Behavioral Health Access Line Data Report

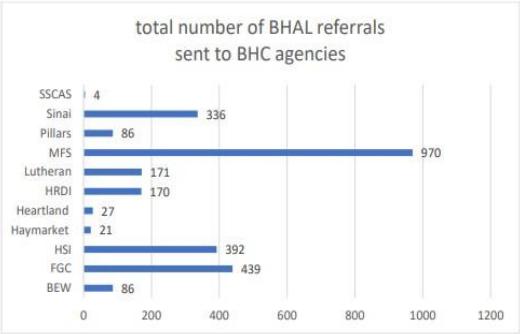
Service Selection

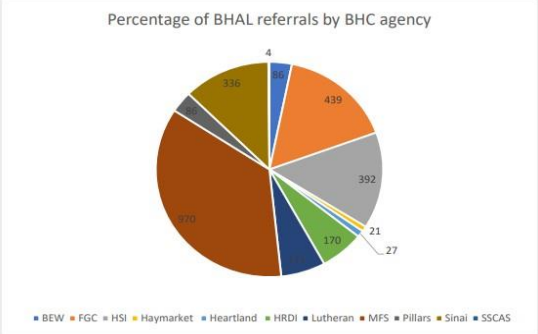




Behavioral Health Access Line Data Report

Referrals by Agency





In summary-
Our focus is to hire adequate staff required to sustain and improve our BH services and provide access to patient care across CCH. We will be embarking upon hiring via BH agenicies/vendors to proactively fill our gaps in care so that no obstacles lmit sustained care for this very vulnerable population.

Our hiring will focus on:

2 BHAL triage Social Worker
10 Recovery Coaches
2 Psych Social Workers
2 APRN-Advanced Parctice Nurses with BH expereience
1 Chief Psychologist
1 Ch Div. Child/Adolescent Psych-
1 Ch Div. Psych ER

Cermak Health Services

#1 - General information on the population served, including how patients were identified or applied for services, a breakdown of where patients of the program(s) reside in Cook County and the number of patients served over the last 24-month cycle

Cermak Health Services ("Cermak") provides care for detainees remanded to CCSO's custody in Cook County Department of Corrections' Cook County Jail ("Jail"). Cermak provides care only for population housed inside jail, and not for community corrections (Electronic Monitoring, diversion programs, etc.).

Detainees have a constitutionally protected right to have access to health care services for their serious medical and mental health conditions when detained.

Upon entering the compound, detainees are booked and then 100% of them are screened in Intake to identify emergently needed mental health services and the populations that will require mental health follow up and care during their incarceration for their chronic mental health conditions.

95% of male and 93% of female detainees who require Mental Health services during their incarceration are identified in Intake. Subsequently, MH staff identifies detainees in need of MH services through detainees' health care request process, referrals from DOC staff, and routine contacts with general population detainees.

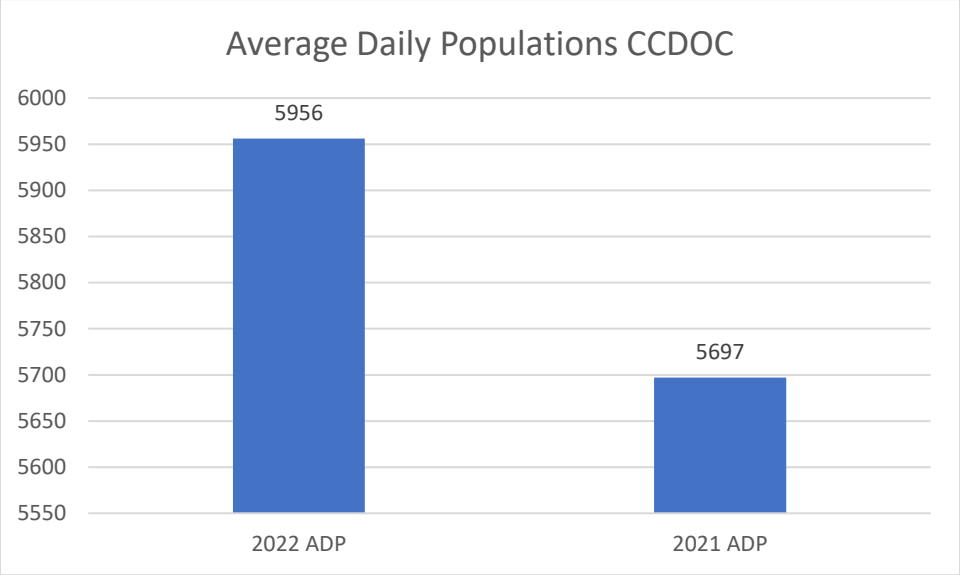
Detainees who are included in the Mental Health caseload are housed on the Jail compound depending on their acuity level, risk/required level of observation and supervision as well as degree with which they can engage in activities of daily living.

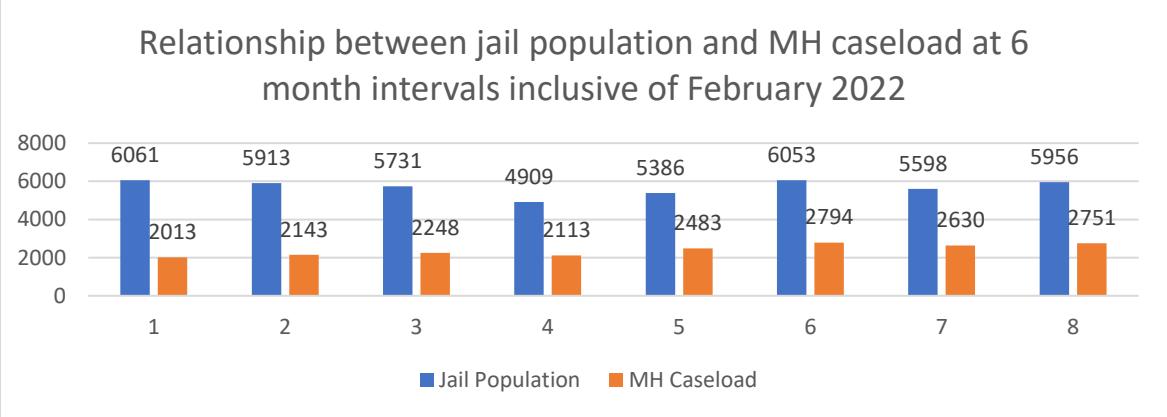
In addition to providing emergent, urgent, and routine Mental Health services to detainees included in the MH caseload, Cermak extends its services to any detainee confined to custody at the Jail on an as-needed basis.

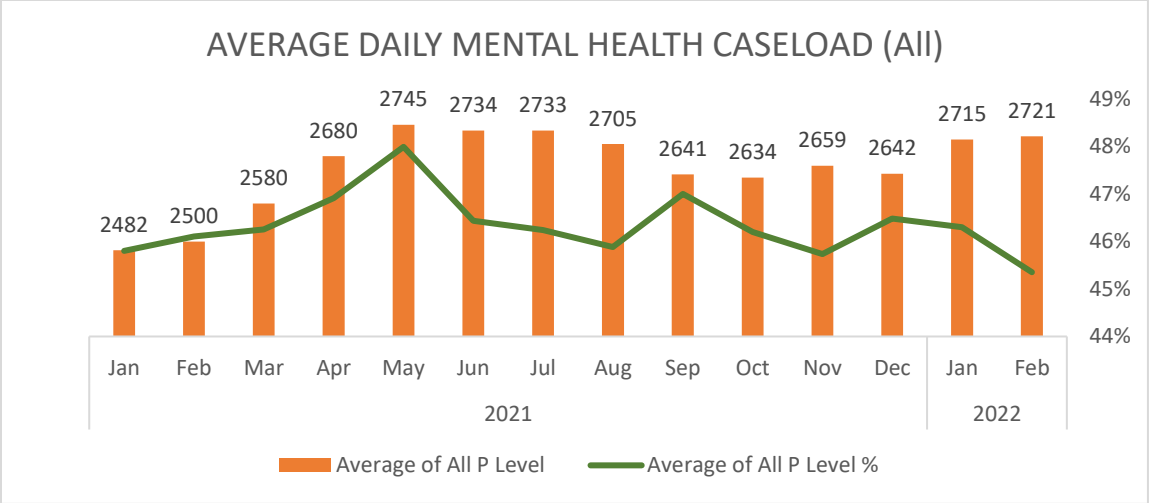
Over the years, MH caseload followed contractions and expansions in jail census, however, recently there has been a significant expansion of Mental Health caseload in relation to the overall Jail population.

Over the past two years, MH population has grown in absolute numbers and also as a percentage of the total behind-the-walls population. It now constitutes nearly 45% of the Jail census. That ratio had plateaued over the past 4 months and now is trending downward.

This year so far there has not been evidence that there is more turnover, manifested via the number of bookings and discharges, as compared to 2021, however, average jail population has grown, which correlates with increases in caseload. Slow rate and intermittent nature of transfers of detainees to IDOC (Illinois Department of Corrections) continues to contribute to the census on the compound. IDOC transfers continue to be systemically delayed which presents additional operational and clinical challenges to the facility. As of last week of February 2022, CCDOC held approximately 900 already sentenced detainees awaiting their transfer to IDOC.

