Description of the Issue

Persons with mental illness (MI) and substance use disorder (SUD) are more likely to engage with the criminal justice system for non-violent crimes.[1] Many end up spending time in jail, where their conditions can be exacerbated, when what they really need is treatment. In cases where mental illness or co-occurring mental health and substance use disorders (CMISA) may be at play, this could be worse. In the United States, it is estimated that almost 20 percent of the population in correctional settings have a mental health disorder. In counties across the U.S., the number of people with mental illness in jails has now outnumbered the number of patients in their psychiatric hospitals.[2]

Youth in the juvenile justice system also experience a prevalence of mental health and substance use disorders. A number of studies point to the overrepresentation of youths with mental/behavioral health disorders, some suggesting that about two thirds of youth in detention or correctional settings have at least one diagnosable mental health problem, compared with an estimated 9 to 22 percent of the general youth population.[3] Some posit that as many as 70 percent of youths have a diagnosable mental health problem at certain contact points in the system. Additionally, a systematic review by Fazel and Langstrom (2008) found that youths in detention and correctional facilities were almost 10 times more likely to suffer from psychosis than youths in the general population. The Cook County juvenile justice system is no different. In a 2013 study, a research group at Northwestern University found that in a group of 1,800

[1] NAMI, 2019
[2] The Stepping Up Initiative
[3] Office of Juvenile Justice and Delinquency Prevention (2017) https://www.ojjdp.gov/mpg/litreviews/Intersection-Mental-Health-Juvenile-Justice.pdf

youths who were arrested and detained in Cook County, 46 percent of males and 57 percent of females had two or more psychiatric disorders.[4]

Cook County Health (CCH) operates correctional healthcare services for Cook County Jail and the Juvenile Temporary Detention Center (JTDC). CCH has recognized this as a persistent issue within our population and has been a leader in solving this dilemma. In September of 2017, Cook County was awarded the Justice and Mental Health Collaborative (JMHCP) Category I grant for adults and set out to reform its bond system. That funding identified the system's gaps through a Sequential Intercept mapping process; the strongest opportunity for improvement across all intercepts was to better align existing work and to strengthen linkages to community care. Through the JMHCP and MacArthur Safety + Justice Challenge, stakeholders have been regularly convening to work around issues of criminal justice, recidivism reduction and focusing on clients with mental illness. In October 2019, Cook County Health was awarded JMHC Category 3 grant to expand efforts of diversion of MI and CMISA defendants. In partnership, the court, Public Defender's Office, State's Attorney Office, provider partners and Illinois Department of Human Services developed and piloted a process by which misdemeanor adult defendants who demonstrate significant mental or behavioral health issues be referred directly to community-based (rather that detention-based) clinical services aimed at addressing mental illness, rather than being referred for a fitness evaluation and potential detention-based treatment seeking to restore them to fitness. Using innovative court orders, modified I-bonds and mobile crisis team dispatch, the project diverts clients to mental, behavioral and opioid use treatment and link to further social supports. In January 2020, the

[4] Office of Juvenile Justice and Delinquency Prevention (2017) https://www.ojjdp.gov/mpg/litreviews/Intersection-Mental-Health-Juvenile-Justice.pdf

program had a total of 99 referrals, 95 to outpatient care and 4 to inpatient. Of the 99 referrals, 24 cases had been successfully discharged. Under the Juvenile Justice and Mental Health Collaboration Program, Cook County Health's Juvenile Temporary Detention Center (JTDC) aims to increase public safety by facilitating cross-system collaboration among juvenile justice, mental health, and substance abuse agencies to improve responses and outcomes for justice-involved youth with MI and CMISA.

The residents of the JTDC range from ages 13-18 with 83% African American and 13% Hispanic and 90 % male, 10% female. The average length of stay for residents in the JTDC is 15-30 days. As of May 2019, 47% of the JTDC population had an active psychiatric disorder. The most common mental health issues observed among JTDC residents include: adjustment issues, anxiety and mood disorders, ADHD, substance abuse, conduct and oppositional disorders, and trauma/Post Traumatic Stress Disorder (PTSD). Cook County Health has partnered with the Behavioral Health Consortium (BHC) to provide mental health and substance use disorder treatment for patients in the community.

