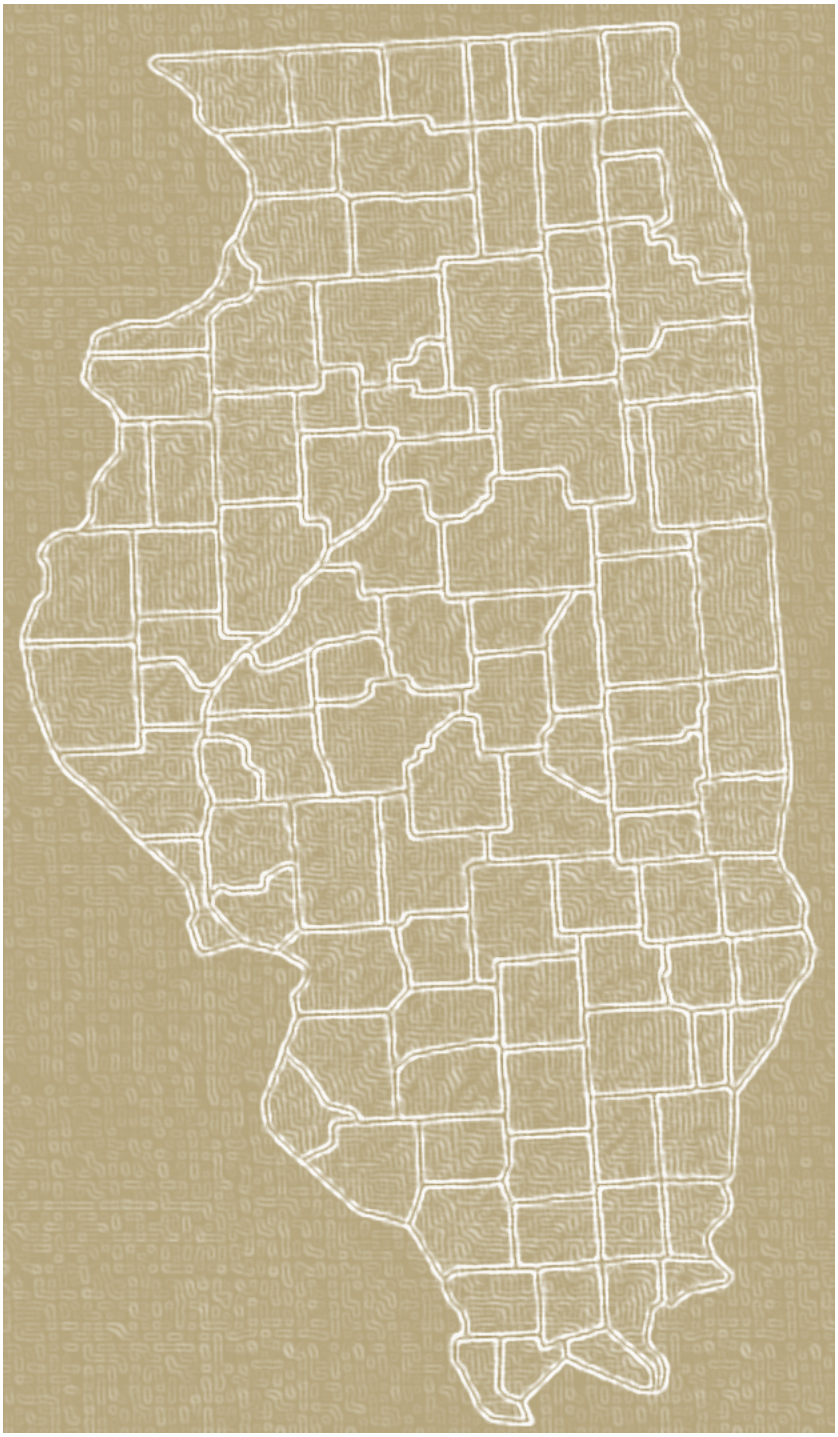

Administrative Office of the Illinois Courts

Mental Health Task Force Action Plan

September 2022

PROJECT DIRECTOR
Michelle O'Brien, JD

PROJECT TEAM
Liz Barnhart, MS

National Center for State Courts

This document was developed under grant number SJI-T-048 from the State Justice Institute. The points of view expressed are those of the authors and do not necessarily represent the official position or policies of the State Justice Institute.

Acknowledgements

The NCSC Project Team would like to thank Chief Justice Anne M. Burke and the Illinois Supreme Court for their support and vision to improve the court and community response for individuals with mental illness and co-occurring substance use disorders. The NCSC Project Team would also like to thank Marcia Meis, Justice Kathryn Zenoff, Scott Block, Nick Lurz, Judge Maureen Ward Kirby, Judge Michael Feetterer, Chief Judge Katherine Gorman, Judge Phoebe Bowers, Judge Jo Beth Weber and the Department of Human Services, Division of Mental Health, and Division of Substance Use Prevention and Recovery for their leadership and assistance with the regional mapping workshops and the community assessment. In addition, NCSC would like to thank everyone who participated in the regional mapping workshops and community assessment.

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Executive Summary

On March 30, 2020, the Conference of Chief Justices and Conference of State Court Administrators (CCJ-COSCA) established the National Judicial Task Force to Examine State Courts' Response to Mental Illness with a charge to "assist state courts in their efforts to more effectively respond to the needs of court-involved individuals with serious mental illness." Since convening, the National Task Force has worked with the National Center for State Courts to further this initiative with financial support from the State Justice Institute. Further reinforcing the urgency and priority of this issue, CCJ-COSCA has adopted the stance that "court leaders can and must... address the impact of the mental health system on the nation's courts—especially in partnership with behavioral health systems."

Modeling the way, CCJ-COSCA's Annual Conference, which was hosted by Illinois and held in Chicago from July 23 to July 27, 2022, was titled *Behavioral Health and the State Courts—Finding Solutions and Resources*. During the conference, attendees heard from national experts, as well as the Illinois Mental Health Task Force as they shared experiences, research, resources, and best practices to improve the courts' response to individuals with serious mental illness and co-occurring substance use disorders.

The conference culminated with each respective Board unanimously validating and approving the work of the National Task Force by adopting Resolution 1: "In Support of the Recommendations of the National Judicial Task Force to Examine State Courts' Response to Mental Illness." The Resolution urges each member of the Conferences to lead, examine, educate, and advocate for system improvements in their state or territory.

This action marks the end of the National Task Force, and the beginning of a journey in which CCJ-COSCA will support future efforts with the leadership from its Behavioral Health Committee and support from the National Center for State Courts. Future efforts include the implementation of the Task Force recommendations, developing performance measures for state courts and communities, and monitoring and reporting progress and success.

Illinois Mental Health Task Force: Action Plan Development

From January through May of 2022, the Illinois Supreme Court Mental Health Task Force (Illinois Task Force) distributed and compiled responses from a community assessment survey and hosted a series of five judicially led, multidisciplinary Regional Councils and Resource Mapping Workshops within five regions throughout the state. The Regional Councils and Resource Mapping Workshops used the National GAINS Center Sequential Intercept Model framework to facilitate the process.

Overall, the Illinois Task Force efforts engaged hundreds of justice and behavioral health partners and led to development of this Action Plan, including recommendations to support strategies related to each of the following primary activities:

- Courts as Conveners
- Training Opportunities Across the Intercepts
- Awareness Across the Intercepts
- Best Practices: Intercepts Zero – Five

As the Illinois Task Force, with support from the Illinois Supreme Court, Illinois Circuit Courts, and various justice and behavioral health partners move to effectuate national and statewide efforts to lead, examine, educate, and advocate, proposed next steps include the following actions:

- Present this Action Plan to the Illinois Conference of Chief Judges.
- Distribute a message from the Supreme Court which encourages all Chief Judges and Trial Court Administrators to convene and lead efforts in their circuits and communities through operationalizing the template set forth in the National Task Force: Leading Change Guide for Trial Court Leaders: Improving the Court and Community's Response to Mental Health and Co-Occurring Disorders and using established Resources and Publications to inform efforts.
- In partnership with the National Center for State Courts, host a statewide online seminar to promulgate the Action Plan content.
- Engage Trial Court Administrators through outreach efforts.
- Present this Action Plan to justice and behavioral health professionals and partners and seek their engagement.
- Promote the Action Plan Recommendations and provide technical assistance for courts.
- Ensure accountability through transparency and accessible reporting of Action Plan milestones and progress.
- Seek continuous funding opportunities to pilot, implement, and sustain the Action Plan recommendations.

Courts are in a unique position to lead change by following the recommendations and using the resources developed by the National Judicial Task Force to Examine State Courts' Response to Mental Illness and this Action Plan to bring communities together to communicate, collaborate, and make a difference for individuals with mental health needs with compassion and hope. Furthermore, all activities should be viewed through a lens of justice, equity, and inclusion.