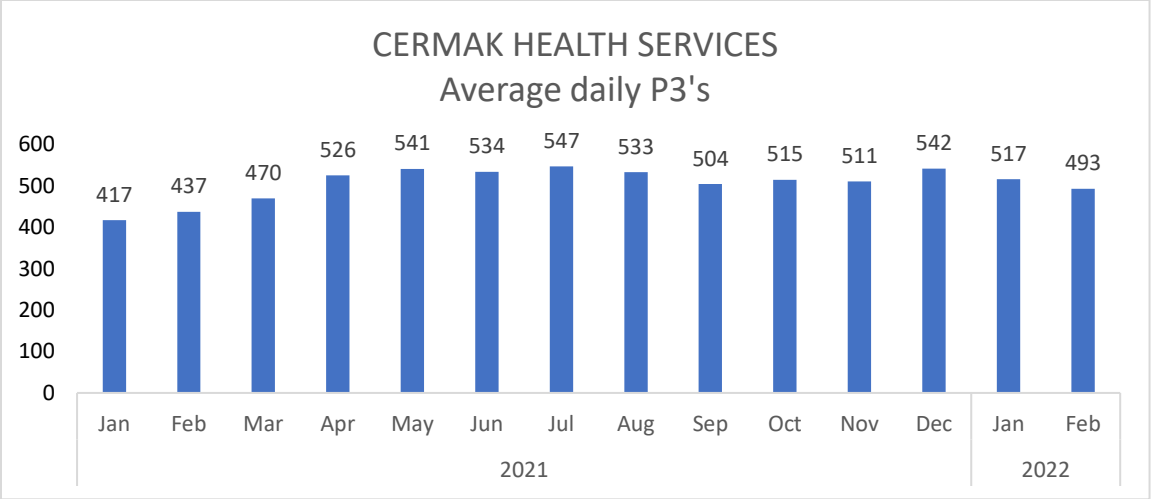




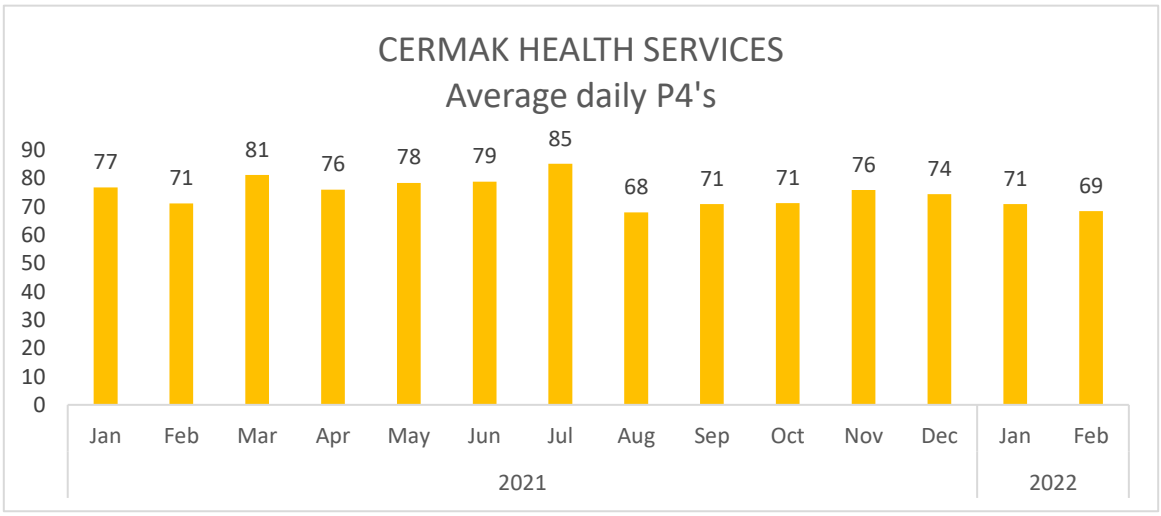


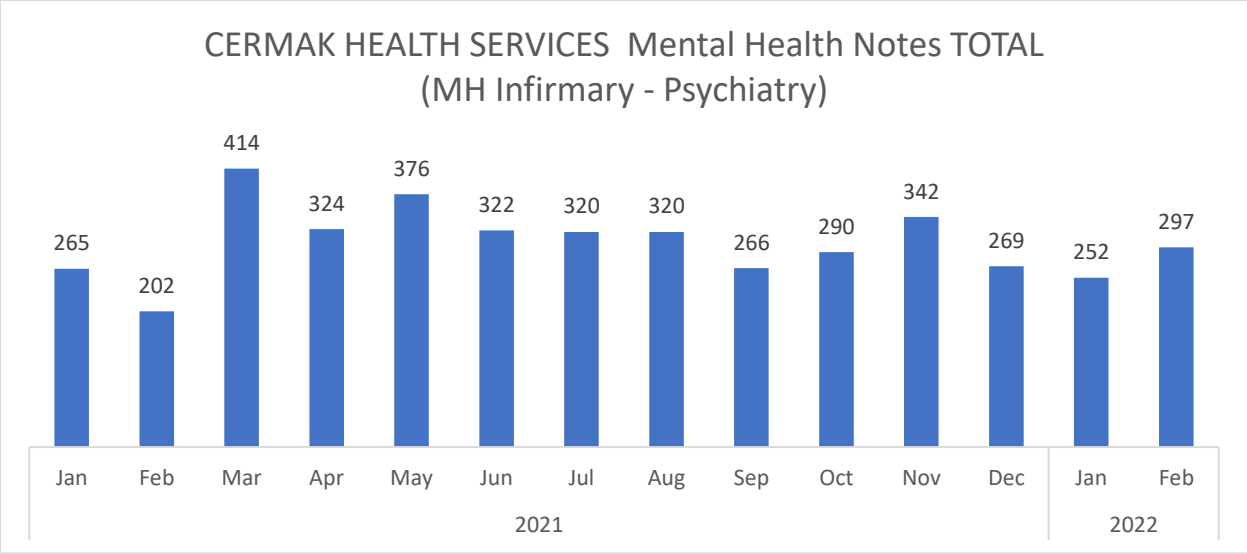
Correspondingly, the number of detainees who require intensive services (Cermak-P3) has grown as well but then plateaued off over the summer months. Traditionally, these detainees had to be housed in the Residential Treatment Building (RTU) to improve their access to care and enable direct supervision. As of February 2022, 31 % of these male detainees are housed outside of RTU in other divisions (a decrease from 42% in December 2021). That number is also inclusive of 8 P3 male detainees from Intensive Management Unit. Intensive Care Unit provides manualized treatments for P3's with severe behavioral disturbances. Cermak MH is adjusting MH staffing to cover non-RTU areas where P3 detainees are housed. CCDOC and Cermak are slated to move these 8 detainees back to RTU where the original IMU was located until July 2021. That movement promises to further improve their access to care. Female P3 detainees (aside from the new on the compound detainees housed on the second floor of RTU) are housed in 3 annex building which to some degree meets their needs in terms of clinical and group programming space. The goal remains to eventually consolidate all P3 (males and females in RTU). As of February, capacity pressures continue to place P3 male and female detainees outside of RTU in divisional settings. Our Departmental focus is to ensure that these detainees retain access to services in the dormitory settings.

SMI (Seriously Mentally Ill) experience more difficulties with community placement, electronic monitoring compliance/diversion, and adherence to psychiatric treatments that improve overall chance of being released from custody. They require dormitory style housing arrangements, re-entry services, in addition to being frequently adjudicated unfit to stand trial (which leads to significant delays with release). They also, when untreated, are linked to self-injury, use of force, and extended length of stay.

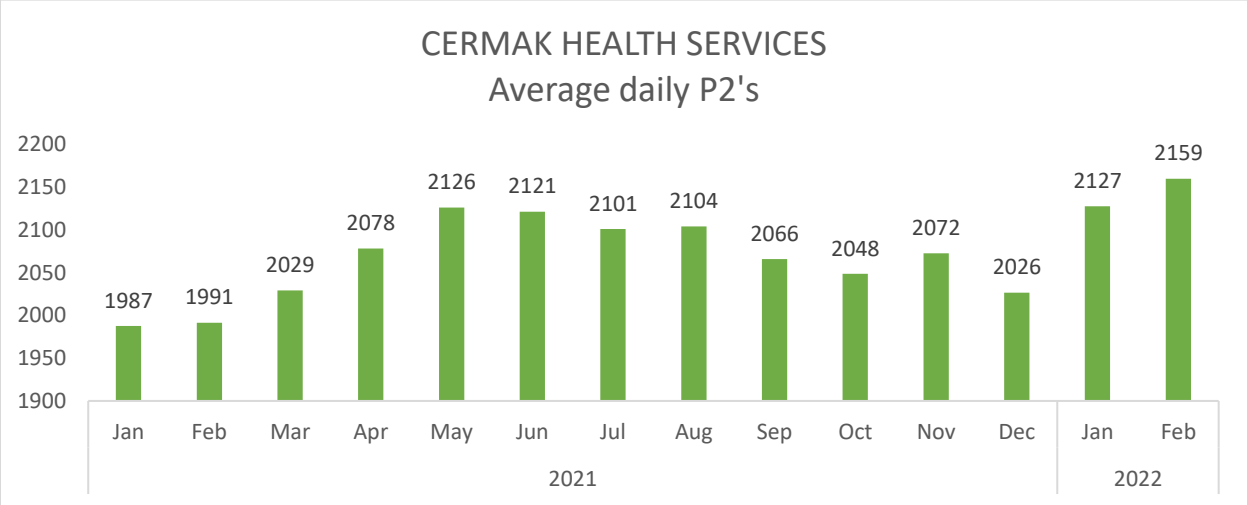


The number of detainees housed in Infirmary Level Care of services (Cermak-P4) has remained relatively constant. The number of referrals and admissions to P4 Level of Care (Infirmary) has overall increased over the past 12-month period. Fluctuations in these numbers are cyclical, and frequently seasonal, increasing in the spring and summer and decreasing in the late autumn. As an overriding principle, Cermak strives to provide services in the less acute settings to meet detainees' mental health needs to minimize the number of infirmary admissions.



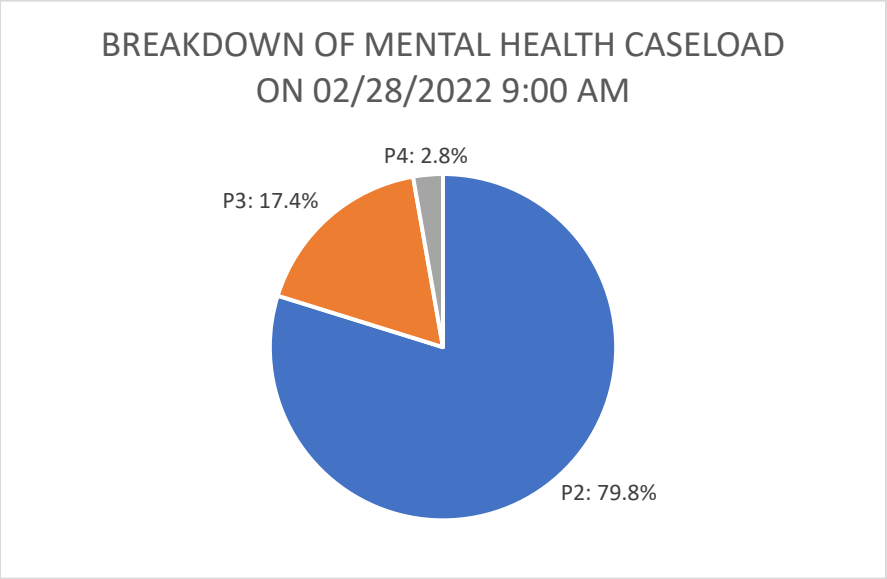


Although P2 detainees represent the lowest acuity level, increase in their numbers puts pressure on capacity limited housing locations in terms of adequate supervision and access to services, given the facts that CCDOC and Cermak staffing formulas are not designed to absorb large fluctuations in case load.



#2 - Overall goals of behavioral health program(s) including goals unique to the specific population served

Detainees with similar MH needs are housed together across the compound and triaged into 3 levels of care: P4, P3, and P2. Cermak arranges for all levels of care and ensures quality, accessible, equitable, efficient, and timely MH services.



Cermak- P4 (Psychiatric Special Care Units)- houses detainees who are:

a. suicidal and require either constant or close monitoring and supervision in a suicide-resistant setting.
b. aggressive/agitated and require enhanced supervision.
c. grossly disorganized/refusing treatments.
d. persistently self-injuring.
e. cognitively compromised.

Cermak-P3 (Residential Treatment Unit Care) – houses detainees who typically reside in supportive settings outside of corrections (e.g., intermediate care facilities, nursing homes, group homes etc.) and need daily contacts with MH staff.

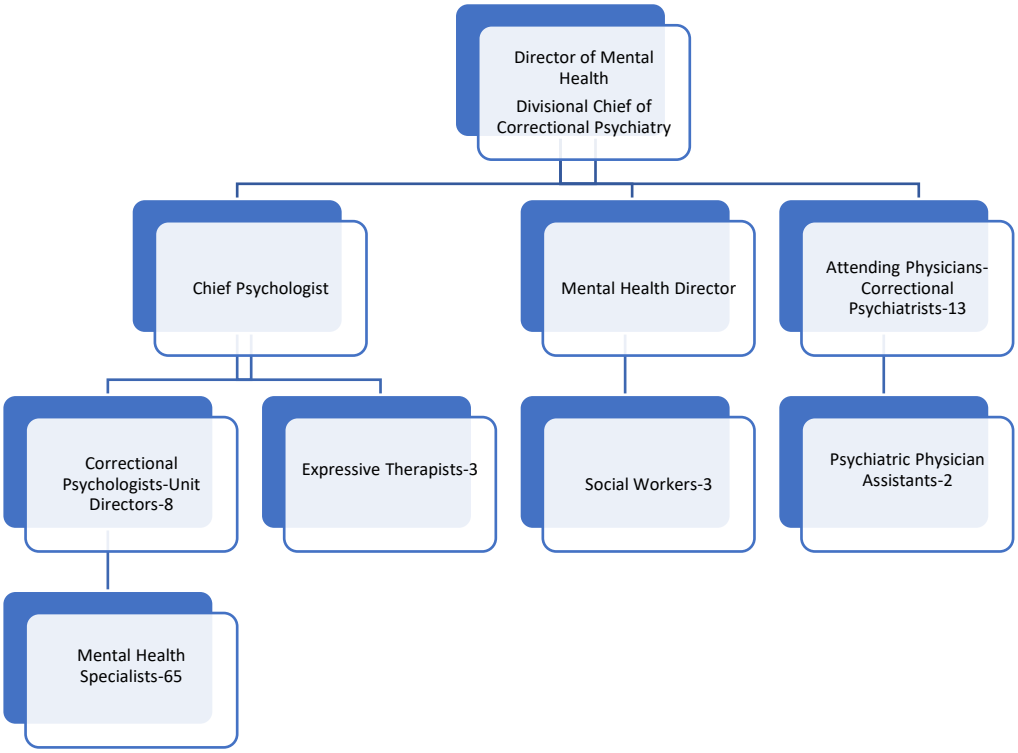
Cermak-P2 (Outpatient Level of Care) - houses detainees who have recovered from the episodes of mental illness, are able to meet the challenges of activities of daily living, avoid self-injury, and participate in the creation of and comply with treatment plans generated by MH staff.

#3 - Information on the providers, managers, and/or operators of the behavioral health care program, activity or service and any overlap in funding, to the extent it is known.

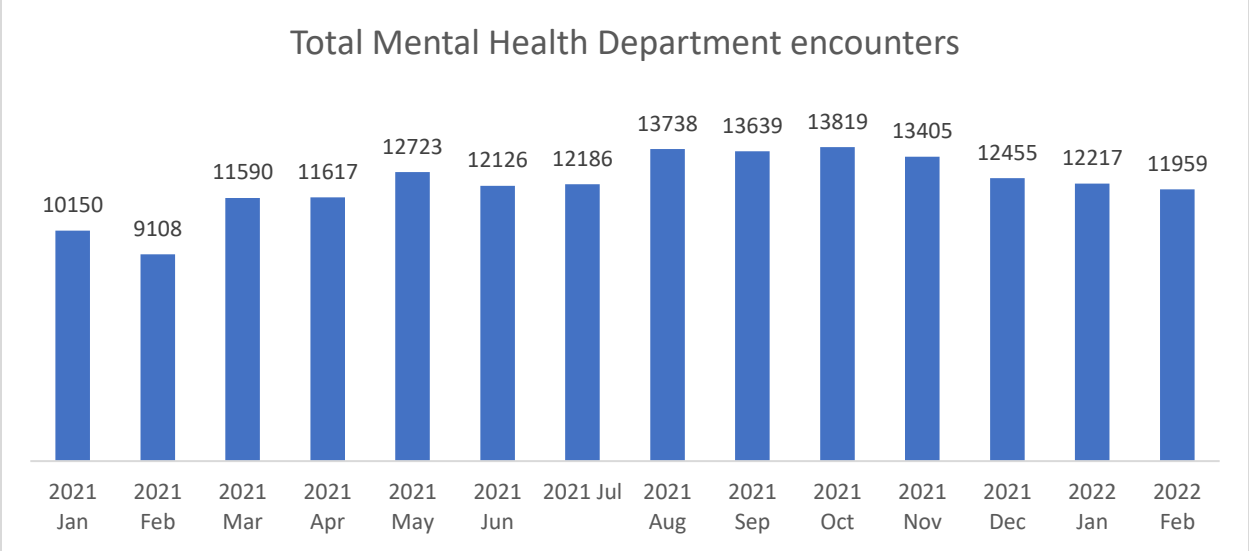
All the Providers and Managers at Cermak Health Services Mental Health Department are CCH employees. MH Department does not employ contractors or vendors to provide services.