Project Design and Implementation

Priority Considerations

CCH is one of the nation's largest public integrated healthcare delivery systems serving the 132 contiguous urban and suburban municipalities of Cook County including the City of Chicago. CCH operates two hospitals, fifteen community health centers, correctional healthcare services for the county jail and juvenile detention center, a comprehensive medical home for patients with HIV/AIDS, and the Cook County Department of Public Health (CCDPH) serving suburban Cook County. As of 2014, CCH also administers CountyCare, a Medicaid managed care plan for Cook County residents, which serves nearly one in every 10 Cook County residents

with Medicaid. CCH's patients are some of the most economically disadvantaged and disconnected from regular care in the region, evidenced by the high proportion of those who are uninsured.

The majority of CCH patients are urban, low socioeconomic status, and often underemployed or unemployed with a high school education or less. They are also of minority status—10.4% are Non-Hispanic White, 78.6% Non-Hispanic Black, 0.5% Non-Hispanic Asian/Pacific Islander, and 9.3% Hispanic. About 5% of patients are foreign-born and 3.6% have limited English proficiency (40% of our patients used an interpreter). 55.61% identify as female, 44.36% as male, 0.02% as transgender and 0.01% unknown. For sexual orientation, 2.3% identify as bisexual; 4.3% as lesbian, gay, or homosexual; 81.2% as straight/heterosexual; and 12.11% did not want to disclose. While more patients have become insured under the ACA, many of our patients remain underinsured & uninsured (60%).

This program will serve clients hailing from qualified opportunity zones. Of the State of Illinois' 327 Qualified Opportunity Zones, 181 are in Cook County. This grant will also serve individuals who reside in high-poverty areas. In Chicago, 20.6% of the population lives below the poverty line[5], mostly concentrated in neighborhoods on the west and south sides of the city where the poverty rate ranges from 40-60%[6]. Cook County Health is strategically placed on the south and west sides to best serve these vulnerable communities.

Collaborating Stakeholders

The Juvenile Justice Care Coordination (JJCC) team at the Juvenile Temporary Detention Center (JTDC) at CCH will lead this initiative with additional stakeholders participating in the

[5] Data USA, 2020
[6] US Census data, 2010

planning, implementation and evaluation processes- the Behavioral Health Consortium (BHC)- a network of behavioral health provider, the Cook County Office of the Chief Judge (OCJ), the State's Attorney's Office (SAO), and the Public Defender's Office. CCH and OCJ have lead multiple initiatives to decrease incarceration rates in Cook County and has helped foster relationships, collaboration and a platform to report out initiatives. Criminal justice agencies, medical and behavioral health providers, other social support providers and people with lived experience are represented in this team.

Timeline: Please see Attachment.

Phase 1 – Planning: The planning phase will focus on establishing a shared language through training line-level stakeholders and establishing criteria and structure for the proposed project. This planning phase will take six months.

1. Conduct cross-systems specialized training for criminal justice stakeholders. Cross-systems specialized training will equip line-level criminal justice and behavioral health practitioners to provide and support evidence-based services across systems. Training will focus on signs/symptoms of MI/CMISA in adolescents, broad training relating to MI/SUD/trauma in adolescents, criteria for referrals to the Juvenile Justice Care Coordination (JJCC) team Medicaid eligibility and enrollment, and social determinants of health.
2. Examine the target population and set concrete clinical and criminal justice involvement inclusion and exclusion criteria for referrals. Develop consensus among stakeholders regarding definitions of MI/CMISA for referral purposes. Develop a workflow for referrals/adolescents navigating the system as identified grant participants
3. The basic inclusion criteria include:

a. Diagnosis with a MI or CMISA or manifest obvious signs of MI or CMISA during arrest or confinement or before any court;
b. Unanimously approved for participation in this pilot by relevant State's Attorney's Office, Public Defender's Office, probation or corrections official, judge, and a representative from CCH'S JJCC team, and having been determined by each of these relevant individuals to not pose a risk of violence to any person in the program, or the public;
c. Have not been charged with or convicted of any sex offense or any offense relating to the sexual exploitation of children, or murder or assault with intent to commit murder.