Overview

Introduction

State courts have increasingly become the default system for addressing the needs of individuals living with behavioral health concerns. Commonly cited statistics evidence approximately 70% of court users have a diagnosable behavioral health disorder leading to 20% of inmates in jails and 15% of inmates in state prisons with a serious mental illness and nearly 68% of people in jail with a diagnosable substance use disorder. As a result, jails and prisons have become known as the largest behavioral health providers in the state.[1]

Considering many courts are ill-equipped to provide a meaningful response to this overrepresentation of individuals with mental illness and co-occurring mental illness and substance use disorders (MI/CMISUD) within the institutional walls, many of these individuals repeatedly cycle through the justice system. This cycle has profound effects on individuals, families, communities, health care systems, and public institutions. To reduce these societal effects, the Illinois Supreme Court (Court) and its Administrative Office of Illinois Courts (AOIC) developed a judicially led statewide Mental Health Task Force (Task Force). Through the Task Force, the Court/AOIC is working to champion system level changes and improvements at the intersection of behavioral health and justice.

Statement of the Issue

A 2018 study by the Schaeffer Center for Policy and Economics on the cost of mental illness in Illinois examined the prevalence of mental illness and its costs to the state. The study cites the 2016 National Survey on Drug Use and Health report that found more than a million Illinoisans experienced serious psychological distress in the prior twelve months. More than a quarter of those persons reported unmet treatment needs for their distress. This is in part due to Illinois' below average Medicaid reimbursement for behavioral health treatment. On average, Illinois reimbursed behavioral health treatment at a rate of 61 cents on the dollar in 2016—ranking it 43rd in the nation, and 38th in the nation for per capita overall spending on mental health. Additionally, Illinois hospitalized patients for mental illness at a rate of 1.5 times more and longer than the rest of the US. Illinois is also facing a serious shortage of behavioral health professionals, with only 20 out of 102 counties meeting the needs of their populations. Illinois saw the highest increase in the Midwest (201%) for behavioral health professional shortages between 2017 and 2018.[2]

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[1] NCSC, What We Have Learned and What We Must Do! https://www.ncsc.org/__data/assets/pdf_file/0021/66450/What_We_Have_Learned_What_We_Must_Do.pdf

[2] Heun-Johnson, H., Menchine, M., Goldman, D., and Seabury, S. (2018). The Cost of Mental Illness: Illinois Facts and Figures. USC Schaeffer Center for Health Policy & Economics. https://healthpolicy.usc.edu/wp-content/uploads/2018/07/IL-Facts-and-Figures.pdf

Although recent years have seen Illinois enact significant budgetary, legislative, and policy actions to improve the current state of behavioral health systems, these problems often compound one another and contribute to individuals with serious mental illnesses (often low income) without adequate care decompensating and eventually engaging with the justice system. Cook County Jail has been described as the largest mental health facility in the state, with more than 50 percent of its population on any given day having a mental illness.[3] In the US, 24 percent of incarcerated individuals reported a clinical diagnosis or treatment for MI/CMISUD within the past year and 49 percent reported experiencing symptoms of MI/CMISUD.[4] Research estimates one million individuals with MI/CMISUD are on probation or parole in the US.[5] Despite the disproportionately high prevalence of MI/CMISUD, only 63 percent of individuals with a history of MI/CMISUD in the US received treatment in prison from 2011 to 2012, and only 45 percent of those jailed received treatment.[6] Additionally, individuals with MI/CMISUD spend significantly more time in jail.[7] The Schaeffer Center study noted 8,202 prisoners (18 percent) with serious mental illness in Illinois prisons, costing the state over $193.3M annually.[8]

A very small number of crimes committed by individuals with mental health disorders are a direct result of their mental health symptoms; researchers estimate only one in 10 arrested individuals with MI/CMISUD are involved with the justice system due to mental health symptoms.[9] Research has shown individuals with MI/CMISUD have largely the same predictors and risk factors for criminal justice involvement as individuals without MI/CMISUD.[10]

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[3] Cook County Sherriff Tom Dart on the Criminalizing of Mental Illness (2021). https://www.cookcountysheriff.org/criminilization-of-mental-illness/

[4] James, D. J., & Glaze, L. E. (2006). *Mental health problems of prison and jail inmates* (Bureau of Justice Statistics Report NCJ-213600). Washington, DC: U.S. Department of Justice, Office of Justice Programs. Retrieved from https://www.bjs.gov/content/pub/pdf/mhppji.pdf

[5] Louden, J. E., Manchak, S., O'Connor, M., & Skeem, J. L. (2015). Applying the sequential intercept model to reduce recidivism among probationers and parolees with mental illness. In P.A. Griffin, K. Heilbrun, E.P. Mulvey, D. DeMatteo, & C.A. Schubert (Eds.). The sequential intercept model and criminal justice: Promoting community alternatives for individuals with serious mental illness (pp. 118-136). USA: Oxford University Press.

[6] Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011-12. (Bureau of Justice Statistics Report NCJ-250612). Washington, DC: U.S. Department of Justice, Office of Justice Programs. Retrieved from https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf

[7] Haneberg, R., & Watts, K. "Stepping Up" to beat the mental health crisis in U.S. jails. *Criminal Justice/Corrections.* New York, NY: Council of State Governments Justice Center. Retrieved from http://knowledgecenter.csg.org/kc/system/files/Haneberg Watts 2016.pdf

[8] Heun-Johnson, et al., *supra* note 1

[9] Skeem, J. L., Manchak, S., & Peterson, J. K. (2011). Correctional policy for offenders with mental illness: Creating a new paradigm for recidivism reduction. Law and Human Behavior, 35(2), 110-126.

[10] Bonta, J., Law, M., & Hanson, K. (1998). The prediction of criminal and violent recidivism among mentally disordered offenders: a meta-analysis. Psychological Bulletin, 123(2), 123.; Epperson, M. W., Wolff, N., Morgan, R. D., Fisher, W. H., Frueh, B. C., & Huening, J. (2014). Envisioning the next generation

The Illinois Criminal Justice Information Authority (ICJIA) published a review of Illinois pretrial practices in 2018. Using 2016 data, it was noted that 90% of those jailed statewide were held in a pretrial detention status, with all jails reporting a range of 51%-100% of their jail beds being utilized for pretrial detention. Moreover, research shows pretrial detention does not decrease the likelihood of recidivism but increases the likelihood defendants will plead guilty and be sentenced to jail or prison for longer terms than their counterparts who are released before trial. Those held in pretrial detention are four times more likely to be sentenced to jail, three times more likely to receive longer jail sentences, three times more likely to be sentenced to prison, and two times more likely to receive longer prison sentences than their released counterparts.[11] Pretrial detention has even further adverse effects on persons with mental illness. If they are detained pretrial, their treatment is often interrupted, and they experience other discontinuities in care. Many decompensate while in jail due to absent or inadequate medications and treatment and being held in a non-therapeutic setting. They may lose employment, housing, and even medical insurance. Missed appointments while incarcerated can also mean the loss of hard to come by service providers.[12] Work has already begun to address pretrial issues through the Illinois Pretrial Fairness Act and the Office of Statewide Pretrial Services where individuals with mental illness can be diverted from the criminal justice system.

Evidence-based practices (EBPs) have demonstrated consistently positive outcomes through empirical research and evaluation. Some promising programs and practices are associated with positive outcomes but need further research to support them as EBPs.[13] Many EBPs are focused on treating MI/CMISUD, and there are several EBPs for preventing/reducing criminality. Washington State Institute on Public Policy (WSIPP) has established a database of cost-benefit analyses of EBPs, including those for criminal justice and behavioral health. Many of the most beneficial criminal justice interventions are those that overlap with behavioral health, such as cognitive behavioral therapy.[14]

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of behavioral health and criminal justice interventions. International Journal of Law and Psychiatry, 37(5), 427-438.

[11] Reichert, J. and Gatens, A. (2018). An Examination of Illiois and National Pretrial Practices, Detention, and Reform Efforts. Illinois Criminal Justice Information Authority. https://icjia.illinois.gov/researchhub/articles/an-examination-of-illinois-and-national-pretrial-practices-detention-and-reform-efforts#fn30

[12] Fader-Towe, H. and Osher, F. (2015). Improving Responses to People with Mental Illnesses at the Pretrial Stage: Essential Elements. Council of State Governments. https://university.pretrial.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=ea8c3b3c-01ab-ef16-6b08-f3074922adc9

[13] Blandford, A., & Osher, F. (2012). A checklist for implementing evidence-based practices and programs (EBPs) for justice-involved adults with behavioral health disorders. Delmar, NY: SAMHSA's GAINS Center for Behavioral Health and Justice Transformation.