Operational, administrative, and clinical leadership of the Department is carried out by the Chief Psychiatrist, Chief Psychologist, and Mental Health Director.

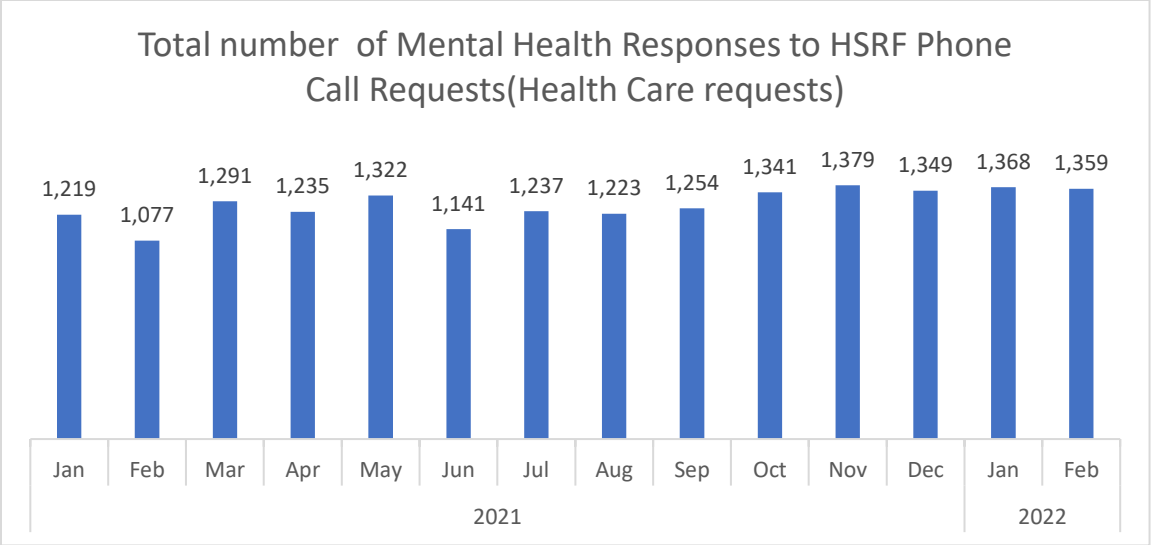
Presently, Cermak MH Department has 97.8 FTE's



Compound-wide COVID-19 response "depressed" clinical activities and interpersonal encounters. As a result, Cermak saw a decrease in direct contacts with patients. While the compound is returning to normalcy of operations, we are seeing a surging demand for MH services. The emergence of the delta variant in the summer of 2021 did not reverse the uptrend and the Department has not decreased access to MH services as evinced by the data. Following a brief lull in the fall associated with the decline of positivity rate from the Delta variant, the compound had to adjust to escalating positivity rates from the highly contagious omicron variant with the resultant restrictions on patient movement and patient encounters and loss of productivity. Many tiers go on the quarantine and isolation status making contacts with detainees more problematic. Cermak MH staff uses telephone or telehealth contacts with the detainees if they cannot leave restrictive tiers. As the additional pressures presented as the result of Cermak and CCDOC's response to the Omicron variant are receding toward the end of February 2022, MH Department is planning to resume previously delayed or adjusted activities (including but not limited to therapeutic on and off the tier programming which had to be modified to limit the number of participants in each group session due to the need to socially distance in a place without adequate ventilation).

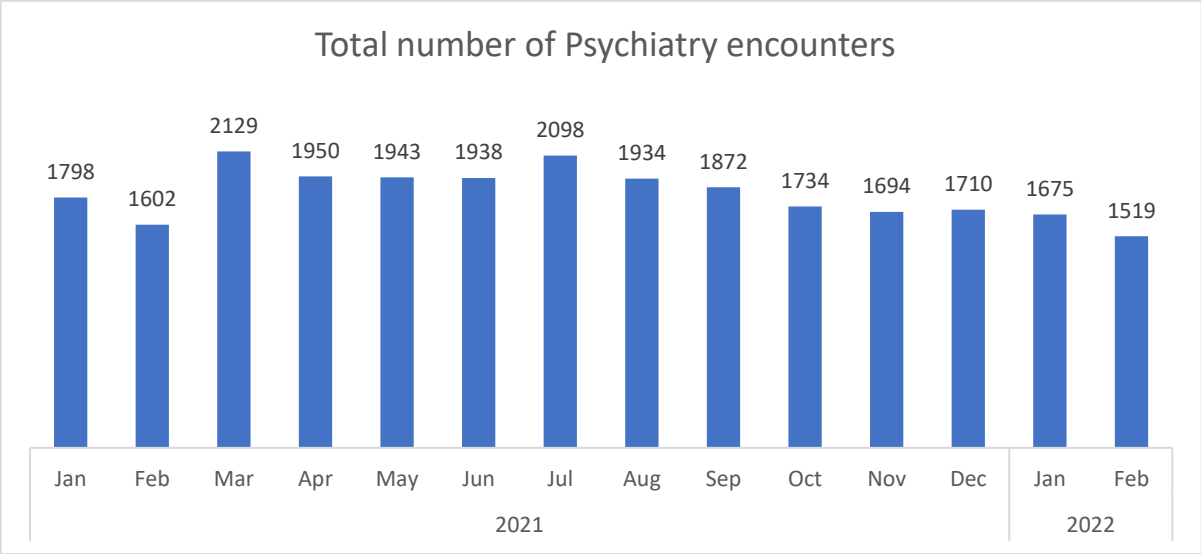


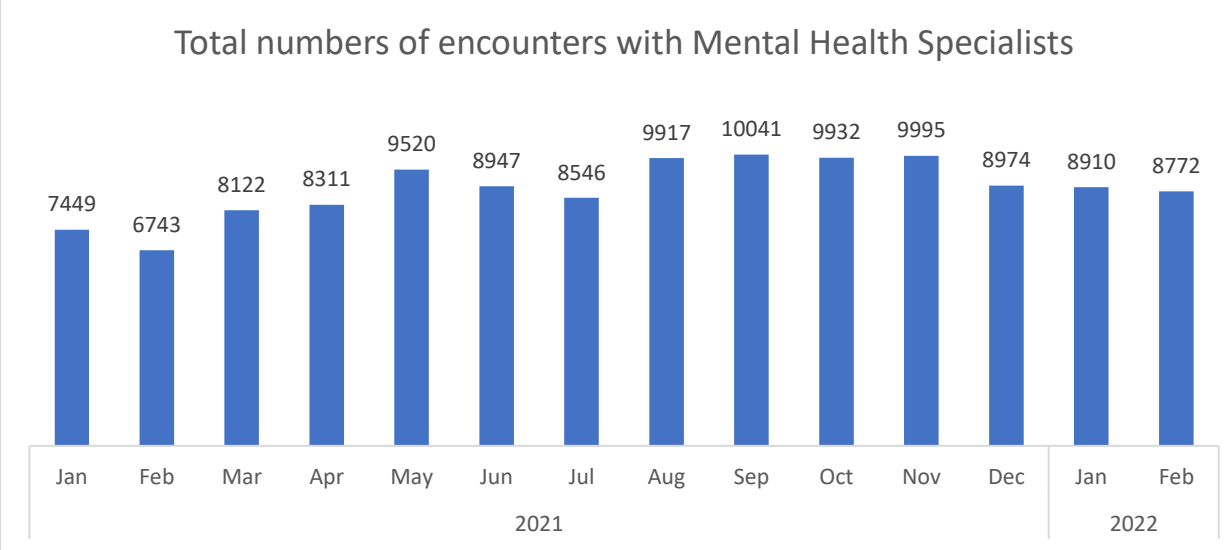
As patient movement across the compound is normalizing, more and more detainees reach out to MH staff to address their MH needs. An important mechanism by which detainees can directly request MH services is the Health Care Request process. Through self-referral, detainees may request access to MH services regardless of their housing location or level of care. MH staff respond to the pent-up demand.



Increase in patient contacts is happening across the whole spectrum of levels of care and in all clinical disciplines.

Most of the MH encounters now occur face-to-face and the Department is moving away, when appropriate and safe, from relying on telephone contacts with the patients which was temporarily seen as necessary at the peak of the pandemic. As the rates of vaccinations among staff and detainees are increasing, MH Department has been returning to structured group therapeutic activities (on and off housing tiers) and face -to-face individual live encounters while following infection control guidelines about PPE and social distancing. Even with the introduction of the Omicron variant on the compound the Department did not shut down the operations like we witnessed in March 2020. Operational resilience has been acquired and serves to preserve the integrity of operations (ensure contact with MH staff) as the Department follows infection mitigation measures. The fact that the services were not significantly curtailed even at the height of the Omicron wave proves that the department has strengthened its operational response to the pandemic.


Total number of Psychiatry encounters
1798
1602
2129
1950
1943
1938
2098
1934
1872
1734
1694
1710
1675
1519
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
2021
2022


Total numbers of encounters with Mental Health Specialists
7449
6743
8122
8311
9520
8947
8546
9917
10041
9932
9995
8974
8910
8772
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
2021
2022

#4 - Key performance indicators measuring the results of the program.

The goal of a successful MH program in the jail setting is to ensure that detainees have access to care for their serious mental health needs. Patients are seen by qualified mental health staff, receive competent diagnosis, and receive care that is ordered.

A. Cermak ensures that any detainee who screens positively for mental illness or suicidal ideation during the intake screening process, through a mental health assessment, or who is otherwise referred for mental health services, receives a clinically appropriate mental health evaluation in a timely manner, based on emergent, urgent, and routine mental health needs from a Qualified Mental Health Professional.

B. Cermak ensures clinically appropriate and timely treatment for detainees, whose assessments reveal serious mental illness or serious mental health needs, including timely and regularly scheduled visits with Qualified Mental Health Professionals.

C. Cermak ensures that treatment plans adequately address inmates' serious mental health needs and that the plans contain interventions specifically tailored to the detainees' diagnoses.

D. Cermak provides 24-hour/7-day psychiatric coverage to meet detainees' serious mental health needs and ensures that Psychiatrists see inmates in a timely manner.

E. Cermak ensures timely provision of therapy, counseling, and other mental health programs for all detainees with serious mental illness. This includes adequate array of structured therapeutic programming.

F. Detainees have access to appropriate infirmary psychiatric care when clinically appropriate.

G. Cermak ensures an adequate array of crisis services to appropriately manage the psychiatric emergencies that occur among detainees.

H. Cermak ensures that detainees have access to appropriate acute infirmary care, comparable to in-patient psychiatric care, within the Cermak facility.

I. Cermak ensures timely implementation of physician orders for medication and laboratory tests. Cermak ensures that detainees who are being treated with psychotropic medications are seen regularly by a physician to monitor responses and potential reactions to those medications, including movement disorders, and provide treatment where appropriate.

#5 - Quality measures or expectations for contracts involved in the program, where applicable

Not applicable. Cermak Health Services does not contract out for the provision of mental heal services at the jail.

#6 - Information on how the care being provided in this program serves the best interests of the patient/recipient of care as well as the communities where the patient/recipient of care or services resides.

Jails and prisons traditionally fill the gap in services caused by the paucity of accessible Mental Health programs available to some of the most disenfranchised populations in our communities. Second to the Illinois Department of Corrections, Cermak provides an array of services to the largest Mental Health single site population in the State of Illinois.

Frequently, when detainees enter the facility, they have acute and pressing MH needs related to housing insecurity, violence, lack of social support, poverty, and other social determinants of mental health.

These individuals are at risk of decompensation in a highly structured correctional environment and require intensive stabilization efforts.

Individuals with mental illness are at an increased risk of self-injury/suicide when incarcerated. By providing a comprehensive scope of services to these individuals, Cermak mitigates this risk.

Cermak's primary focus is patient safety. All initial evaluations are conducted with specific attention to suicide risk factors. Along the spectrum of MH care at Cermak, from Intake to the point of release, detainees receive numerous suicide risk screenings and assessments.

Detainees participate in multidisciplinary treatment team meetings and can provide input for their treatment plans that seek to address long-term deficits from MH illness, failure to adapt to correctional environment, and to restore psychosocial functioning.

Cermak's MH reentry initiatives ensure that detainees who are being released from CCDOC have a safe path to successful reentry and are connected with Providers and services in the community.