4. Examine potential relationship between the Juvenile Risk Assessments (Ohio Youth Assessment System) being completed by Juvenile Probation (JPD) and the assessments/screening completed by JJCC team in order to effectively stratify risk to identify appropriate grant participants.
5. Hire grant funded care coordinator(s) to specialize in screening/assessment and who will provide immediate screening and assessment of adolescents identified in court as meeting criteria, as a part of CCH's JJCC team. These individuals will be present and available as needed for mobile assessment.
6. Develop a detailed expansion plan and timeline for the Implementation phase.
7. Complete and submit the new P&I guide.

Phase 2- Implementation: After BJA approves the P&I Guide developed by the grantee during Phase 1, remaining grant funds will be used to support the following activities:

1. An identified/specific court room(s) will host as the pilot. This allows for expansion of existing efforts of JJCC, creating an increased collaboration in the court room through use of additional crisis response assessments through grant funded care coordinator(s) who specialize in screening and assessment. The JJCC team will collaborate with OCJ and JPD (via planning phase) to insure the utilization of the mobile crisis response, when appropriate. With the expansion of the program, implementation will be specifically tailored to the need of the court room.
2. Judges, attorneys, and youth probation officers will identify adolescents who fit needed criteria for referral to JJCC. All JJCC care coordinators will be experienced licensed clinicians that will be able to conduct initial mental health screenings and assess the behavioral health needs of the youth and family to create specific/individualized Care Plans to create a strength-based treatment plan. The screenings completed by the JJCC team are a structured interview, DSM-5 Level 1 Cross Cutting Symptom Measure, Child and Adolescent Trauma Screen (CATS), and the Child and Adolescent Service Intensity Instrument (CASII). The youth and identified community providers, accessed through the Behavioral Health Access Line (BHAL) will review the Care Plan at specific time frames which will be determined by the level of care needed for each youth, with grant participants required to be in the high risk category. The overarching goal will be to assess the appropriate level of care for each youth and provide effective case management services to insure warm hand offs to community providers. Assessment tools include a structured interview used to score the IM+CANS (Illinois Medicaid Comprehensive Assessment of Needs and Strengths); identified DSM-5 Level 2 Cross Measures (PHQ-15; PROMIS (anger, anxiety, sleep, and depression), ARI, C-FOCI,

ASRM, ASSIST), and the Child and Adolescent Service Intensity Instrument (CASII). Care plans will be developed following a staffing of the youth/family, informed by the totality of all assessment tools, resulting in IM+CANS scores and will focus on use of youth/family strengths. Staffing will include all applicable parties including: youth, guardian, other supportive family, JJCC team members, probation officers, after care specialists (from Illinois Department of Juvenile Justice), identified community providers, DCFS caseworkers, mentors, detention providers, representatives from the youth's educational supports, and other identified supports.

3. If it is determined inpatient psychiatric hospitalization is warranted by the JJCC care coordinator, SASS will be contacted for further safety evaluation and placement. The overall goal of developing a partnership with SASS will be to ensure a youth is evaluated and placed when acute symptoms warrant an inpatient level of care. SASS will appropriately look for an inpatient adolescent unit and secure placement as needed.
4. JJCC care coordinators will maintain contact with BHAL providers throughout court involvement in order to provide updates on the case and then sends reports to the court, pursuant to HIPAA, mental health code and mental health confidentiality act. Should a youth/family refuse services or be non-complaint with services, care coordinators will share that information. If the youth is hospitalized during a specific court date; it will be waived or rescheduled until the youth is stable. The goal will be to have court appearances be held in a therapeutic manner and review with the youth his or her progress with the Specific Care Plan. If hospitalizations occur during involvement with the program, at the time of discharge from any psychiatric hospital, the care plan will be reviewed to ensure warm handoffs to identified community providers.

5. The JJCC team will assist youth and families applying for medical insurance. The JJCC team will also asses for social support needs and develop goals and referrals to resources, such as housing assistance, food assistance, etc.
6. The overarching goal of the JJCC team is a commitment to addressing barriers of health care access for low income people and how the lack of equitable access impacts the overall mental health of an individual. This will include having the youth and family actively participate in the development of the Care Plan to create ownership of their Plan. The JJCC team (comprised of care coordinators and community health workers) will be active participants with the youth and will assist with any lack of housing, food, transportation, and/or other basic needs not being addressed. The JJCC team will also provide reminders for court appearances, treatment appointments, and any barriers within the education system.