[14] Washington State Institute for Public Policy Benefit-Cost Results. Retrieved from: https://www.wsipp.wa.gov/BenefitCost?topicId=2

National Context

National Judicial Task Force

In 2019, the State Justice Institute (SJI) funded a three-year project called the National Initiative to Improve the Justice System Response to Mental Illness and Co-Occurring Disorders. A National Initiative Advisory Committee was appointed to guide the work. The SJI grant recognized that state court leaders require resources, education and training, data and research, best practices, and other tools to devise solutions to the growing number of ways in which state courts are impacted by cases involving individuals with behavioral health disorders.

On March 30, 2020, based on the recognition of the importance and need to improve the state courts' response to mental illness, the National Initiative was elevated to a National Judicial Task Force. The Conference of Chief Justices (CCJ) and Conference of State Court Administrators (COSCA) established the National Judicial Task Force to Examine State Courts' Response to Mental Illness (National Judicial Task Force) with a charge to "assist state courts in their efforts to more effectively respond to the needs of court-involved individuals with serious mental illness." Led by four chief justices and four state court administrators, joined by 40 additional judges and court and behavioral health experts, and funded by SJI, the National Judicial Task Force developed tools, resources, best practices, findings, and policy recommendations for the state courts. The National Judicial Task Force delivered its findings and during the 2022 CCJ/COSCA Annual Meeting in Chicago in July 2022 and signed a Resolution supporting the findings and recommendations. The National Judicial Task Force will deliver its final report in October and this action will mark the termination of the National Judicial Task Force and the beginning of a journey in which CCJ/COSCA will support with the leadership from its Behavioral Health Committee and the National Center for State Courts. Anticipated future activities include the implementation of the Task Force recommendations, developing performance measures for state courts and communities, and monitoring and reporting progress and success.

National Regional Summits

The National Judicial Task Force conducted five national regional summits. In October 2019, CCJ and COSCA hosted a Midwest Regional Summit in Deadwood, South Dakota. The respective Midwest Chief Justices and State Court Administrators appointed multidisciplinary teams to attend the Midwest Summit, which combined educational sessions with opportunities for state teams to identify opportunities for improvement and to develop priorities for change.

Eleven (11) states participated in the 2019 CCJ/COSCA Midwest Region Summit on Improving the Court and Community Response to those with Mental Illness. While every state is grappling with similar issues, the states, and especially the state judiciaries, are involved in very different ways. In some states, the courts are central players in convening constituent groups and facilitating solutions. In other states, the issue is only front and center now because of successful lawsuits, and the courts are only peripherally involved. Nonetheless, the elements of the state action plans developed on the final day matched the themes heard throughout the summit—the role of the judiciary as convener, adoption of the Sequential Intercept Model

(SIM), the importance of diversion from the traditional criminal justice system, meaningful data collection, and the importance of innovative wraparound services.

After the Midwest Regional Summit, states were encouraged to submit requests for funding from SJI to accomplish the goals of their action plans including technical assistance from the National Center for State Courts (NCSC), opportunities for national learning, and national speakers for statewide summits.

The National Diversion Landscape[15]

In 2021, the National Judicial Task Force conducted a survey to create a picture of the national landscape regarding adult behavioral health diversions and practices available in each state and published the results in the National Diversion Landscape Continuum of Behavioral Health Diversions. The survey was completed by State Court Administrators or State Court Behavioral Health Administrators and oftentimes in conjunction with input from State Behavioral Health Departments. The survey results provide a national landscape that helped inform the work of the Task Force and provide helpful resources to courts going forward. For more information about the survey results, see Appendix A.

As noted in the report, "In order to address behavioral health needs in our communities and the overrepresentation of individuals with behavioral health needs in local courts and jails, community resources and diversion pathways and practices must be available, accessible, and used. To reduce unnecessary involvement, support those who need services, and promote fairness throughout the criminal justice system, judges and other behavioral health and criminal justice partners must come together to create a system that will improve outcomes for all."[16]

Person-Centered Caseflow Management

In June 2022, the National Judicial Task Force published A New Model for Collaborative Court and Community Caseflow Management. Traditional criminal case processes are not meeting the needs of the individuals served, and a new comprehensive, collaborative approach is necessary to ensure public safety, control costs, and create fair and effective criminal justice and caseflow management systems that meet the challenges of individuals with behavioral health needs. The new model strengthens community responses and minimizes criminal justice system involvement, promotes early intervention and effective management of court cases, institutionalizes alternative pathways to treatment and recovery, and improves outcomes and manages post-adjudication events and transitions effectively. This work is informed by extensive research, including the Effective Criminal Case Management (ECCM) project and the Model Time Standards for State Trial Courts.

Leading Change

As leaders of their courts and communities, judges are in a unique position to expand and improve the response to individuals living with MI/CMISUD. For decades, courts have gained

[15] NCSC (2022). National Diversion Landscape: Continuum of Behavioral Health Diversions Survey Report. https://www.ncsc.org/__data/assets/pdf_file/0022/77143/National-Diversion-Landscape.pdf
[16] Ibid, p. 7

experience in convening diverse stakeholders to tackle complex problems both within and outside of the justice system. From the evolution of problem-solving courts to dependency dockets, courts are often at the vanguard of responding to societal issues. This reality has paved the way for an independent but involved judiciary. In their unique position as respected leaders, judges are optimal conveners of these diverse stakeholders. The Leading Change Guide for State Court Leaders and Leading Change Guide for Trial Court Leaders developed by the National Judicial Task Force are two guides that will help judges and court administrators start or advance processes for collaboration and improve responses for individuals with mental illness. The Leading Change Guides build upon the framework of the Sequential Intercept Model by encouraging the examination of all case types such as civil, child welfare, family, and juvenile justice in addition to criminal justice. It is important to recognize that individuals with MI/CMISUD are involved throughout the entire justice system and that better coordination and communication needs to occur between the different case types to provide person-centered justice. More information can be found at the Behavioral Health Resources Hub.

Sequential Intercept Model[17]

The Sequential Intercept Model (SIM) was developed by Policy Research Associates (PRA) as a conceptual model to inform community-based responses to people with mental health and substance use disorders involved with the criminal justice system. SIM is used as an applied strategic planning tool to improve cross-system collaborations to reduce involvement in the justice system. SIM is most effective when used as a community strategic planning tool to assess available resources, determine gaps in services, and plan for community change.

These activities are best accomplished by a team of multidisciplinary stakeholders across systems, including mental health, substance use, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, people with lived experiences, family members, and many others. SIM helps to develop a comprehensive picture of how people with mental health and substance use disorders flow through the criminal justice system. The model depicts the justice system as a series of points of "interception" at which an intervention can be made to prevent people from entering or from penetrating deeper into the criminal justice system.

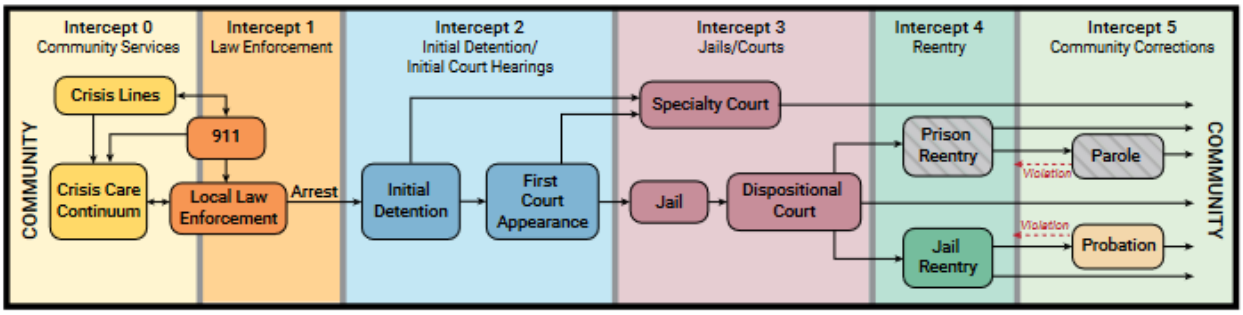
Points of interception include:

- Intercept 0: Community Services
- Intercept 1: Law Enforcement
- Intercept 2: Initial Detention and Hearings
- Intercept 3: Jail and Court

[17] Policy Research Associates (2018). THE SEQUENTIAL INTERCEPT MODEL: Advancing Community-Based Solutions for Justice-Involved People with Mental and Substance Use Disorders https://www.prainc.com/wp-content/uploads/2018/06/PRA-SIM-Letter-Paper-2018.pdf