#7 - Information on how the continuum of care may be addressed through this program.

Cermak measures its success in ensuring continuity of care by the extent to which preexisting conditions are identified and addressed during the intake and jail stay followed by safe hand-off and linkage for those who are leaving custody. Patient MH care is coordinated and monitored from admission to discharge.

Cermak patients receive MH services per prescribers' recommendations, orders, and evidence-based practices. Cermak Providers utilize clinical protocols consistent with national clinical practice guidelines for the treatment of chronic MH conditions.

Health care for detainees requires input, information, and services from a variety of institutional, CCH systemwide, and community-based resources. Cermak ensures that collateral medical records from community providers are obtained. Outside providers are routinely contacted to verify care in the community. Cermak, as part of CCH, has a shared electronic health record with CCH and all its affiliates and clinics.

Cermak is a congregate setting, and not a hospital. It is important to ensure that detainees have unfettered access to hospital and specialty care during the period of their incarceration when necessary. Upon return to the Jail, detainees are seen by qualified Cermak staff, and the recommendations are reviewed for appropriateness of use in the correctional setting. Cermak ensures that health information from Cermak follows the patient to outside clinics and that a summary of the specialty care visit and associated recommendations are received and added to the patient's health record so that the ordered services are implemented.

Discharge planning is provided for detainees with serious MH health needs whose release is imminent. For planned discharges, health care staff arrange for a reasonable 1-month supply of current medications. For detainees with serious needs, arrangements or referrals are made for follow up services with community prescribers, including exchange of clinically relevant information, including problem lists, medications, procedures, and test results. Prior to planned release staff emphasizes the importance of appropriate aftercare and follow up.

#8 - Information on the best practices in this type of programming.

Cermak has developed several clinical and patient safety practices that allowed the organization to come in compliance with all of the provisions of the Agreed Order between the DOJ and the County of Cook in April 2018. Some of these practices include:

A. Weekly Divisional inter-agency management meetings between CCDOC Divisional leadership and Cermak Correctional Psychologists.

B. Monthly MH Suicide Prevention Committee (Cermak and CCDOC).

C. Establishment of Therapeutic Tiers for enhanced programming and creation of a therapeutic community.

D. Intensive Management Unit serving the institutionally disruptive seriously mentally ill.

E. Incentives program in P4 Level of Care (Infirmary).

F. Coordination with CCH and retail pharmacies for post-discharge medications.

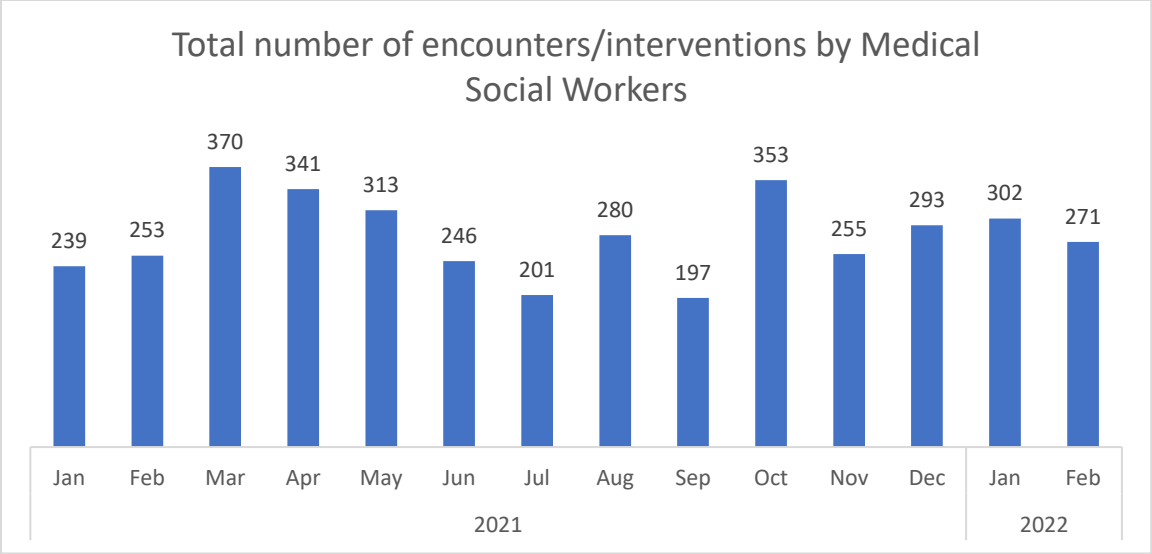
G. Leadership rounding.

H. Assisted Outpatient Treatment program that facilitates outpatient commitments for detainees who are being released from CCDOC.

I. Post critical incident Psychological First Aid program.

#9 - Information detailing meetings and coordination on patient identification, programs and goals with other Cook County agencies, City of Chicago or other partners or entities on this program, where applicable

Most of the reentry services and liaison work between agencies are conducted by Medical Social Workers in coordination with community partners/agencies and CCSO staff. Social workers are responsible for a vast array of services including:



A. Collaboration with CCDOC programs and departments for coordinated releases of the detainees requiring direct admissions to nursing and intermediate care facilities.

B. Coordination with Thresholds Justice Team (outside provider contracted through the Cook County Court bond system). Follow up and continuity of care for released pretrial detainees providing clinical assistance for detainees who remain in custody, as well as developing aftercare plans upon release from CCDOC.

C. Referrals for outpatient care and follow up for detainees who are released from custody through Trilogy, Heartland Alliance, and Bobby Wright as well as behavioral Health Consortium (including Community Counseling Centers of Chicago (C4), Metropolitan Family Services, Human Resources Development Institute Inc. (HRDI), Habilitative Systems, Inc. (HSI), the South Suburban Council on Alcoholism and Substance Abuse, and Family Guidance Centers Inc.)

D. Collaboration with the Circuit Court of Cook County: Mental Health Court Program-AMITA, Veteran's Court, Drug Court, Affordable Care Treatment Court, and Adult Redeploy program.

E. Coordinated transition of care for VA patients upon release from custody.

F. Coordination of discharge medications and patient appointments for Justice Advisory Council who manage no place to stay detainees who are leaving on Electronic Monitoring. JAC sends Cermak a daily list of who they want to place that evening and the location of where they are being placed. Cermak staff review the charts to make sure the placements can accommodate the medications they are prescribed and any additional needs (medical issue, MAT). Cermak staff set up discharge medications and inform JAC that medications will need to be picked up and notify EM if movement is needed for additional medical appointments. Cermak also inform MAT staff so they can set up MAT services.

G. Coordination of services with the Bail Bond Project Initiative. Bail Bond Project sends a list each week of those whom they have decided to bond out. Cermak staff review the charts and enter discharge medication alerts, if needed, and inform BBP and TASC that the patient will have medications available at JSH outpatient pharmacy.

H. Collaboration with the Cook County Community Resource Center. The Cook County Sheriff's Office operates the Community Resource Center (CRC). The initiative will provide linkages to services for at-risk recently released detainees in need of supportive services. Services include direct connections to financial coaching, medical and behavioral health treatment, employment opportunities, food, clothing, and housing resources within their communities. Cermak staff refer prescreened detainees in need of services to CRC.

I. Participation in the Safety and Justice Challenge Population Review Committee comprised of Cook County Justice Stakeholders commissioned to collaborate and strategize to reduce the jail population, reduce pretrial lengths of stay and address social inequities and mental health needs of the incarcerated. Individual case reviews are also presented for patients with complex medical and mental health needs to identify alternatives to incarceration and reentry support for compassionate considerations and/or to potentially reduce the cycle of incarceration.

J. Collaboration with the Fitness/Jail Diversion Program designed to divert arrested individuals who have serious MH needs to Madden Medical Center for immediate treatment and further services coordination and before they enter CCDOC compound.

K. Medical Social Workers work with the State of Illinois Department of Human Services facilitating transfer of detainees remanded to DMH to and from DMH-run facilities.

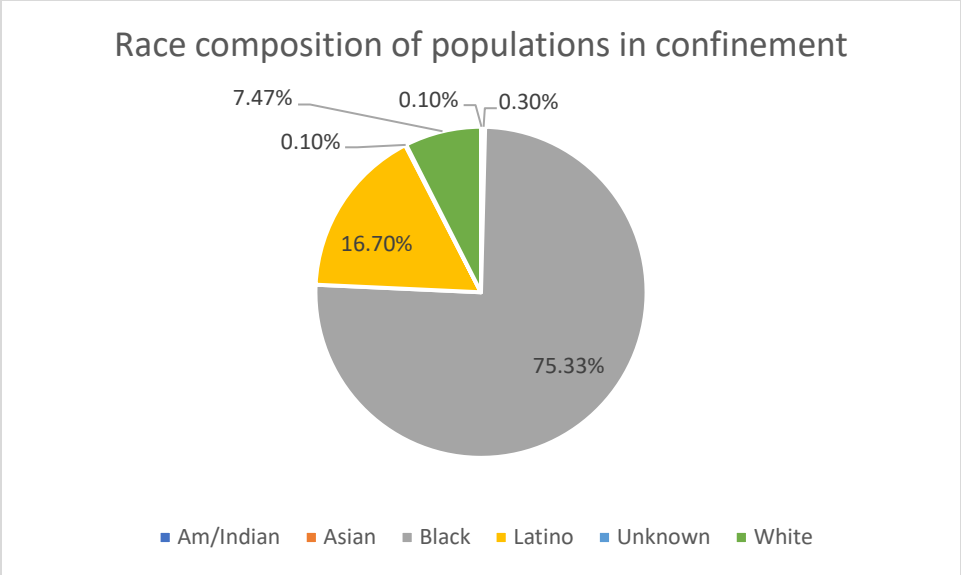
#10 - An evaluation of the program and an overview of any overlap in outreach, communities served, and programs with other Cook County and City of Chicago Agencies, and an evaluation of the impact of the program and an overview of its effectiveness, particularly as it pertains to vulnerable populations, racial and ethnic minorities; and populations facing disparities in behavioral health outcomes, behavioral health care, and behavioral healthcare access.

Cermak is the sole health care provider for detainees at Cook County Jail. Cermak works in conjunction with the CCSO's Department of Programs and Operational Leadership to identify opportunities for expansion of services and leads advocacy efforts on behalf of the detainees. Determining a scope of services is frequently a collaborative task between Cermak and CCSO Operational Leadership whereas objectives, locations, and volume of services are determined based on the established previous benchmarks created by the provisions of the DOJ Agreed Order, allocated resources, as well as current operational and clinical needs.

Cermak Health Services evaluates the effectiveness of the MH program by:

1) *Provision of suitable services*- Cermak provides services across the continuum of care on-site (inpatient/infirmary level of care, intermediate/residential care, and outpatient level of care)

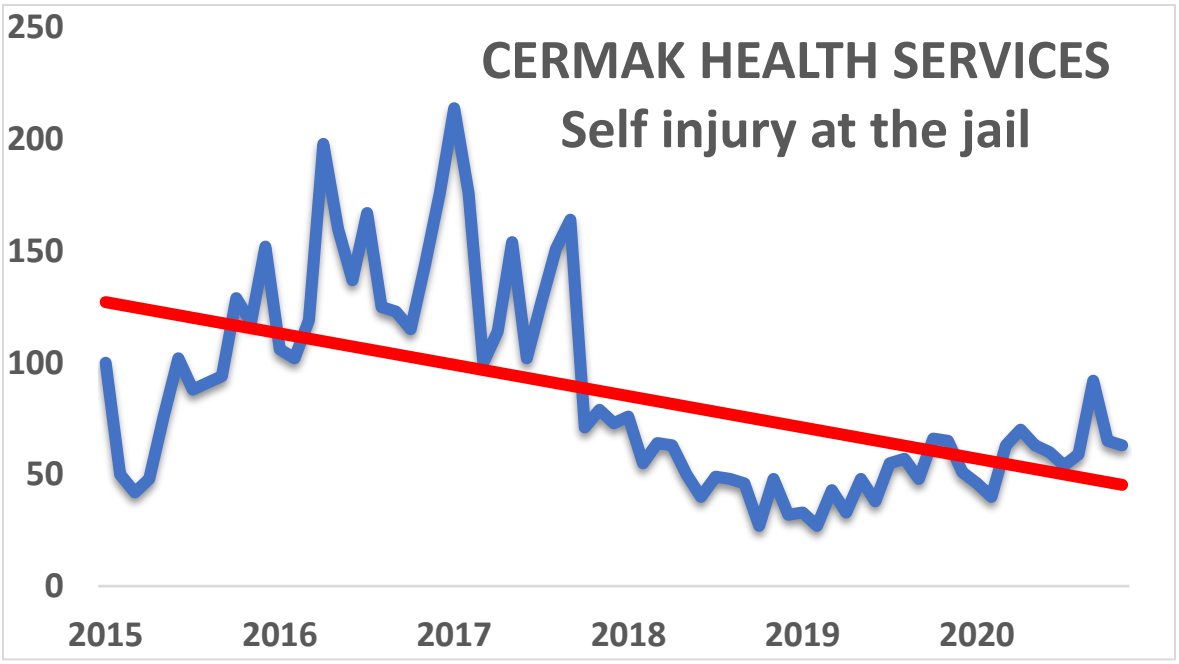
2) *Provision of accessible services*- all detainees at the Jail can access MH services at any time during their detainment. Most detainees experience disparities in access to care in the community. When these individuals are detained at the Jail, Cermak works to minimize and/or remove any barriers to needed care to reduce disease burden and recidivism. Cermak provides services based on individual level of mental health needs. Cermak provides these services regardless of any patient's ability to pay, and Cermak does not bill any services to the patient. Detainees have a constitutionally protected right to have access to health care services for their serious medical and mental health conditions when detained.