The following are **deliverables** for **Phase 2** of the proposed program:

1. Training will facilitate collaboration and enhance competency of personnel working with individuals who have MI in the criminal justice system. Training areas will include:
    a) Signs/symptoms of MI/CMISA in adolescents
    b) Broad training relating to MH/SUD/trauma in adolescents
    c) Criteria for referrals to the Juvenile Justice Care Coordination (JJCC) team
    d) Medicaid eligibility and enrollment
    e) Social determinants of health
2. The JJCC team will conduct screening, assessment, and information-sharing processes to identify individuals with MI or CMISA in order to appropriately inform decision-making and prioritize limited resources and identify needed capacity.

3. Case management and service coordination by JJCC team that is tailored to meet the assessed mental health, substance abuse, and trauma needs of youth.
4. The JJCC will determine eligibility for federal benefits for youth and enroll them in appropriate benefits.
5. The JJCC will work with the BHC as well as community partners to address social determinants of health that would be barriers for successful reintegration. Service provision and placement will be tracked.
6. The offering and enrollment of trainings that address developmental and learning disabilities and problems arising from a documented history of physical or sexual abuse of patients to the care coordinators will be tracked.
7. The provision of affordable legal representation for adolescents with MI/CMISA.
8. JJCC will evaluate the program identifying patient outcomes, system outcomes and any information that can be shared to advance the research on competency restoration across the country.

Use of Evidence Based Practices

The following evidence based practices are currently in practice by the JJCC and will be applied to the treatment of adolescents in this project. Implementation of these interventions will not be modified from its original form and the evaluator will monitor fidelity throughout the project.

Motivational Interviewing (MI): MI is an engagement approach focused on improving individuals' readiness for change, and when used in the earliest phases of treatment can have positive impacts on retention in the course of treatment. Staff will use MI to engage patients and enhance a sense of collaborative treatment with patients, fostering patient investment in care and specialty referrals. CCH does not see adaptations needed for this approach. The care coordinators

are all are trained in Motivational Interviewing. Motivational Interviewing is patient-centered, tailoring the intervention to the patient by incorporating the patient's current level of motivation, personal perspective, and perceived barriers. MI's patient-centeredness is ideal for this project given the diverse nature and multiple and complex needs of the target population.

Harm Reduction: Harm reduction incorporates a spectrum of strategies from safer use, to managed use to abstinence to meet drug users "where they're at," addressing conditions of use along with the use itself. Harm reduction refers to policies, programs and practices that aim to minimize negative health, social and legal impacts associated with drug use, drug policies and drug laws. Harm reduction is grounded in justice and human rights - it focuses on positive change and on working with people without judgement, coercion, discrimination, or requiring that they stop using drugs as a precondition of support and encompasses a range of health and social services and practices that apply to illicit and licit drugs. This evidence-based approach will not be modified.

Cognitive Behavioral Therapy (CBT): Cognitive behavioral therapy is a psycho-social intervention that aims to improve mental health. CBT focuses on challenging and changing unhelpful cognitive distortions (e.g. thoughts, beliefs, and attitudes) and behaviors, improving emotional regulation, and the development of personal coping strategies that target solving current problems. The Project Coordinator is a trained CBT therapist.

Illness Management and Recovery (IMR): Illness Management and Recovery is an evidenced-based practice designed to provide mental health consumers with knowledge and skills necessary to cope with aspects of their mental illness while maintaining and achieving goals in their recovery. IMR is a curriculum in which a trained mental health practitioner or trained peer specialist uses psychoeducation, behavioral tailoring, relapse prevention training,

and coping skills training to assist in symptom management and goal formulation. The Project Coordinator is a certified IMR specialist and would be applicable to clients with psychoeducational needs.

Medication Assisted Treatment: Medication-assisted treatment (MAT) is the gold standard of treatment for opioid use disorder. It is the use of FDA-approved medications, in combination with patient-centered behavioral health support, to provide a "whole-patient" approach to the treatment of substance use disorders. Medications for OUD are associated with decreased risk of fatal overdose and all-cause mortality, improved retention in care, decreases illicit substance use, and decreased risk of infectious disease, among other positive outcomes. We will be using the MAT assessment and treatment guidelines as outlined in SAMHSA TIP #36 and ASAM's National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use.