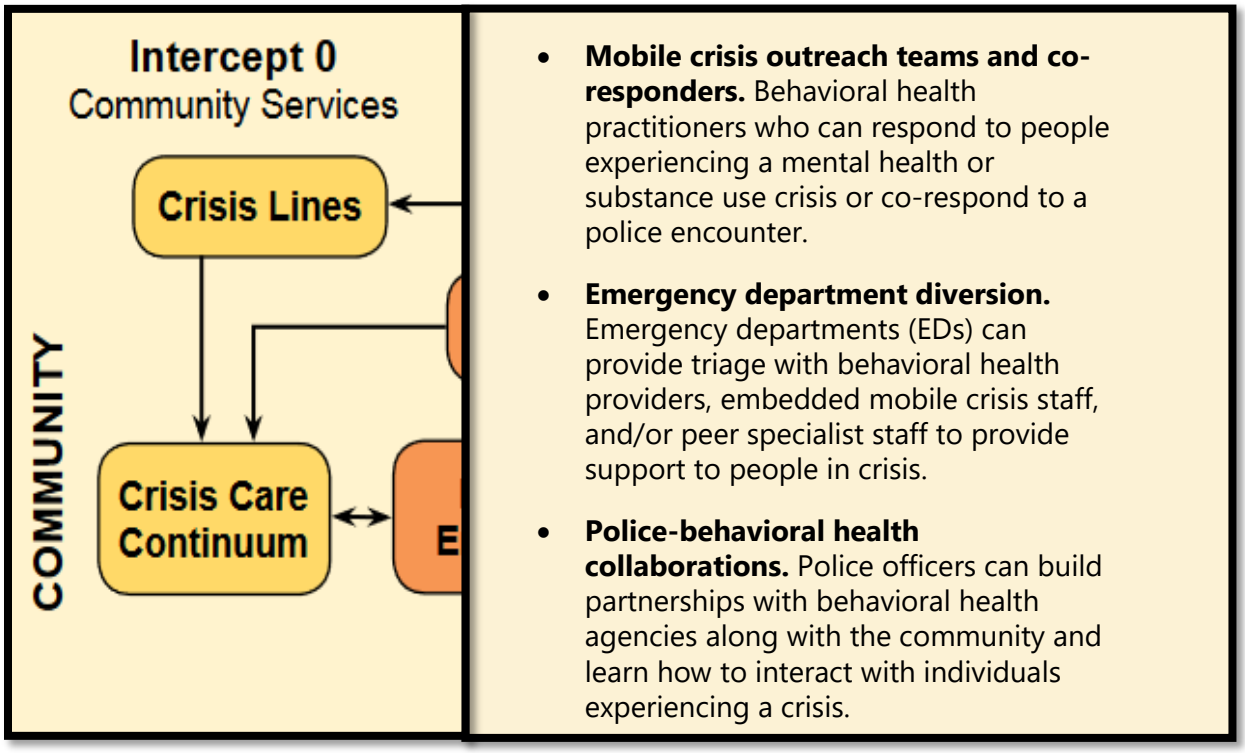
- Intercept 4: Reentry
- Intercept 5: Community Corrections

FIGURE 1: SEQUENTIAL INTERCEPT MODEL



Key Issues at Each Intercept

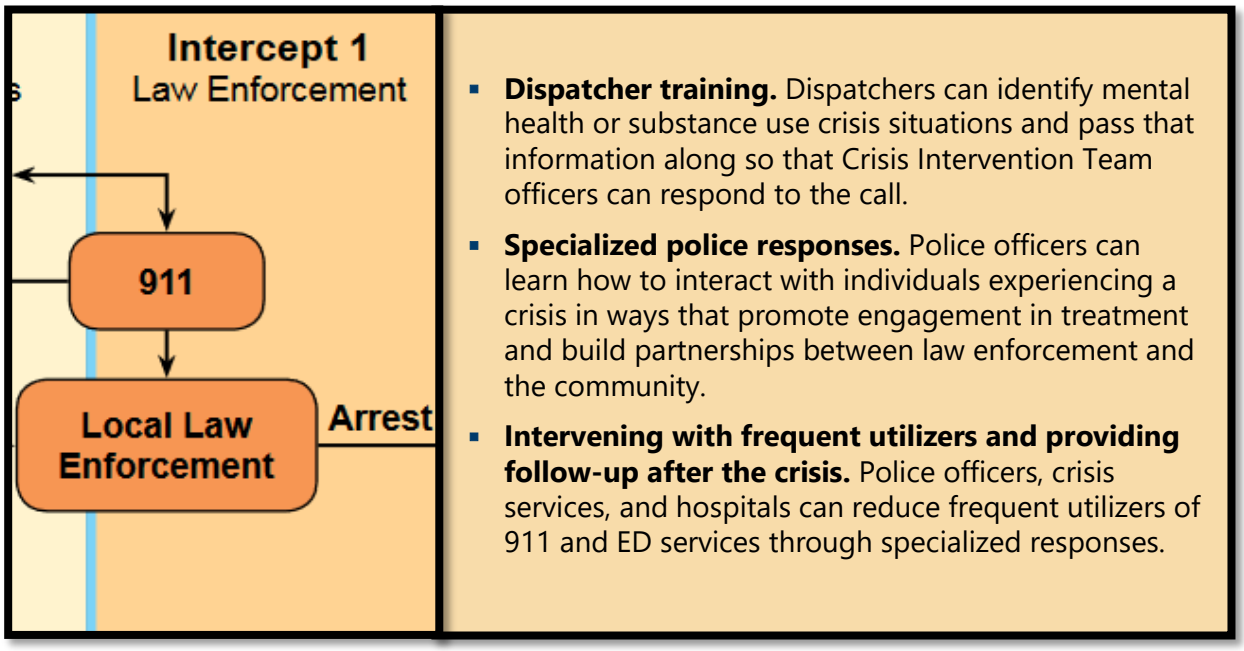
This section takes language from two Policy Research Associates publications on SIM, *The Sequential Intercept Model: Advancing Community-Based Solutions for Justice-Involved People with Mental and Substance Use Disorders* and *Data Collection Across the Sequential Intercept Model: Essential Measures*[18] to explain best practices at each intercept.



[18] PRA, Inc. (2018). *The Sequential Intercept Model: Advancing Community-based Solutions for Justice-Involved People with Mental and Substance Use Disorders*
https://store.samhsa.gov/sites/default/files/d7/priv/pep19-sim-brochure.pdf

Intercept 0

Intercept 0 involves interventions for people with mental health and substance use disorders prior to formal involvement with the criminal justice system. The critical components of this intercept include the local continuum of crisis care services and resources that reduce reliance on emergency response, hospitalizations, and law enforcement to serve people in crisis or with low-acuity mental health needs.

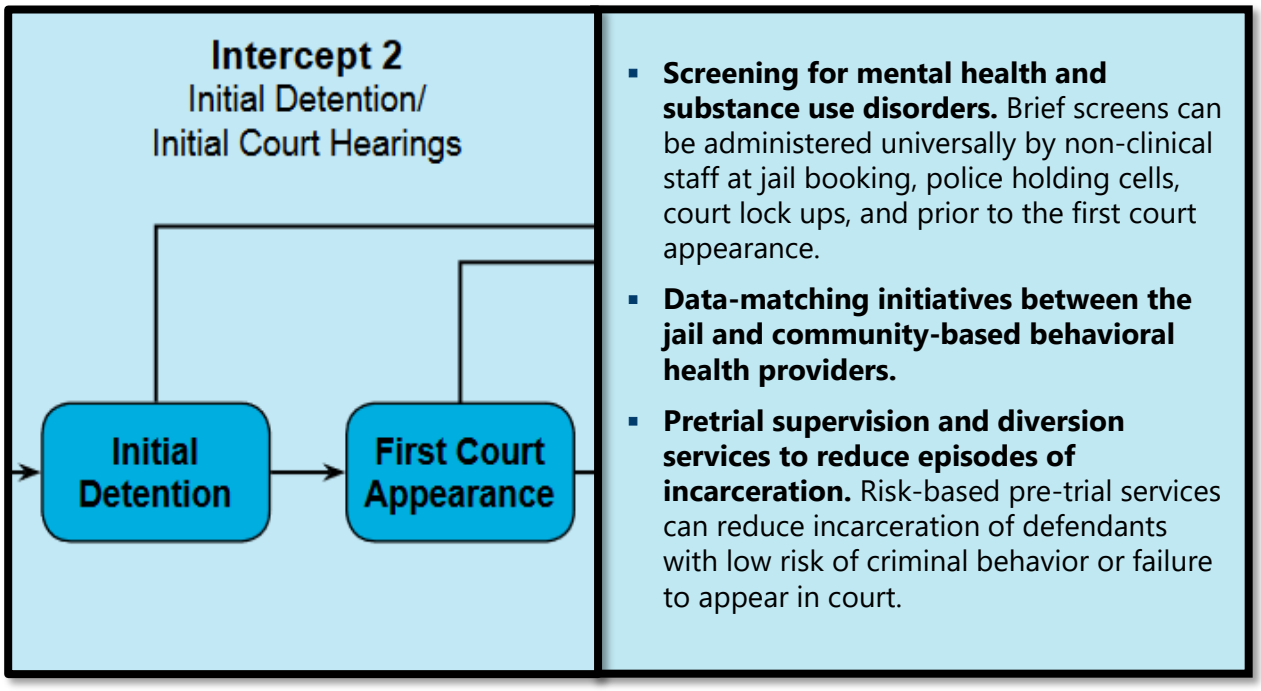


Intercept 1

At Intercept 1, law enforcement and other emergency service providers respond to people with mental health and substance use disorders who are in crisis in the community. When a person in crisis exhibits illegal behavior, law enforcement officers have the discretion to place the person under arrest or to divert them to treatment or services. Effective diversion at Intercept 1 is supported by trainings, programming, and policies that integrate behavioral health care and law enforcement to enable and promote the deflection of people with mental illness away from arrest and a subsequent jail stay and into community-based services.