3) *Provision of services that are acceptable to patients*- patients are provided services aligned with an individualized treatment plan based on individual needs/goals

4) *Ensuring continuity of services*- patients can move up or down in level of services based on their level of care needs. Cermak promotes access to care by providing 24/7/365 coverage for all mental health needs across the Jail compound including crisis services, special care units, medication monitoring, and residential treatment level of care.

5) *Provision of safe services*- patients are provided with a safety/suicide risk assessment at each point of contact with Mental Health providers. The total number of self-injuries across the jail compound is tracked and analyzed. The below graph suggests that there is a negative overall trend in self-injuries over the past 4-5 years. Recent analysis indicates that while trending down during the peak of the pandemic, now we can see trend stabilization:



One of the central aims of the Cermak MH program is decreasing detainee self-injury and suicide in the Jail. Admissions related to self-injury/suicidal ideation/behavior are housed in a heavily monitored and suicide resistant Psychiatric Special Care Unit (P4 level of care). Department is charged with assessing level of risk during all patient encounters and taking appropriate action when risk is identified.

#11 - Information with the costs associated with the program(s) and funding source(s)

Fiscal allocations for the Cermak Mental Health Program for 2021 totaled 15.5 million dollars. Funding for the program is provided through the Cook County Health Enterprise Fund.

#12 - Any additional information which may facilitate the Committee's understanding of the program, initiative, or activity

Cermak's focus is on meeting detainees' serious and routine mental health needs while integrating the provision of services with the operational demands on the compound, safety and security of staff and detainees, and collaborating with partnering organizations in the community with the goal of linking detainees with post release services. One of the most essential tasks is removing barriers to care and improving access to services during the COVID-19 compound wide response. Several important activities of the program are reflected in the following:

A. Cermak ensures access to services by timely conducting MH screenings and dispositions in Intake as well as tailoring individual treatment plans to changing clinical objectives and when detainees are unable to meet treatment plan goals.
B. One of the central tasks is the maintenance of Cermak's robust Suicide Detection and Prevention program that provides detainees with timely detection of urgent MH needs (suicide risk screens and suicide risk assessments), supervision by qualified staff, access to suicide resistant settings, and schedules for follow up.
C. Accessibility and frequency of contact with Providers have been modified during the pandemic and, presently, the ongoing compound wide normalization of scheduling operations and patient movement boosts treatment and supportive face-to-face interventions contributing to improvement in treatment outcomes.
D. Readmission rates to Cermak intensive treatment settings (P3 and P4) have remained below national rates and suggest that despite of challenging adjustments due to COVID-19 response, Providers have been able to maintain positive treatment outcomes while adhering to national practice guidelines.

#13 - Any additional information which may foster a more accurate assessment of behavioral health care needs and opportunities for collaboration or growth within the Cook County Government entity's behavioral health care programs.

While the MH Department's mission has been centered around meeting detainees' mental health needs on the compound, the reentry services' allocations have been relatively less robust. Presently, the Department deploys 3 Social Workers (with three unfilled vacancies) to provide linkage services for nearly 2,700 detainees who are maintained on the MH caseload. Since the last report, one Social Worker has been hired. Possible future expansion of linkage services and Social Workers' staffing levels at Cermak can enhance the program's efficiency by facilitating reentry and reducing recidivism based on unmet MH needs in the community. Partnership opportunities and already-developed collaboration venues need to be matched with manpower.

MH Department continues to experience relatively high rates of attrition among Psychiatry. One of the crucial measures that enables correctional facilities to recruit and retain talent is Educational Loan Repayment through any of the public service programs, the best known being National Health Care Corps loan repayment

program. Presently, Cermak is not a qualifying site which significantly impedes qualified candidates from joining Cermak.

The Equity and Representation in Health Care Act is sponsored by SB3734 – Senator Hunter and HB4645 – Representative Greenwood at the state level.

Supporting a health care workforce that better reflects, represents, and understands the patients they serve will help address these challenges.

The Equity and Representation in Health Care Act seeks to address racial and other disparities in health care through the recruitment and retention of a diverse and representative health care workforce. The Act will do this through:

a. Providing new and increased funding to support loan repayment and scholarship programs.
b. Filling gaps by adding health care professions eligible to participate and
c. Prioritizing populations that continue to be underrepresented in the health care workforce.

The Equity and Representation in Health Care Act will build and strengthen the workforce at community-based provider locations that serve a high-proportion of Medicaid and uninsured patients, specifically at FQHCs, FQHC Look-A-Likes, and provider locations operated by Cook County Health.

#14 - Any additional information if patients receive follow up care at a Cook County hospital including medication management as a part of aftercare.

Detainees prescribed psychotropic medications while in detention at CCDOC are assessed to determine if they can receive a 30-day prescription for their medications at CCH's Stroger Outpatient Pharmacy or at the retail Pharmacy of their choice.

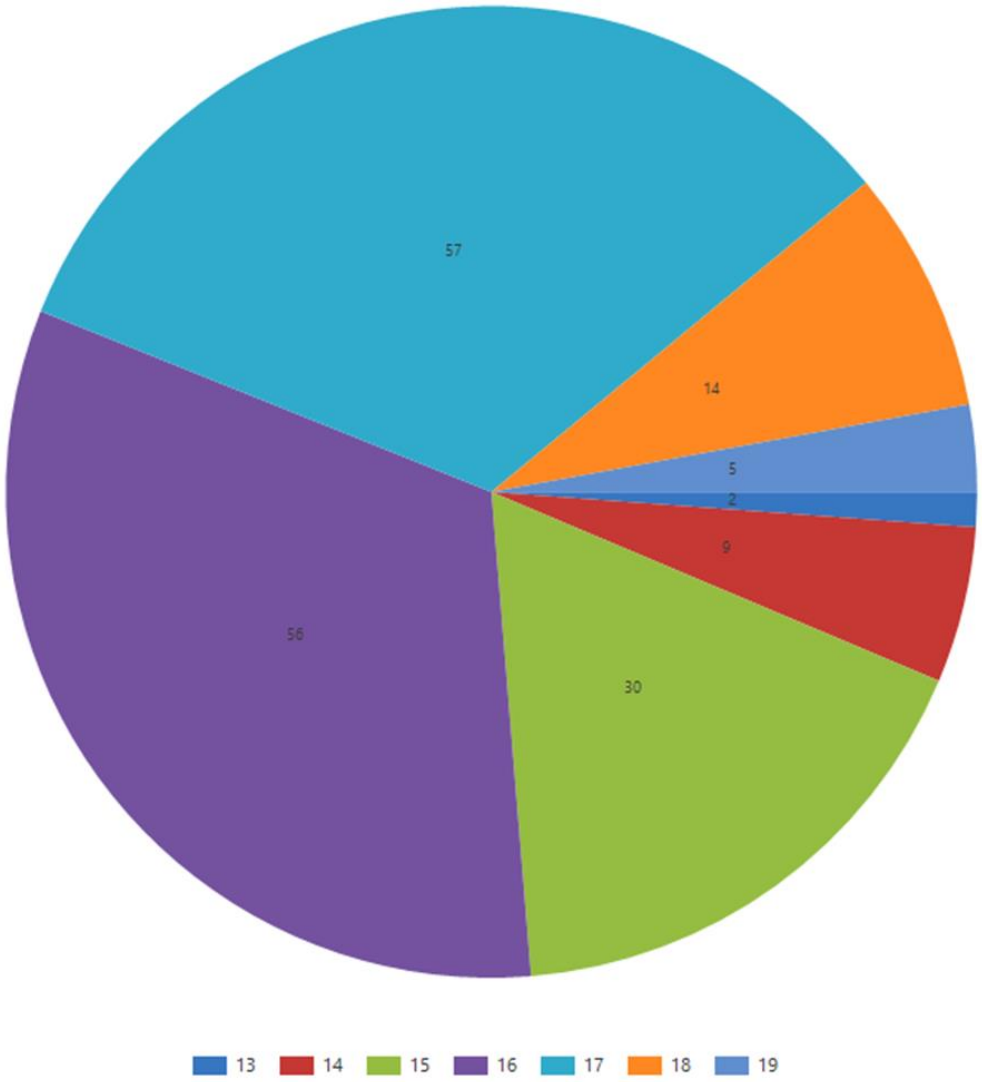
Cermak coordinates with CCH to e-prescribe detainees' psychotropic and other medications at a pharmacy agreed upon by the patient.

Medical Social Workers schedule appointments with the outpatient clinics (including the injection clinic for those who take long lasting psychotropic medications administered via intramuscular injections) for the patients who leave CCSO custody and are interested in ongoing follow up and medication management services/aftercare at CCH.

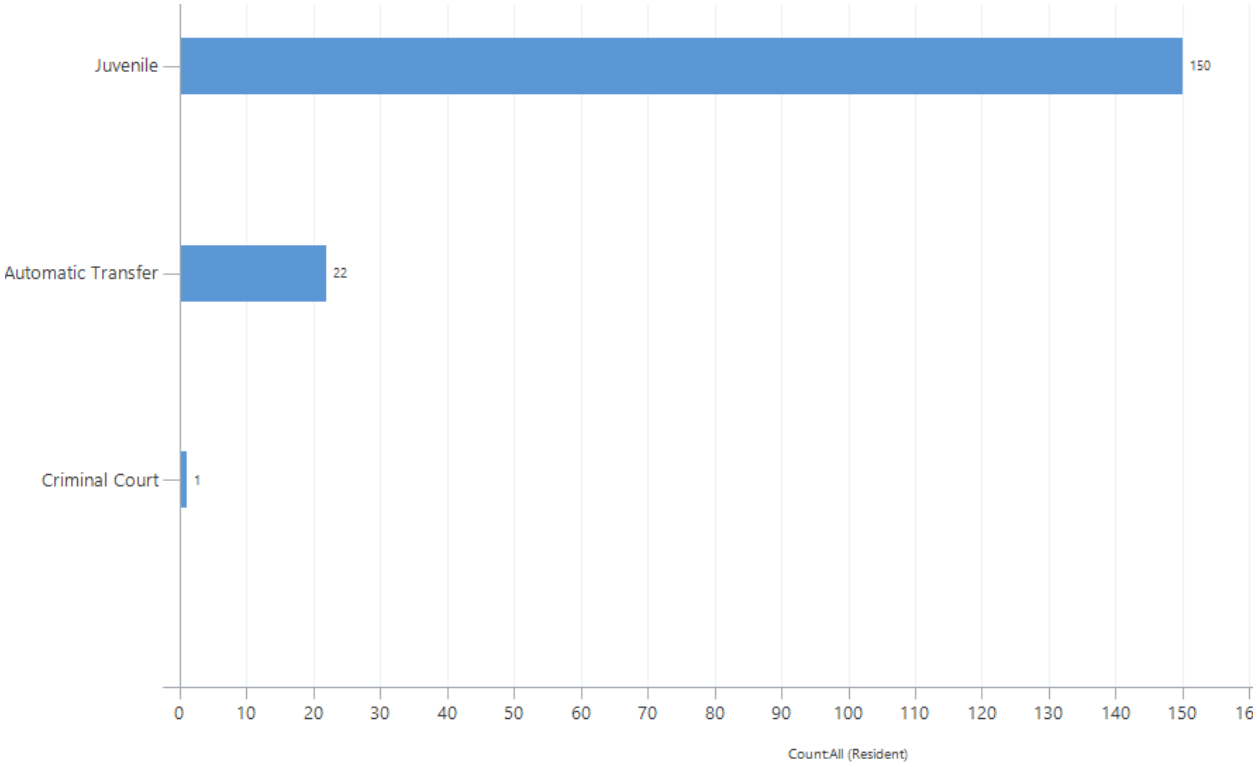
Juvenile Temporary Detention Center Health Services

#1 - General information on the population served, including how patients were identified or applied for services, a breakdown of where patients of the program(s) reside in Cook County and the number of patients served over the last 24-month cycle

The Cook County Juvenile Temporary Detention Center (JTDC) Behavioral Health (BH) Program, operated by Cermak Health Services of Cook County Health (CCH), provides care for youth detained at the JTDC. These youth range in age from 13 to 19 years old. The current age breakdown (March 7th, 2022) is as follows:



The majority of youth at the JTDC are being held on juvenile charges with a smaller percentage being charged as adults (March 7, 2022):



Patients are identified for service via several mechanisms. Behavioral Health staff conduct Mental Health Screenings and make appropriate referrals within 72-hours of a youth's admission to the JTDC. All residents who enter the JTDC receive the Massachusetts Youth Screening Instrument- Second Version (MAYSI-2) and the Behavioral Health Intake Screening and Initial Treatment Plan.