Leveraged Resources

CCH recognizes the need for internal commitment to this project in order to create buy-in from stakeholders and success in the implementation. CCH is dedicating 20% of staff time in Years 1 and 2 through commitment from the Project Director, Project Coordinator and the Care Coordinator Consultant and 40% of staff time in Year 3 with the addition of the Project Evaluator.

Plan for Sustainability

CCH and the JMHCP are continuously looking for funding to support and enhance our efforts. The MacArthur Foundation Safety + Justice Challenge grant was awarded in 2017 helped initiate a pilot study for adults, among other efforts. Reapplication to the MacArthur Foundation is underway, and other potential funding sources have been identified. CCH and stakeholders are

working to systematize this program into the regular operations of the court and towards long term funding mechanisms through Medicaid billing. In addition, CCH was awarded two Department of Justice, Justice and Mental Health Collaboration awards that aimed to reduce incarceration rates among adult offenders (2016-MO-BX-0020 and 2019-MO-BX-0036). Reapplication to funding entities will be continuously monitored in an effort to support efforts on the reduction of incarceration among individuals with MI/CMSI. CCH is committed to reducing disparities in Cook County, especially among adolescents, in an effort to creating healthy communities.

Capabilities and Competencies

Cook County Health (CCH) is a comprehensive, integrated system of care, operating two hospitals, fifteen community-based health centers, correctional health care services for the county jail, and a comprehensive medical home for those with HIV/AIDS. CCH is currently managing $30 million in external funding from federal, state, and local entities to support community driven initiatives such as MAT provision, offender re-entry, supportive housing, family planning, and legal aid for our area's most vulnerable. Specifically, CCH has been awarded several grants addressing justice involved individuals. The MacArthur Foundation Safety + Justice Challenge grant was awarded in 2017 to build a collaborative partnership among the Chicago Police Department, Office of the Chief Judge, State's Attorney's Office and other community partners to reduce local jail populations and reduce racial and ethnic disparities in the justice system. These two goals are supported by data collection at the site and initiative level, and by strategies that utilize strong community engagement for shared problem solving, information sharing, and stakeholder buy-in. In September of 2016, Cook County was awarded the Justice and Mental Health Collaborative (JMHCP) Category I grant (2016-MO-BX-0020)

and set out to reform its bond system. Chief Judge Evans launched this effort which set forth new procedures for bond court and pretrial release including the introduction of a Pretrial Risk Assessment (PSA) that measures a client's risk of reoffending and missing their court appearance. These efforts have shown significant results: according to a recent report, in the 15 months following the general order the average daily jail population dropped by 16% in a year.. In September 2019, CCH was awarded another JMHC Category 3 grant (2019 2019-MO-BX-0036) to evaluate a strategic expansion of the misdemeanor diversion court program to other branch courts, thereby safely diverting more people with mental health and co-occurring mental illness (MI) and substance abuse (CMISA) from unnecessary incarceration and enhancing linkage to services at these critical intercepts. Preliminary results have shown a total of 108 referrals to community partners for assessment with 4 being referred to inpatient facilities and 104 to outpatient services.

The Project Management Team (PMT) will leverage existing expertise at the Cook County Health Juvenile Justice Behavioral Health Program. Dr. J. Brian Conant will serve as the Project Director. J. Brian Conant, PsyD is the Juvenile Justice Behavioral Health Director for Cook County Health at the Cook County Juvenile Temporary Detention Center (JTDC) and has over 20 years of clinical experience. In his role as Behavioral Health Director, Dr. Conant oversees the development, coordination, and administration of mental health services and programming for the JTDC and other areas of the Cook County Juvenile Justice System. Dr. Conant is currently a Lecturer at the Northwestern University Feinberg School of Medicine and has teaching experience in the areas of clinical/forensic psychology, correctional mental health, child development, and crisis intervention for law enforcement. Dr. Conant will dedicate 10% of his time in kind to this project in Years 1 and 2 and 30% in Year 3. Katherine Hall, LCSW,