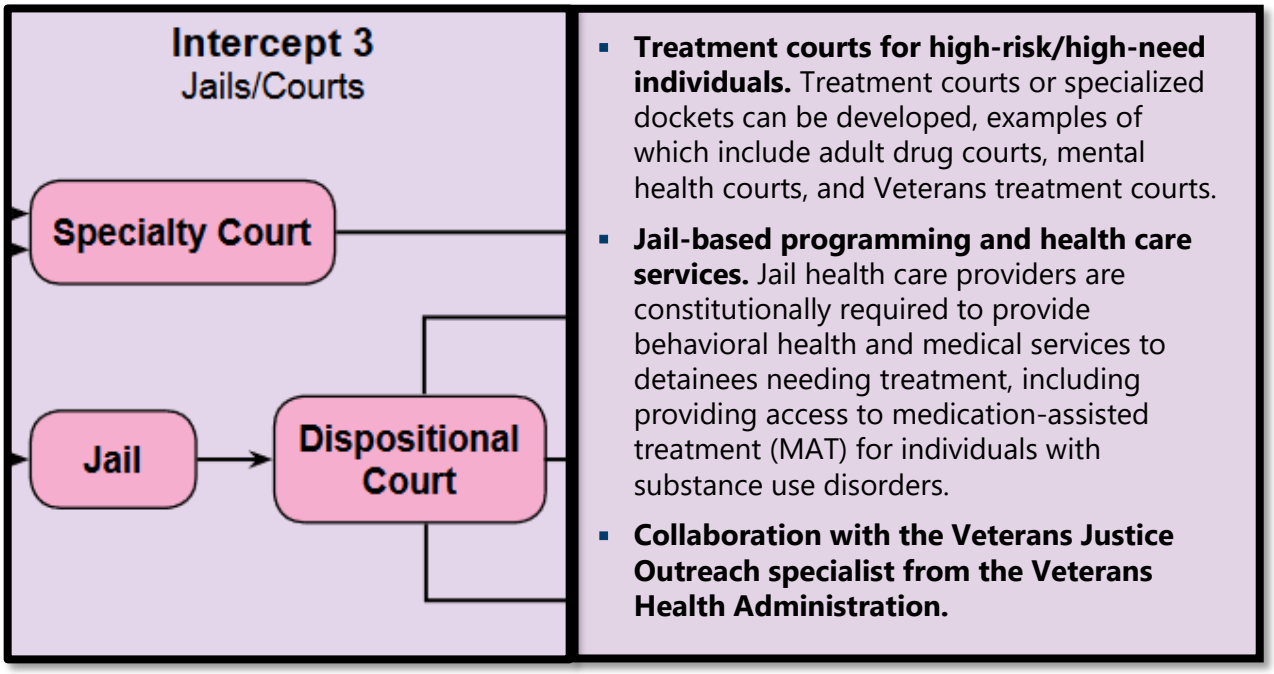
PRA, Inc. (2019). *Data Collection Across the Sequential Intercept Model: Essential Measures* developed for SAMHSA as a GAINS Action Brief.
https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/data_across_the_sim.pdf

Intercept 2



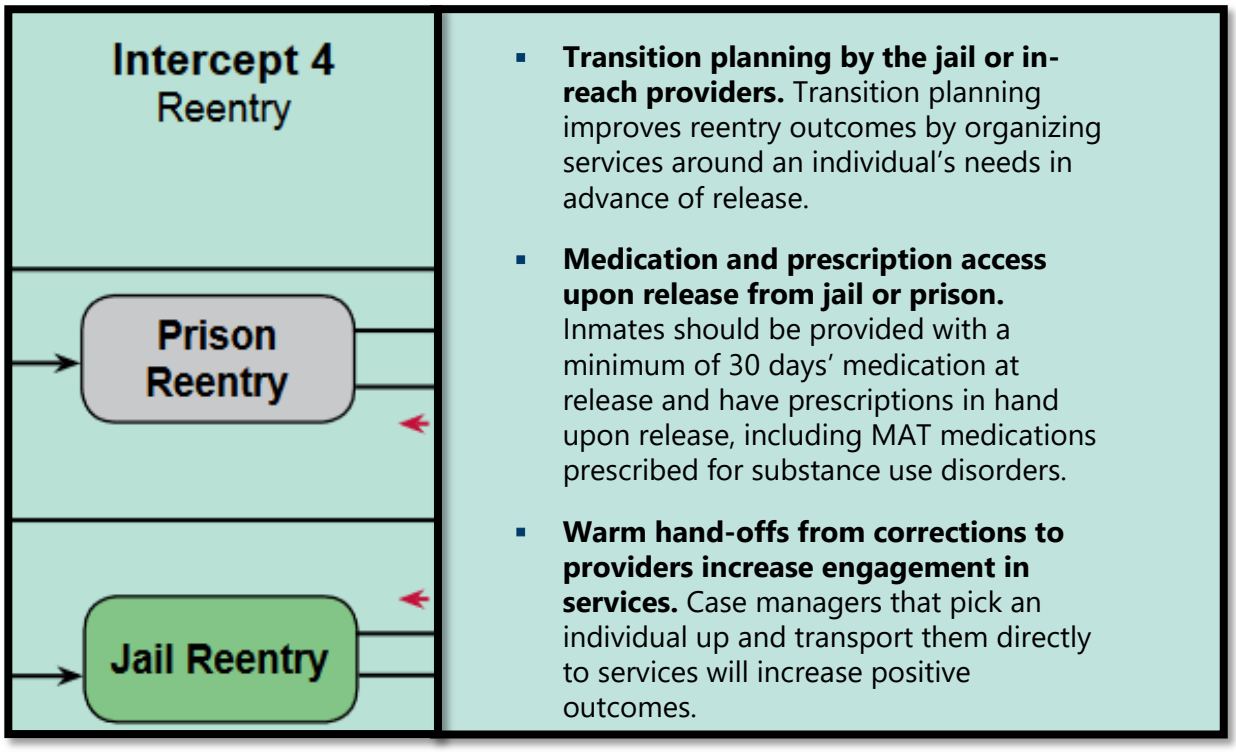
At Intercept 2, individuals who have been arrested will go through the intake and booking process and will have an initial hearing presided over by a judicial official. Important elements of this intercept include the identification of people with mental health and substance use disorders being processed and booked in the jail, placement of people with mental health and substance use disorders into community-based treatment after intake or booking at the jail, and availability of specialized mental health caseloads through pretrial service agencies.