The MAYSI-2 is a 52 question self-report tool that is administered to youth within 4 hours of entering the JTDC. The MAYSI-2 has six main scales including: Alcohol/Drug Use; Angry-Irritable; Depressed-Anxious; Somatic Complaints; Suicide Ideation; and Thought Disturbance (for boys only). Results of the MAYSI-2 are provided to Qualified Mental Health Professionals (QMHP) who review the data and use it to make treatment recommendations.

In addition to the MAYSI-2, the Behavioral Health Intake Screening and Initial Treatment Plan is administered by QMHP within 72 hours of the youth's arrival to the facility. The following domains are included in the screening:

- Medical History
- Head Injury Questionnaire
- Medication Treatment History
- Mental Health Symptom History
- Mental Health Treatment History
- Family Relationships History
- Family Medical / Mental Health History
- Prenatal History
- Current Eating and Sleeping Patterns
- Sexuality (Sexual Orientation, Gender Identification, Preferred Pronouns, etc.)
- Abuse / Neglect History
- Prison Rape Elimination Act (PREA) Assessment
- Educational History
- Substance Use Assessment
- CRAFFT Screening Interview (for substance abuse)
- Impacts of Substance Use Assessment
- Suicide and Self-Injury Assessment
- Assault and Homicide Assessment
- Child and Adolescent Trauma Screen (CATS) – Youth Report
- Strengths and Interests Assessment
- Mental Status Exam
- Treatment Recommendations

Based upon the findings of the Behavioral Health intake screening and the MAYSI-2, clinicians will make recommendations that may include placement on the Mental Health Follow Up Status (MHFU). MHFU residents receive treatment planning, weekly staffing, at least weekly individual therapy, and care coordination services. Criteria for placement on MHFU include history of Behavioral Health or substance abuse treatment; current symptoms of mental illness including trauma related symptoms, current or recent treatment with psychotropic medication, significant substance use, intellectual functioning or developmental delay issues, and other special needs that may require Behavioral Health support.

For Q1 2022, Behavioral Health Services at the JTDC have placed an average of 54.2% of the population on MHFU status. For FY2020, the average was 54.0% of the population.

Mental Health Population	FY 2022 Ave Through Q1
Mean Active Treatment Cases	86.7
Mean JTDC Population	155
Percent JTDC Population Active Treatment Cases	56%

All youth at JTDC have access to Behavioral Health services and do not require a diagnosis or placement on MHFU status to receive services. Youth can request services through a user-friendly referral system and/or Behavioral Health outreach/milieu activity. All residents are also provided group counseling services and group psychoeducation. Any resident may also request re-entry planning services from one of the Behavioral Health social workers.

#2 - Overall goals of behavioral health program(s) including goals unique to the specific population served

The JTDC Behavioral Health Program provides efficient, competent and high quality services that are consistent with relevant professional standards, the Juvenile Standards of the National Commission on Correction Health Care ("NCCHC"), the American Correctional Association ("ACA") and the established best practices within the fields of psychiatry, clinical psychology, and social work. The JTDC Behavioral Health program provides on-site clinical coverage 365 days per year from 8am to 10pm and has 24-hour psychosocial and psychiatric on-call services.

The JTDC Behavioral Health Program provides clinical services including:

- Behavioral Health Screening and Assessment
- Psychiatric Evaluation and Treatment
- Comprehensive Treatment Planning
- Crisis Intervention
- Daily Clinical Rounds on All Living Units
- Daily Assessment of Youth in Confinement
- Weekly Clinical Staffings
- Individual Counseling/Therapy
- Family Counseling
- Behavior Management
- Substance Abuse Counseling
- Psycho-educational Groups
- Trauma Screening and Treatment
- Evidence Based / Supported Programming
- Consultation to the Court and Probation
- Referrals for Hospitalization
- Comprehensive Re-entry Planning Services

The overall goal of the program is to meet the mental, emotional, developmental and social needs of the residents using a biopsychosocial approach. This work is carried out using multi-disciplinary and team-driven methods customized to the needs of the individual youth. Having smaller clusters of centers, with a core group of Behavioral Health professionals in each, gives greater stability to residents, improves communication, and makes their work more efficient. Each of the 7 JTDC centers has a designated Behavioral Health team consisting of a Clinical Psychologist, Mental Health Specialists, Licensed Clinical Social Workers, and Psychiatrist.

JTDC Behavioral Health staff conduct daily Clinical Rounds of all JTDC residential areas ("pods") to identify residents' problems and provide interventions to address the problems as early as possible, before they become worse. During rounds, a JTDC clinician will speak with direct care staff, case workers, and center management staff about any Behavioral Health concerns and/or Behavioral Health referrals. The clinician may also review the pod's log book, incident reports and any major rule violations. The clinician also speaks directly with any youth who requests

services, youth who are confined, and youth who are serving extended cool-offs. In our experience, increasing the volume of clinical rounds contributed to decreasing numbers of Behavioral Health related crises and psychiatric hospitalizations.

#3 - Information on the providers, managers, and/or operators of the behavioral health care program, activity or service and any overlap in funding, to the extent it is known.

All the Providers and Managers in the Behavioral Health Department at the JTDC are Cook County Health employees. The JTDC Behavioral Health Program does not employ contractors or vendors to provide services.

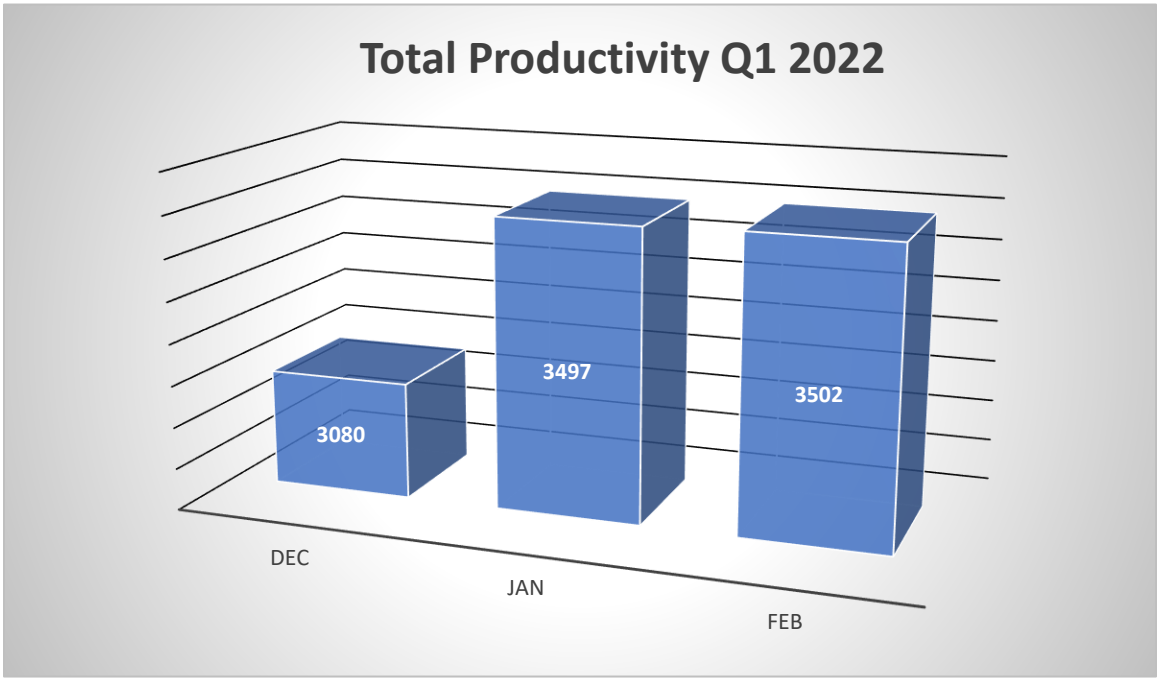
Operational and clinical leadership of the Department is carried out by the Juvenile Justice Behavioral Health Director and the Chief Psychologist.

Cermak BH staff at the JTDC (FTE) presently includes:

Juvenile Justice Behavioral Health Director	**1**
Chief Psychologist	**1**
Psychiatrists	**1.5**
Psychologists	**4**
Postdoctoral Fellows	**2**
Psychiatric Social Workers	**2**
Mental Health Specialists	**11**
Grand Total	**23.5**

Total behavioral health encounters and clinical activities over the last 18 months (compared to the previous year) were lower due to COVID-19. Restrictions on movement, social distancing requirements, and less access to the milieu meant fewer opportunities for face to face clinical encounters. That said, a significant increase in productivity was observed in the second quarter of 2021. In the third and fourth quarters there was a decrease in productivity and referral contact volume, likely due to recent turnover and a protracted job action effecting the majority of JTDC behavioral health staff. In the first quarter of 2022, an increase in both referrals and productivity has been observed.


Total Referrals Q1 2022
400
350
300
250
200
150
100
50
0
Dec
Jan
Feb
Total Referrals


Total Productivity Q1 2022
3080
3497
3502
DEC
JAN
FEB

#4 - Key performance indicators measuring the results of the program.

The overall goal of the program is to meet the mental, emotional, developmental and social needs of the JTDC residents using a biopsychosocial approach. As an accredited facility with the NCCHC, the JTDC Behavioral Health program must comply with all NCCHC Juvenile Standards. Success of the program is measured by:

- Proof of ongoing compliance with NCCHC Juvenile Standards (as measured by NCCHC during accreditation surveys)
- Adherence to established protocol / practice guidelines outlined in the CCH Health Policy Manual:
    - Administration of the Behavioral Health Intake Screening and Initial Treatment Plan within 72 hours of admission
    - Completion of master treatment plan for all MHFU residents within 10 days of being assigned to parent center
    - At least weekly individual therapy sessions for all MHFU residents
    - At least weekly psychoeducational groups on all JTDC living units
    - Daily rounds on all JTDC living units
    - Twice daily re-assessments for all residents on suicide precautions
    - Initial assessments for confined residents within 3 hours of confinement
    - Daily re-assessments for all confined residents
    - Weekly multidisciplinary staffings for all residents on MHFU
    - Response to all non-emergency referrals within 24 hours
    - Immediate response to all emergency referrals
    - Daily wellbeing checks for all residents on the RESET pod
    - Power Source groups twice weekly for all residents on the RESET pod
    - Daily follow up encounters for all residents housed on the Stabilization Unit

- Results of ongoing program evaluation initiatives including quarterly Continuous Quality Improvement (CQI) meetings, annual CQI studies (e.g. Chronic Disease Protocols Study, Annual Resident Survey, etc.) and annual peer review exercises
- Ongoing monitoring of psychiatric crises at the facility and related outcomes

Specific Mental Health Contacts	Q1 Sum
Intakes	225
Referrals	995
Individual Therapy Sessions	690

#5 - Quality measures or expectations for contracts involved in the program, where applicable

Not applicable

#6 - Information on how the care being provided in this program serves the best interests of the patient/recipient of care as well as the communities where the patient/recipient of care or services resides.

Detention facilities often fill the gap in services caused by the paucity of accessible Mental Health programs available to some of the most disenfranchised populations in our communities. The JTDC is the largest single site juvenile detention facility in the country and as such it provides a high volume of needed services to justice involved youth in Cook County.

Frequently, when youth enter the JTDC, they have acute and pressing MH needs related to housing insecurity, violence, lack of social support, poverty, and other social determinants of mental health.
A high percentage of these youth have trauma histories (research suggests over 90%) and many have substance use disorders. As such, thorough assessment and stabilization and patient safety are primary foci of the JTDC Behavioral Health program.

Detained youth who suffer from mental illness are also at an increased risk of self-injury/suicide. By providing a comprehensive scope of services to these individuals, the JTDC Behavioral Health Program mitigates this risk. All initial evaluations are conducted with specific attention to suicide risk factors. Along the spectrum of Behavioral Health care at the JTDC, from Intake to the point of release, youth receive numerous suicide risk screenings and assessments.

#7 - Information on how the continuum of care may be addressed through this program.

In 2015, the Office of the Chief Judge asked the Chapin Hall Center for Children at the University of Chicago (Chapin Hall) to conduct an independent review of relevant mental health screening, assessment, referral, and service delivery practices, and make recommendations to help the Office of the Chief Judge achieve an integrated system of mental health for youth involved with the Juvenile Justice Division of the Cook County Circuit Court. Specific deliverables included recommendations for addressing problem areas based on a comprehensive review of how current mental health screening, assessment, referral processes and relevant clinical interventions function in comparison to evidence from existing literature about best practices.

Cook County Health (CCH) entered into a Memorandum of Understanding (MOU) with the Office of the Chief Judge (OCJ) on July 17, 2018. Per the MOU, which was based in part upon recommendations from Chapin Hall, it is the intent of the OCJ to create an integrated Behavioral Health delivery system that improves the collaboration among the OCJ's youth-serving departments, increases care coordination, and implements the reforms necessary to enhance current BH services. It is also the goal of the OCJ and CCH to promote continuity and comprehensiveness across the continuum of clinical intervention points within the BH delivery system. The purpose of creating this singularly-focused, integrated system is to enable the OCJ and CCH to better align services with the BH needs of court-involved youth.