CCHP, is the Manager of Juvenile Justice Care Coordination and will serve as the Project Coordinator. Ms. Hall has extensive experience managing and leading a multidisciplinary team composed of social workers, community health workers and other mental health professionals to provide effective, efficient behavioral health care coordination for justice involved youth. She will dedicate 50% of her time to this project in kind. Kathleen Young, MSW, will serve as a care coordinator consultant to the project. Ms. Young has experience in complete screenings, assessments and care plans in accordance with contractual requirements and Care Coordination policies and procedures while clinically evaluate all information to create Individualized Care Plans for justice involved youth transitioning. Her expertise in this area will help train and supervise the care coordinators hired to be on this project. Ms. Young will dedicate 15% of her time in kind in Years 1 and 2 and 30% in Year 3. Andrew Hillum is a data analyst at the JTDC and will serve as the Project Evaluator. Mr. Hillum has extensive data collection and analysis experience, specifically with incarcerated youth. He has spent almost the past ten years working with the JTDC in administration. He will dedicate 15% of his time in kind in Years 1 and 2 and 30% in Year 3. Kelsey Moore will be hired as a special project consultant as she has an extensive background in criminal justice and has worked on the two previous JMHC and MacArthur Foundation grants awarded to CCH. She will dedicate 5% of her time to this project.

The following stakeholders have been identified as key partners in the development and implementation of this project. The Behavioral Health Consortium of Illinois, LLC (BHC) is a clinically integrated network of community mental health and substance use treatment providers serving CCH patients, as well as County Care patients. Currently, the BHC consists of twelve member organizations—Community Counseling Centers of Chicago (C4); HRDI (a subsidiary of Friend Health); Family Guidance Centers; Metropolitan Family Services; Habilitative Systems,

Inc.; Lutheran Social Services of Illinois; Haymarket Center; Sinai Health System; Heartland Alliance Health; Bobby E. Wright Behavioral Health; Pillars; and South Suburban Council on Alcoholism and Substance Abuse. The BHC provides a single, streamlined access point for care to this vulnerable patient population. They have the capacity to offer services such as medication assisted treatment (MAT), residential and outpatient mental health and SUD treatment, as well as other support services. They will dedicate 20% of their time to this project. Additional stakeholders include the Cook County Juvenile Probation and Court Services, the State's Attorney's Office, and the Public Defender's Office.

Plan for Collecting the Data. The Data Analyst will coordinate the data collection from the project partners. Client-level behavioral health data and court data will be collected and client follow up will happen at the 0-, 7-, 14-, 30-, 60- and 90-day marks by the project partners. Mr. Andrew Hillum at the JTDC will be analyzing data.

Data. The evaluation of the project will be based on systematic collection and analysis of programmatic, mental health, and criminal justice data. This process of data collection will result in a case-specific timeline for each JJCC participant detailing the timing and nature of detention and treatment activities. Specific data to be collected include: 1) Client characteristics: age, gender, race/ethnicity, housing status, employment, benefits; 2) mental health variables: client diagnosis, assessment information, treatment referrals, treatment engagement, substance use, length of stay in various treatment episodes; 3) Criminal justice: current charge, arrest/incarceration history, disposition of case, post-detention arrest and incarceration data; and 4) Process data: Time from JJCC referral to evaluation, initial referral outcome, admission and discharge dates for inpatient treatment, outpatient appointment attendance, disposition date and type.

Data analysis. Descriptive statistics will be generated for participants, detailing key mental health and criminal justice outcomes, with particular focus on number of days in detention, number of inpatient hospitalization days, post-release arrests and incarceration. Once a sufficient number of individuals have participated in the Juvenile Justice Care Coordination program (i.e. 50 or more participants) their criminal justice and mental health outcomes will be statistically compared to a relevant comparison group (i.e. youth detention rates). The project will be evaluated based on its impact on days in detention, inpatient hospitalization days, and post-program criminal justice involvement.

Qualitative evaluation activities. Because the project is in its early stage of development, it is important to develop a comprehensive understanding of the program through experiences of those most directly involved. To attain this understanding, the evaluator will conduct qualitative interviews with 10 staff who work directly or indirectly with the project, including: judges, defense attorneys, prosecutors, care coordinators, and mental health workers. Additionally, 10 Juvenile Justice Care Coordination clients will be interviewed to explore their experiences in the program and their recommendations to enhance or improve it. Thematic analyses will be conducted on qualitative interviews to elicit key program characteristics and experiences.