Intercept 3



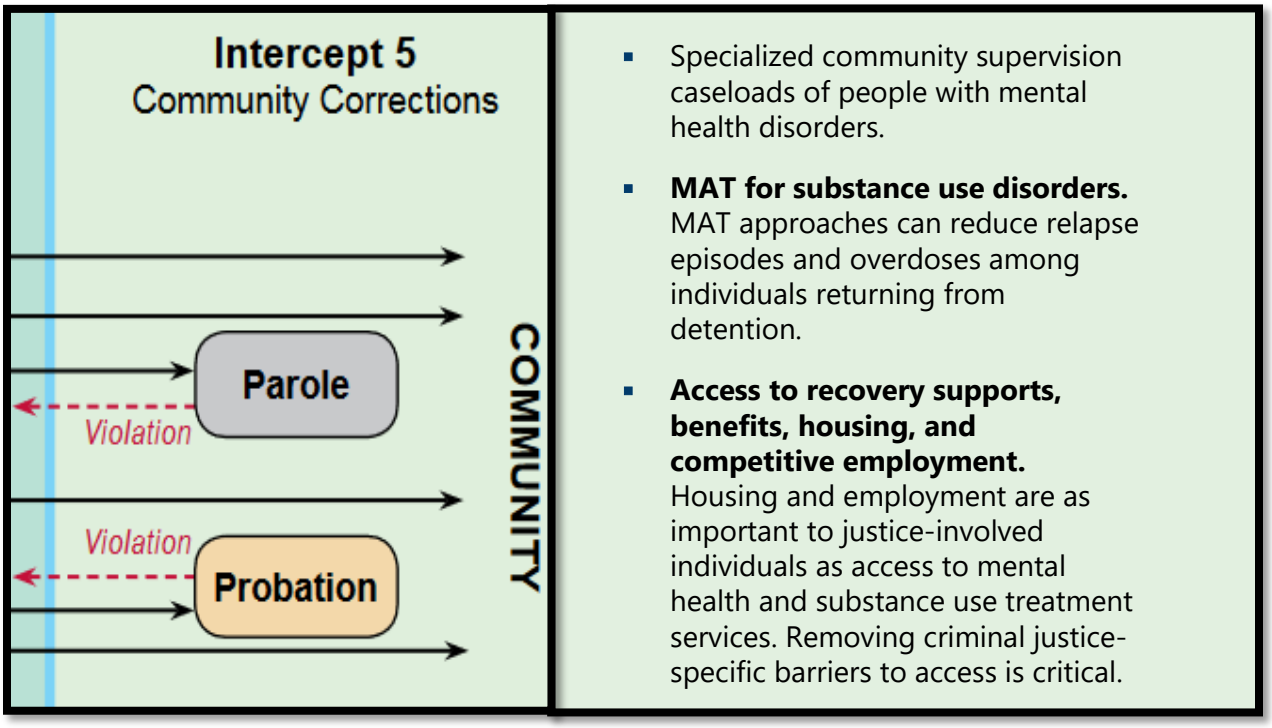
At Intercept 3, individuals with mental health or substance use disorders who have not yet been diverted at previous intercepts may be held in pretrial detention while awaiting disposition of their criminal cases. This intercept centers around diversion of individuals from the jail or prison into programs or services that allow criminal charges to be resolved while also addressing the defendant's mental health and substance use disorder needs. The intercept also involves jail- and prison-based programming that supports defendants in a trauma-informed, evidence-based manner during their incarceration.

Intercept 4



At Intercept 4, individuals transition from detention or incarceration in a jail or prison back to the community. This intercept requires transition planning with specific considerations to ensure people with mental health and substance use disorders can access and utilize medication and psychosocial treatment, housing, healthcare coverage, and services from the moment of release and throughout their reentry back into the community.

Intercept 5



At Intercept 5, community corrections agencies (also called probation and parole) provide essential community-based supervision, as an arm of the court, to individuals released to the community. People with mental health and substance use disorders may be at risk for probation or parole violations and benefit from added supports at this intercept. Use of validated assessment tools, staff training on mental health and substance use disorders, and responsive services, such as specialized caseloads, are vital to reducing unnecessary violations, decreasing criminal re-offense, and improving behavioral health outcomes, through enhanced connections to services and coordination of behavioral health treatment and criminal justice supervision goals.

Best Practices Across the Intercepts

In addition to best practices at each intercept there are also best practices that should span all the intercepts. This section utilizes language from the Sequential Intercept Model: Advancing Community-Based Solutions for Justice-Involved People with Mental and Substance Use Disorders[19] to describe best practices across the intercepts.

Cross-systems collaboration and coordination of initiatives. Coordinating bodies serve as an accountability mechanism and improve outcomes by fostering community buy-in, developing priorities, and identifying funding streams.

Routine identification of people with mental health and substance use disorders. Individuals with mental health and substance use disorders should be identified through routine administration of validated, brief screening assessments and follow-up assessment as warranted.

Access to treatment for mental health and substance use disorders. Justice-involved people with mental health and substance use disorders should have access to individualized behavioral health services, including integrated treatment for co-occurring disorders and cognitive behavioral therapies addressing criminogenic risk factors.

Linkage to benefits to support treatment success, including Medicaid and Social Security. People in the justice system routinely lack access to health care coverage. Practices such as jail Medicaid suspension (vs. termination) and benefits specialists can reduce treatment gaps. People with disabilities may qualify for limited income support from Social Security.

Information sharing and performance measurement among behavioral health, criminal justice, and housing/ homelessness service providers. Information-sharing practices can assist communities in identifying frequent utilizers, provide an understanding of the population and its specific needs, and identify gaps in the system.

[19] PRA, Inc. (2018). *The Sequential Intercept Model: Advancing Community-Based Solutions for Justice-Involved People with Mental and Substance Use Disorders*
https://store.samhsa.gov/sites/default/files/d7/priv/pep19-sim-brochure.pdf

Illinois Context

Illinois Department of Mental Health 2008 Strategic Plan

In 2008, the Illinois Department of Human Services (DHS), Division of Mental Health (DMH) worked with PRA to develop a strategic plan to better serve justice-involved individuals with behavioral health issues. Collaborators in this endeavor included the Illinois Department of Corrections, DHS Division of Alcohol and Substance Abuse (now Substance Use Prevention and Recovery, or SUPR), Sheriff's Association, National Alliance for Mental Illness (NAMI), Supreme Court, and many community providers and key stakeholders.

PRA worked with stakeholders through their *ACTION: Transforming Systems and Services* initiative to utilize the Sequential Intercept Model to map criminal justice and behavioral health system intersections, identify resources, assess gaps in service, and develop priorities for change. The statewide process resulted in 19 recommendations, 16 general and three specifically for the judiciary. For more information, see Appendix B.

The work of the Illinois Mental Health Task Force is building upon the Illinois DMH 2008 Strategic Plan, Leading Change Guides, and the Sequential Intercept Model.

Illinois Mental Health Task Force Regional Summit

Illinois Supreme Court Chief Justice Anne M. Burke and Illinois State Court Administrator Marcia Meis assembled and led an Illinois delegation at the Midwest Regional Summit. Four main priorities were established by the Illinois delegation during team meetings:

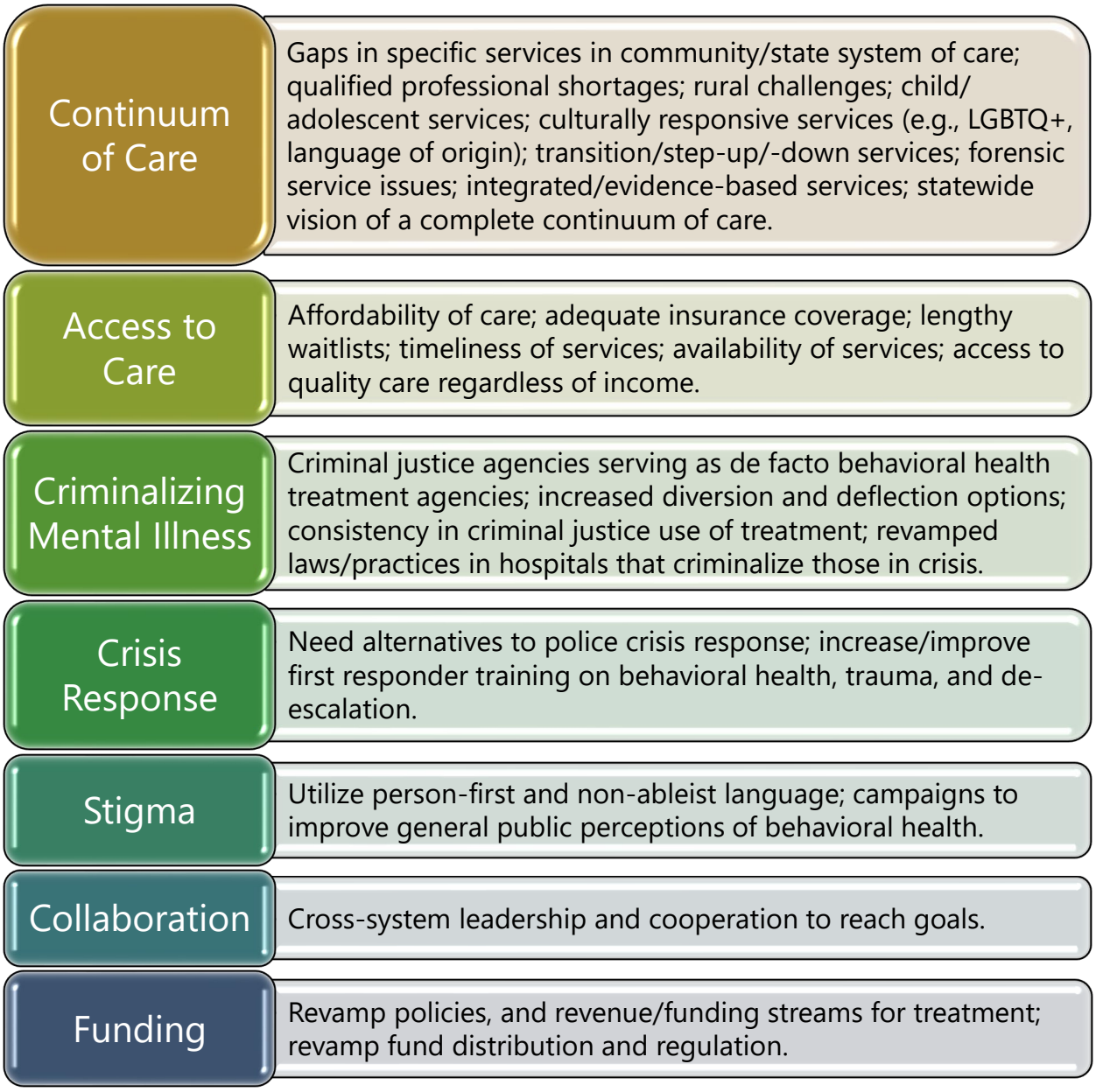
- Bring stakeholders to the table to develop a statewide multi-branch commission, committee, or task force focused on improving responses to those with mental illness;
- Hold a statewide summit;
- Improve data and information sharing across systems, analyzing what data is collected and developing strategies and partnerships to establish collaborative data; and
- Add a national partner to assist with identifying stakeholders to develop next steps and accomplish priorities.