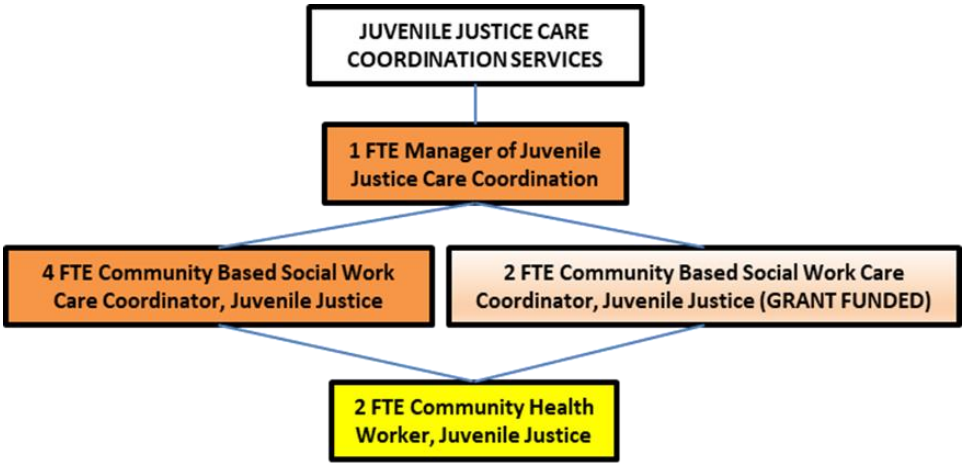
Behavioral Health services have historically been provided across multiple clinical intervention points within the three youth-serving departments that are under the authority of the Chief Judge. Each of these clinical intervention points represents an opportunity 1) to identify youth needs through screening and assessment; and 2) to refer youth to appropriate follow-up services. These services, including screening, assessment, and related interventions, have been provided by multiple individuals, including court employees, contracted on-site providers, and community-based providers. At the time the MOU was signed, these independent organizations had no formal unifying structure, which has resulted in missed opportunity for the continuity and cohesiveness of services.

Cook County Health has created an infrastructure that promotes ongoing collaboration, communication, planning and oversight across the juvenile justice behavioral health system of care. To this end, CCH created three primary committees/workgroups that have been participating in the design and planning of an enhanced juvenile justice system of care and are providing ongoing monitoring to ensure system goals are achieved and that innovation continues to be part of the new culture. Specifically, CCH launched: The Juvenile Justice Behavioral Health Clinical Steering Committee (11/30/18), the Behavioral Health Stakeholder Advisory Workgroup (4/19/19), and the Quality Assurance Workgroup (5/29/19).

One of the primary concerns noted by Chapin Hall was the lack of cohesive communication and coordination between system actors in Cook County. This has resulted in a disjointed system of care where redundant efforts have resulted in both inefficiency and confusion. On February 20, 2019, CCH presented a systems review of care coordination in Cook County's juvenile justice

system to the JJBHCSC. CCH included an overview of the care coordination system being utilized by the CCH Integrated Care Department. The committee unanimously agreed that care coordination will be critical if improved outcomes for justice involved youth are to be realized. The core principle of integration is also consistent with the CCH mission to deliver integrated health services.

In early 2020, CCH launched the **Juvenile Justice Care Coordination Program (JJCC)**, headed by a Manager of Juvenile Justice Care Coordination to provide both assessment and care planning services for justice involved youth, including those housed at the JTDC. Supported by Community Health Workers, the care coordination team has the ability to effectively connect youth to CCH based and other community behavioral health services. The following diagram represents the structure of the care coordination team:



	Q1 2022
Incoming Referral details:	
Referral Type:	
General:	42
Deferred Prosecution:	12
Referral Source:	
Probation Officer	20
Public Defender/Defense Attorney	0
Education Attorney	2
State's Attorney	12
Cermak	10
Juvenile Court Clinic	10
IDJJ After Care	0
Chicago Police Department	0
Community Partner	0
Guardian	0
Self	0
Other	0

Outcomes for the JJCC's Deferred Prosecution referrals are being independently evaluated by Chapin Hall. Preliminary recidivism findings are very positive but more rigorous evaluation still needs to be completed.

#8 - Information on the best practices in this type of programming.

As an accredited facility with the NCCHC, the JTDC Behavioral Health program must comply with all NCCHC Juvenile Standards. Success of the program is measured by:

- Proof of ongoing compliance with NCCHC Juvenile Standards (as measured by NCCHC during accreditation surveys)
- Adherence to established protocol / practice guidelines outlined in the CCH Health Policy Manual:
    - Administration of the Behavioral Health Intake Screening and Initial Treatment Plan within 72 hours of admission
    - Completion of master treatment plan for all MHFU residents within 10 days of being assigned to parent center
    - At least weekly individual therapy sessions for all MHFU residents
    - At least weekly psychoeducational groups on all JTDC living units
    - Daily rounds on all JTDC living units
    - Twice daily re-assessments for all residents on suicide precautions
    - Initial assessments for confined residents within 3 hours of confinement
    - Daily re-assessments for all confined residents
    - Weekly multidisciplinary staffings for all residents on MHFU
    - Response to all non-emergency referrals within 24 hours
    - Immediate response to all emergency referrals
    - Daily wellbeing checks for all residents on the RESET pod
    - Power Source groups twice weekly for all residents on the RESET pod
    - Daily follow up encounters for all residents housed on the Stabilization Unit

The two primary goals of the JTDC Behavioral Health Strategic Plan are to increase the availability of behavioral health services to justice involved youth and to enhance those services already in place by introducing more evidence based practices (EBP). A core, guiding principle for this reform effort, EBP is also consistent with CCH's larger vision to provide high quality care to the residents of Cook County. Two areas for EBP enhancement that are being targeted specifically are trauma treatment and substance use treatment. On March 30th 2019, the Juvenile Justice Behavioral Health Steering Committee (JJBHCSC) reviewed results of a EBP systems review conducted by CCH. As a result, the committee discovered several opportunities for collaboration around EBP in the areas of substance abuse treatment and trauma treatment. Today, the JTDC has the following EPB in place:

- Power Source: Taking Charge of Your Life (emotional literacy based EBP)
- Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
- Trauma Grief Component Therapy for Adolescents (TGCTA)
- Maryville Academy Substance Abuse Programming

#9 - Information detailing meetings and coordination on patient identification, programs and goals with other Cook County agencies, City of Chicago or other partners or entities on this program, where applicable

The Juvenile Justice Behavioral Health Clinical Steering Committee (JJBHSC) is composed of designees from CCH, the OCJ, Juvenile Temporary Detention Center (JTDC), the Juvenile Probation Department (JPD) and the Cook County Juvenile Court Clinic (CCJCC) operated by Northwestern University. The initial charge of this committee is to oversee the development of the strategic plan to implement the vision for an evidence-based and responsive system of care (as outlined in the MOU). Both the Behavioral Health Stakeholder Advisory and Quality Assurance Workgroups report up to this oversight committee. As opportunities arise for collaboration, this committee will serve as a screening and decision-making body that will determine the roles in these initiatives. In addition, this committee provides a platform for cross-office communication and problem solving for internal issues that arise within the system of care. The JJBHSC is chaired by the Juvenile Justice Behavioral Health Director and convenes monthly.

The Behavioral Health Stakeholder Advisory Workgroup (SAW) is composed of leadership staff representatives from the OCJ, JTDC, CCJCC, community behavioral health providers, individuals representing youth and families with lived experience receiving services within the juvenile justice system, and care manager representation from organizations serving youth and families within Cook County. This workgroup provides a forum for stakeholders to provide feedback to the juvenile justice system regarding the success or challenges specific to the strategic changes to the system of care. In addition, the workgroup provides ongoing feedback on initiatives adopted by the Court and review outcomes. Select membership on the workgroup ensures the Court is apprised of collaborative opportunities for both state and local initiatives. Lastly, this workgroup has the opportunity to review outcome measures prioritized by the Quality Assurance Workgroup, assisting in holding the system of care accountable.

Facilitated by the Juvenile Justice Behavioral Health Director, **the Quality Assurance Workgroup** (QAW) is composed of representatives from the OCJ, JTDC, JPD, and the CCJCC. The primary charge of the QAW is to determine the quality measures to be collected by the system of care, inclusive of the juvenile justice system and specialty community behavioral health provider network and review these measures to ensure the system is achieving goals set out in the strategic plan.

#10 - An evaluation of the program and an overview of any overlap in outreach, communities served, and programs with other Cook County and City of Chicago Agencies, and an evaluation of the impact of the program and an overview of its effectiveness, particularly as it pertains to vulnerable populations, racial and ethnic minorities; and populations facing disparities in behavioral health outcomes, behavioral health care, and behavioral healthcare access.

#11 - Information with the costs associated with the program(s) and funding source(s)

Program costs are budged for via CCH budget. The JJCC was awarded some grant funding via the OJJDP that will help to expand the program.

#12 - Any additional information which may facilitate the Committee's understanding of the program, initiative, or activity

None

#13 - Any additional information which may foster a more accurate assessment of behavioral health care needs and opportunities for collaboration or growth within the Cook County Government entity's behavioral health care programs.

None

#14 - Any additional information if patients receive follow up care at a Cook County hospital including medication management as a part of aftercare.

Youth who were taking psychotropic medications at the JTDC are provided with 30 days' worth of their medications. JTDC coordinates with JSH that youths psychotropics (as well as medications prescribed for physical problems) are e-prescribed to the agreed upon locations.

Cook County Department of Public Health

#1 - General information on the population served, including how patients were identified or applied for services, a breakdown of where patients of the program(s) reside in Cook County and the number of patients served over the last 24-month cycle

Through the **ARPA (American Rescue Plan Act) Behavioral Health Expansion**, Cook County Department of Public Health (CCDPH) Behavioral Health Unit will expand existing mental health and substance use prevention and treatment programs through community based organizations (CBOs) and local partners in priority communities in suburban Cook County (SCC) in five areas: suicide prevention, youth-focused programs, upstream approaches to behavioral health, community-based counseling and treatment, and behavioral workforce development. Priority will be placed on expanding the capacity for organizations serving under-resourced communities in suburban Cook County to provide essential services and programs to address the needs created and exacerbated by the COVID-19 pandemic.

The ARPA **Sustaining Mental Health Hotline for Suburban Residents Initiative** in the Behavioral Health Unit is expanding NAMI's existing mental health support and crises line in the city of Chicago to provide support and referrals for suburban Cook County residents. The hotline will be staffed seven days a week and is expected to field 3,500-4,000 calls per year from suburban Cook County. The hotline will provide emotional support, referrals to appropriate mental health and substance use resources, and intensive case support for callers with significant needs through its clinical support program. While the hotline will serve any resident calling from suburban Cook County, outreach to promote the Helpline will be focused on communities identified by CCDPH as being vulnerable to the impacts of COVID-19 based on the COVID-19 Community Vulnerability Index.

The Behavioral Health Unit will expand its existing opioid-involved overdose prevention activities through its ARPA **Opioid Overdose and Substance Use Prevention Initiative** will build on existing opioid-involved overdose prevention activities to substantially expand harm reduction services in suburban Cook County and address the impact of COVID-19 on opioid and substance use disorder. A qualitative assessment completed by partner agency UIC has revealed harm reduction services are almost non-existent in suburban Cook County. The initiative will include 1) naloxone distribution, safer supply distribution, and harm reduction counseling via technical assistance and capacity-building support for harm reduction services in the South and West suburbs where harm reduction non-profits are very rare, and 2) expanded initiatives to leverage existing and new data sources to gain a better understanding of the illicit drug market to inform opioid- involved overdose prevention efforts, including passive toxicosurveillance in partnership with Cook County Health (CCH) and new and expanded community-based drug checking services. All opioid programs and activities are focused in areas that are at higher risk for opioid-involved overdose. A comprehensive analysis completed by UIC with funding support from CDC Overdose Data to Action (OD2A) indicates that the ZIP codes hit hardest by the opioid epidemic have substantially lower median household incomes ($56,430 vs. $79,313) and correspondingly higher poverty rates (12.7% vs 7.8%).

Through grant funding for the **Opioid Overdose and Substance Use Prevention Initiative**, the Behavioral Health Unit currently supports a deflection program with a local partner, TASC. Deflection, also known as pre-arrest diversion, routes people with substance use and mental health disorders to treatment as an alternative to incarceration. Between December 1, 2021, and February 28, 2022, TASC deflection specialists averaged 8 unique clients each per month who received outreach and engagement services around treatment and care. From the program start in March 2021 to February 28, 2022, TASC has successfully placed three people in substance use treatment. TASC is currently implementing deflection with two law enforcement agencies in Harvey and Justice. Two additional law enforcement agencies are in the process of action planning for deflection implementation. TASC has identified an additional 4 new law enforcement agencies who are interested in creating a deflection program.