After the Midwest Regional Summit, SJI committed to support the state teams that attended, including the Illinois team, with financial assistance to achieve their identified priorities through SJI funding. The Illinois Supreme Court added a national partner, the National Center for State Courts (NCSC), to provide technical assistance. Since doing so, the Task Force has accomplished or made significant progress toward meeting its initial four priorities. Notably, the Illinois Supreme Court assembled a diverse, multi-branch group of leaders to form the Illinois Mental Health Task Force (Task Force). After its assembly, the Task Force immediately began work to plan an in-person Illinois Mental Health Summit (Summit). The COVID-19 pandemic, however, necessitated a change in plans from holding the Summit as a traditional conference to a series of six virtual sessions. The series, *Improving the Court and Community Response to Persons with Mental Illness and Co-Occurring Disorders through Compassion and Hope*, convened by Illinois

Supreme Court Chief Justice Anne M. Burke, started on September 29, 2020, and ended on December 1, 2020.

Each session featured a nationally renowned speaker and was used to highlight issues regarding MI/CMISUD, showcase national and state innovations, and promote a platform to develop an action plan for Illinois to improve court and community responses for persons with MI/CMISUD. A total of 745 people attended the sessions, representing eleven different states, 141 Illinois cities and towns, and 61 Illinois counties. The final session engaged participants in small discussion groups to discuss challenges in Illinois. The discussions, reports, and a post-survey wrap up identified Illinois' most pressing challenges and identified possible solutions and resources to address those challenges. This led to the Task Force's development of three new overarching goals to address the most frequently identified challenge areas which are listed in Figure 2.

FIGURE 2: AREAS OF CHALLENGE



Task Force Goals Following the Summit Series

Following the Summit sessions, the Task Force established three overarching goals in moving forward.

1. To form strong partnerships that drive cross-system collaboration to develop data-informed strategies and solutions at the intersections of mental health, substance use, the courts, and our communities.

2. To share information regularly and widely among partners which promotes the creation of innovative and evidence-based solutions and strategies to address

the mental health and substance use struggles we are facing in our communities and our state.

3. To assess, identify, and efficiently utilize available resources, including funding, for the strategies and solutions necessary for meaningful change in our response to persons with mental illness and co-occurring disorders.

NCSC also developed a report summarizing the work of the Task Force, the information gathered through the Summit series, and made recommendations for the Task Force. These recommendations included continued work to define the Task Force structure, build relationships, and move the efforts of the Task Force forward.

In 2021, AOIC hired Illinois' first Statewide Behavioral Health Administrator. The Statewide Behavioral Health Administrator is in the Executive Division of the AOIC and reports directly to the Executive Director. The Statewide Behavioral Health Administrator provides administrative and leadership support for Supreme Court initiatives aimed at improving the court and community response to mental health and co-occurring disorders and serves as project manager for the Task Force.

With technical assistance from NCSC, the AOIC Statewide Behavioral Health Administrator facilitates the Task Force responses to the established goals:

1. Build a community-by-community approach, supported by statewide leadership from all three branches of government.
2. Conduct a statewide mapping or needs assessment to identify what is working and what gaps exist.
3. Assist in creating a vision for Illinois' mental health continuum of care.
4. Develop and implement a statewide strategic plan.
5. Ensure accountability through transparency and accessible reports on Task Force activities.

Supporting the National Judicial Task Force Work

Through a technical assistance grant allowing for contracting with NCSC, SJI assisted the Illinois Supreme Court in developing a foundation to accomplish the bold goals of the Task Force in coordination with the National Judicial Task Force to Examine State Courts' Response to Mental Illness and relevant federal agencies. This funding and technical assistance not only supports the ambitious and necessary efforts in Illinois but positions Illinois as a leader in the national reform efforts. Through these efforts, strategies were developed to provide tools for a coordinated court and community response to individuals with behavioral health needs and has been shared at the national level. Specific strategies are enumerated in State Court Leadership Briefs which were informed and developed through the NCSC work with Illinois.

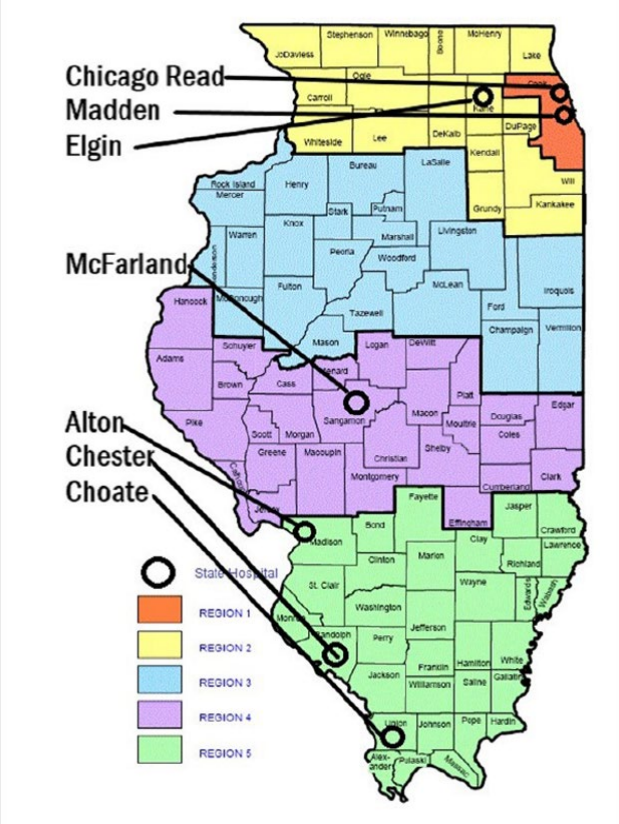
Illinois Approach

Task Force Structure

Under leadership of the Illinois Supreme Court, the project structure includes multidisciplinary, multi-branch members charged with carrying out the Summit goals, including the judicially led Regional Mapping Workshops to facilitate cross-system communication and collaboration and identify resources and data sources; improving early identification and diversion of individuals with mental health and co-occurring disorders encountering the courts; and increasing effective service linkages. Subcommittees will also be developed to examine and promote identified diversion and court-driven strategies designed to lessen the likelihood of individuals recycling through the criminal justice system. See Appendix C for the Task Force Roster.

Regional Councils and Mapping Workshops

To lead the Illinois change initiative, the Task Force chose to develop five judicially-led, multidisciplinary Regional Councils to conduct mapping workshops within each Illinois **Department of Human Services (DHS) state hospital catchment area**. DHS state hospital catchment areas were chosen so work of the Regional Councils and Mapping Workshops can build upon work of the DMH 2008 Action Plan. Where these catchment areas did not match up by judicial district, the districts were not split but assigned to the catchment area that contained most of the circuit. This applied to Circuits 4 and 6 which were included in Region 4; and Circuit 21 which was included in Region 2. Regional councils included representation from multiple court and community stakeholders including but not limited to court personnel, community behavioral health providers, state government department officials, university officials, law enforcement agencies, persons with lived experience, and other interested participants.



The councils were supported by the AOIC Statewide Behavioral Health Administrator and used the SIM framework to facilitate cross-system communication and collaboration to identify resources and data sources, improve early identification and diversion of people with mental health and co-occurring disorders coming into contact with the courts, increase effective service linkages, and lessen the likelihood of persons recycling through the criminal justice system.

Region 1

Counties and Judicial Circuits

Region 1 is composed solely of the Circuit Court of Cook County. Region 1 had 152 unduplicated registrants for the five mapping workshops. The majority of those attending the sessions were service providers (32.9%), followed by those involved in law enforcement (11.2%), attorneys/legal personnel (10.5%), and officials from state agencies (10.5%). A table of the unduplicated number of registrants and their disciplines may be found in Appendix D.