#2 - Overall goals of behavioral health program(s) including goals unique to the specific population served

- Increase the percentage of suburban Cook County residents with access to behavioral health services, support, and treatment
- Advance the behavioral health of suburban Cook County's children, youth, and their families by supporting and expanding initiatives that directly support prevention approaches
- Establish a SCC Behavioral Health Advisory Council to uplift community voices and provide input on departmental initiatives to promote an inclusive, transparent, and comprehensive approach to behavioral health in suburban Cook County
- Develop a SCC Behavioral Health and Policy Database to analyze and track trends in behavioral health risk factors, needs, and services to develop recommendations for policy, programs, and interventions
- Increase the percentage of suburban Cook County residents with access to harm reduction services, support, and treatment

#3 - Information on the providers, managers, and/or operators of the behavioral health care program, activity or service and any overlap in funding, to the extent it is known.

The Behavioral Health Unit will utilize a variety of treatment and social service providers and local CBOs that are committed to addressing mental health and substance use holistically, equitably, and with respect. The Behavioral Health Unit is not aware of any overlap in funding.

#4 - Key performance indicators measuring the results of the program

The Behavioral Health Expansion Initiative

- Increase the percentage of suburban Cook County residents with access to behavioral health services, support, and treatment
    - By November 30, 2026, expand community-based treatment, group therapy, and counseling options, including Living Rooms, in at least two priority communities.
    - By November 30, 2026, address workforce shortages and insufficient diversity in behavioral health by administering grants for paid internships, trainings, and provider incentives to bring providers to under-resourced communities in suburban Cook County.
    - By November 30, 2026, support initiatives that increase the availability of housing, transportation, and other wrap –around services for people with a substance use disorder or mental illness.
- Advance the behavioral health of suburban Cook County's children, youth, and their families by supporting and expanding initiatives that directly support prevention approaches
    - By 2025, expand and/or launch youth-based programming and/or mental health resources to support children at-risk for experiencing mental health symptoms.
    - By 2025, increase the number of suicide prevention programs in schools and community-based organizations.
    - By 2025, support three suburban Cook County community level initiatives that address upstream drivers of behavioral health and community traumas.
- Establish a SCC Behavioral Health Advisory Council to uplift community voices and provide input on departmental initiatives to promote an inclusive, transparent, and comprehensive approach to behavioral health in suburban Cook County
    - By November 30, 2024, the SCC Behavioral Health Advisory Council will review public health data and evidence-based strategies, and promote equitable prevention programs, support, and treatment for suburban Cook County residents.
    - By November 30, 2026, the SCC Behavioral Health Advisory Council will provide action steps, identify funding streams for the Behavioral Health Unit, local agencies, and community partners to work together and to improve behavioral health prevention programs, support, and treatment.
- Develop a SCC Behavioral Health and Policy Database to analyze and track trends in behavioral health risk factors, needs, and services to develop recommendations for policy, programs, and interventions
    - By November 30, 2025, the SCC Behavioral Health and Policy Database will inform the Behavioral Health Unit’s program and policy work, and serve as a resource for accessible, accurate data for the suburban Cook County residents, agencies, and organizations to track trends and monitor progress and impact of public health policies, programs, and intervention.

Sustaining Mental Health Hotline for Suburban Residents

- Increase the percentage of suburban Cook County residents with access to behavioral health services, support, and treatment
    - By November 30, 2023, the Mental Health Hotline will provide mental health support to 3,500-4,000 calls per year from SCC

The Opioid Overdose and Substance Use Prevention Initiative

- Increase the percentage of suburban Cook County residents' access to harm reduction services, support, and treatment
    - By November 30, 2025, increase the number of naloxone kits distributed in SCC.
    - By November 30, 2026, increase the number of CBOs and agencies able to provide harm reduction services in SCC
    - By November 30, 2026, increase the number of CBOs with the ability to host drug-checking services on site and/or provide samples for analysis
    - By November 30, 2026, create a better public alert system with public harm reduction education materials about novel emerging substances

Currently the Behavioral Health Unit in partnership with TASC has been tracking the following indicators for clients who are referred to the deflection program monthly.

- Average case load per deflection specialist & number of encounters per client receiving deflection specialist outreach and engagement
- Number of clients enrolled in TASC case management (by race/ethnicity, sex, and age)
- Number of clients successfully placed in a treatment program

The Behavioral Health Unit is also currently tracking the following metrics for law enforcement agency training on overdose reversal and naloxone distribution:

- Number of law enforcement agencies who receive the overdose reversal training video from TASC each month
- Number of law enforcement officers who complete certification on the training video (pre/post survey on confidence and knowledge)
- Number of law enforcement agencies receiving naloxone kits each month
- Total number of naloxone kits distributed per law enforcement agency by month.

#5 - Quality measures or expectations for contracts involved in the program, where applicable

Expectations are identified in the scope of work that is included in the contracts with CCDPH.

#6 - Information on how the care being provided in this program serves the best interests of the patient/recipient of care as well as the communities where the patient/recipient of care or services resides.

The Behavioral Health Unit recognizes that addressing structural racism is necessary to achieve health outcomes for all residents of suburban Cook County. Racism, ethnicity, and geography are major drivers of whether a community member will have access to affordable healthcare, safe housing, gainful employment, or high-quality education. Structural inequities and the role of systemic racism in perpetuating inequity have become more apparent in light of the COVID-19 pandemic. The Behavioral Health Unit's ARPA initiatives will align with the WePlan 2025, the community health improvement plan, which was developed with input from a wide range of partner organizations; more than 2000 residents, and public health and healthcare professionals; as well as our ongoing dialogue with community-based partners and residents of suburban Cook County. Our initiatives will help us continue work to advance health equity in our jurisdiction and we will engage community members in developing, implementing, and evaluating the initiatives.

#7 - Information on how the continuum of care may be addressed through this program.

The Behavioral Health Unit will promote the creation of sustainable and effective linkages between community partners, agencies, and organizations to fill gaps and improve access to needed services throughout suburban Cook County. For example, in the mental health hotline will refer callers to appropriate mental health and substance use resources, assist in connecting to other social services when needed, and work to improve current listings and add additional resources to the SCC Behavioral Health Database to best serve the callers. The hotline will also provide intensive case support for callers with significant needs using its Clinical Support program. Another example of how the Behavioral Unit addresses the continuum of care through its deflection program is with TASC's deflection specialists who provide clients with support for food, housing, transportation, and other needs to address common barriers to accessing and staying in treatment.

#8 - Information on the best practices in this type of programming

Where feasible, the Behavioral Health Unit will develop grant parameters to fund evidence-based or evidence-informed programs and services. For instance, grants to establish or expand suicide prevention programs will be limited to strategies identified in the Centers for Disease Control and Prevention's Technical Package on Suicide Prevention.

The Behavioral Health Unit is also preparing a series of harm reduction research briefs to compile all of the evidence and research for best practices in the field. The goal of the harm reduction research briefs is to compile research and evidence-based best practices for harm reduction in concise, easily digestible formatting that is accessible to both policymakers and practitioners on the ground. Our hope is the briefs will help to guide more widespread adoption of evidence-based harm reduction practices. The first brief in this series, on Overdose Prevention Sites (OPS), was released with a media availability event on February 23, 2022. The final version of the brief can be found on the CCDPH Behavioral Health Opioids webpage, under the CCDPH Opioid Reports sidebar. Future briefs will cover topics such as: medications for opioid use disorder (MOUD); cannabis treatment for opioid use disorder (OUD); availability of naloxone outside of pharmacies/physicians; access to clean needles, drug paraphernalia, and safe administration information; and drug checking services, including fentanyl test strips.

#9 - Information detailing meetings and coordination on patient identification, programs and goals with other Cook County agencies, City of Chicago or other partners or entities on this program, where applicable

The Behavioral Health Unit serves as Cook County Department of Public Health's liaison with local, state, and national organizations on matters involving behavioral health and substance use and represents CCDPH on advisory boards, work groups, taskforce, and consortia for related initiatives, such as the Illinois Children's Mental Health Plan, Illinois Opioid Crisis Advisory Council, Illinois Department of Human Services, Illinois Department of Public Health, Chicago Department of Public Health, and local health departments.

The Behavioral Health Unit convenes a Suburban Cook County Opioid and Substance Use Advisory Council to inform our opioid related efforts and participate in opioid-related work groups. The Advisory Council includes representatives from state and local agencies, substance use treatment providers, harm reduction advocates, and recovery home providers.

The Behavioral Health Unit will establish a SCC Behavioral Health Advisory Council to uplift community voices and provide input on departmental initiatives to promote an inclusive, transparent, and comprehensive approach to behavioral health in suburban Cook County.

#10 - An evaluation of the program and an overview of any overlap in outreach, communities served, and programs with other Cook County and City of Chicago Agencies, and an evaluation of the impact of the program and an overview of its effectiveness, particularly as it pertains to vulnerable populations, racial and ethnic minorities; and populations facing disparities in behavioral health outcomes, behavioral health care, and behavioral healthcare access.

Based on data provided by TASC, the Behavioral Health Unit will evaluate disparities in outcomes for people engaged by the deflection program. The data will be analyzed by race and ethnicity, sex; and age. To date, TASC has established deflection protocols in two communities, Harvey and Justice, and is in the process of establishing deflection protocols with additional law enforcement agencies as discussed in Question #1.

Between December 1, 2021 and February 28, 2022, TASC's outreach specialists have worked with an average of 8 unique outreach clients per month. TASC has found that it often takes a minimum of 10 visits with clients to build trust, especially as many of their clients have been traumatized by previous encounters with substance use treatment. Outreach clients may receive up to 20 outreach visits in a month to build this rapport.

#11 - Information with the costs associated with the program(s) and funding source(s)

The Behavioral Health Unit will receive ARPA funding to launch the Behavioral Health Expansion Initiative, Sustaining Mental Health Hotline for Suburban Residents, and bolster its Opioid Overdose and Substance Use Prevention Initiative.

Funding for the current deflection referral program flows from two sources: the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Chicago Department of Public Health via the Centers for Disease Control and Prevention (CDC (Centers for Disease Control)). CDC dollars fund the planning of the deflection protocols, and the SAMHSA dollars fund the implementation of those protocols, including the support of individuals referred to the program and supported by the deflection specialists. TASC is budgeted for $1,080,184 for four years through SAMHSA funded work, and $450,000 at three years for the CDC funded work.

#12 - Any additional information which may facilitate the Committee's understanding of the program, initiative, or activity.

TASC has experienced difficulties engaging new law enforcement agencies in deflection implementation planning for a variety of external reasons. One reason previously discussed is COVID-19 masking protocols – when the chief of a law enforcement agency opts not to implement mask requirements for staff, TASC is not able to visit the site in-person due to health safety concerns for deflection specialists. Additionally, officer-involved shootings in some areas have delayed deflection implementation action planning due to civil unrest.

The deflection program is part of a larger CCDPH initiative to prevent opioid overdose. The initiative has three other components:

- Training on opioid-involved overdose and naloxone use for community-based organizations and law enforcement agencies
- Distribution of naloxone to community-based organizations and priority law enforcement agencies
- Quantitative and qualitative data collection on opioid use, opioid use disorder, and opioid-involved overdose to help inform public health efforts.

Between December 1, 2021 and February 28, 2022, CCDPH distributed 352 naloxone nasal spray kits (NARCAN®) to 5 law enforcement agencies and first responders throughout suburban Cook County. During this same period at least 8 new law enforcement agencies received the video on fentanyl safety training from TASC, and 37 law enforcement officers completed certification on fentanyl safety, recognizing the signs of an opioid-involved overdose, and naloxone administration.

CCDPH also began distributing naloxone to community-based organizations in 2021, and between December 1, 2021, and February 28, 2022, provided 7 community-based organizations with 105 naloxone kits for use by personnel. Priority community-based organizations to receive naloxone include those providing housing and shelter services, domestic violence resources, and mental health and substance use treatment services.

To date, 19 reports of naloxone administration for opioid-involved overdose reversal have been reported in the Illinois Saves Overdose database by organizations who were trained by and/or received naloxone from CCDPH. In 6 of these instances, multiple doses of naloxone were required to reverse the opioid-involved overdose. 18 uses of naloxone administration were reported by law enforcement agencies, and 1 by a community-based organization.

More information about the program, as well as data reports on opioid use in CCDPH's jurisdiction, is available at: https://cookcountypublichealth.org/behavioral-health/opioids/.

#13 - **Any additional information which may foster a more accurate assessment of behavioral health care needs and opportunities for collaboration or growth within the Cook County Government entity's behavioral health care programs.**

The Behavioral Health Unit will develop a SCC Behavioral Health and Policy Database to analyze and track trends in behavioral health risk factors, needs, and services to ddevelop recommendations for policy, programs, and interventions.

The Behavioral Health Unit will also be working with NAMI Chicago to expand NAMI Chicago's Mental Health Hotline to suburban Cook County. NAMI will be expanding their list of referral partners to include suburban mental health and substance use treatment partners and other social service organizations and anticipated to response to about 3,500 calls from suburban Cook County per year.

#14 - **Any additional information if patients receive follow up care at a Cook County hospital including medication management as a part of aftercare.**

TASC utilizes a variety of treatment and social service providers and may refer to medication-assisted treatment services at Cook County Health ambulatory care clinics.