Innovation Highlights

Outpatient Fitness to Stand Trial Restoration Program

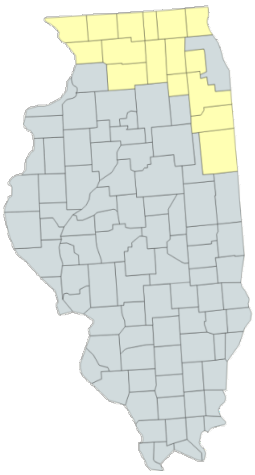
The Forensic Center's program for persons found incompetent/unfit to stand trial is one of the first formal outpatient fitness restoration programs in Illinois. Supported by a $1.5 million grant from the Illinois Department of Human Services (IDHS), the primary treatment goal for persons enrolled in the program is restoration to competency to stand trial, so their legal charges may be fairly adjudicated. Other goals of the program include improvement in mental health outcomes, as well as reduction of recidivism and increase in public safety.

The Community Resource Center

In direct response to the increase in critical situations caused by the COVID-19 pandemic, Sheriff Tom Dart created and launched the Community Resource Center (CRC), a virtual supportive services initiative to connect individuals to resources in their communities. The CRC leverages new and existing community partnerships to provide linkages to members of the community to address an individual's unique mental health, substance abuse, housing, mortgage/rental assistance, trauma, domestic violence, and/or employment and financial needs, regardless of his/her/their involvement in the justice system.

Region 2

Counties and Judicial Circuits



Region 2 is composed of the 12th, 15th, 16th, 17th, 18th, 19th, 21st, 22nd, and 23rd Judicial Circuits. There are 16 counties included in Region 2. Region 2 had 212 unduplicated registrants for the five mapping workshops. The majority of those attending the sessions were service providers (20.8%), followed by those involved in law enforcement (15.1%), those involved in community supervision including pretrial, probation, and parole (13.2%), and attorneys/legal personnel (11.3%). A table of the unduplicated number of registrants and their disciplines may be found in Appendix D.

Innovation Highlights

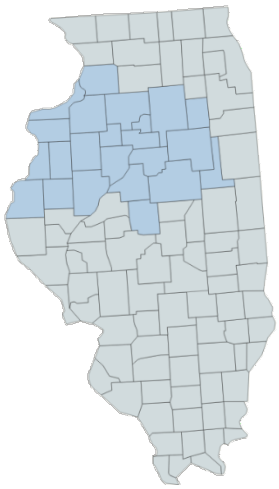
The Rosecrance Mulberry Center

The center combines two closely linked programs—triage and crisis residential—under one roof. These programs are designed to provide an immediate response to people experiencing a psychiatric crisis. The programs aim to help people avoid unnecessary hospitalization or incarceration by providing rapid evaluation, intervention, crisis counseling, and referral to the appropriate level of care when it is most needed.

Kane County Pre-Arrest Diversion Initiative

In response to the ongoing public safety and health effects of substance use disorder, untreated mental health issues, and homelessness, the Kane County State's Attorney established a pre-arrest diversion initiative. The initiative is based on the Law Enforcement Assisted Diversion (LEAD) model. The LEAD model seeks to reduce the harms to self and community caused by these issues through the creation of a system that provides access to necessary care outside the criminal legal system.

Region 3



Counties and Judicial Circuits

Region 3 is composed of the 9th, 10th, 11th, 13th, and 14th Judicial Circuits. There are 23 counties included in Region 3. Region 3 had 98 unduplicated registrants for the five mapping workshops. The majority of those attending the sessions were those involved in community supervision including pretrial, probation, and parole (21.4%), followed by service providers (19.4%), officials from state agencies (15.3%), and the judiciary and court administration (10.2%). A table of the unduplicated number of registrants and their disciplines may be found in Appendix D.

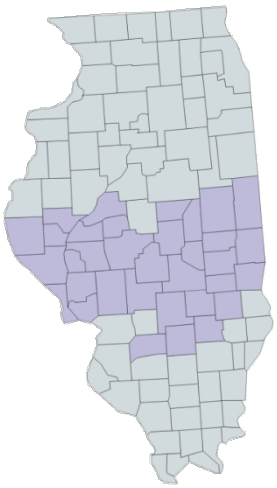
Innovation Highlight

McLean County's Data-Driven Justice (DDJ) Project

Through their DDJ project and other initiatives, McLean County leaders have continued to build on their Mental Health Action Plan with concerted efforts to collaborate and implement initiatives aimed at reducing individuals with mental illness involvement with the criminal justice system and usage of emergency departments and homelessness services. As part of its efforts to address behavioral health treatment needs of community members, McLean County partnered with the Corporation for Supportive Housing (CSH) and adopted its Frequent Users System Engagement (FUSE) model. FUSE identifies frequent users of jails, shelters, hospitals and/or other public crisis services and provides stabilization and wraparound services through supportive housing.

Region 4

Counties and Judicial Circuits



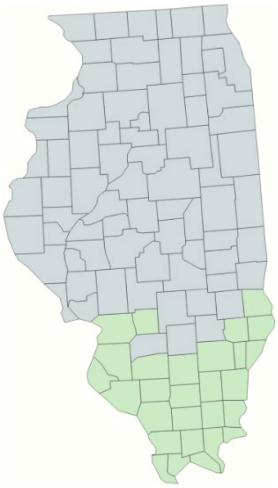
Region 4 is composed of the 4th 5th, 6th, 7th, and 8th Judicial Circuits. There are 34 counties included in Region 4. Region 4 had 77 unduplicated registrants for the five mapping workshops. The majority of those attending the sessions were service providers (29.9%), followed by those involved in community supervision including pretrial, probation, and parole (20.8%), officials from state agencies (19.5%), and attorneys and legal personnel (7.8%). A table of the unduplicated number of registrants and their disciplines may be found in Appendix D.

Innovation Highlight

Heartland CoC Housing Navigator Program

To address the eviction and homelessness crisis, the Heartland CoC, Helping Hands of Springfield, and Springfield Housing Authority partnered to hire a Housing Navigator to design processes to expedite housing placements, work with landlords and property managers to increase housing access, ensure housing is safe and appropriate, and address common barriers that prolong access to permanent housing.

Region 5



Counties and Judicial Circuits

Region 5 is composed of the 1st, 2nd, 3rd, 20th, and part of the 4th Judicial Circuits. There are 28 counties included in Region 5. Region 5 had 95 unduplicated registrants for the five mapping workshops. The majority of those attending the sessions were service providers (30.5%), followed by officials from state agencies (21.1%), those involved in community supervision including pretrial, probation, and parole (13.7%), and persons from advocacy organizations (6.3%). A table of the unduplicated number of registrants and their disciplines may be found in Appendix D.

Innovation Highlight

Take Action Today (TAT)

TAT is a 501c3 not-for-profit aimed at growing recovery resource capacity in Franklin, Jefferson, Perry, and Williamson counties. As a Recovery Community Organization, TAT advocates for the needs of the recovery community, develops training opportunities for people in recovery, and creates service opportunities for people in recovery to give back to their communities. TAT is committed to the development of the Peer Recovery Specialist role and delivering non-clinical support services that help to increase a person's chances of successful long-term recovery.

Regional Councils will continue to convene on a quarterly basis to effectuate recommendations within this Action Plan. The AOIC and Task Force will provide technical assistance for these Regional Councils.

Community Assessment

The Task Force conducted a series of three Community Assessments to supplement the Regional Mapping Workshops. Both the assessments and the workshops utilized the Sequential Intercept Model (SIM) which details how individuals with mental health and substance use disorders come into contact with and move through the criminal justice system and helps identify resources and gaps in services at each intercept.

The assessment was broken into three parts, each covering two intercepts. Part of the assessment asked respondents about the utilization of best practices across the sequential intercepts in their counties. The other part of the assessment was modeled after the SIMPLE Scorecard from Wayne State University's Center for Behavioral Health and Justice, which is used to assess county-level behavioral health and justice collaborations.

The Task Force requested members from each county in each region to complete the assessment to inform future strategic and actions plans and encourage cross-system collaboration to ensure as complete a picture of each community as possible at each intercept. Some respondents had a single assessment completed by a single point of contact gathering information from stakeholders on all questions to ensure accuracy. Others independently completed the assessment. The assessment was open from January through the end of May to encourage and facilitate cross-system consultation when forming responses and to ensure there was enough time to gather information and thoroughly answer each question. The assessment tool also allowed for saving and returning later to complete. There were 147 total surveys completed from 32 counties, 69 for intercepts 0-1, 43 for intercepts 2-3, and 35 for intercepts 4-5. The full survey and responses may be viewed in Appendix E.

Action Plan Recommendations

Since its inception in 2019, the Task Force has embraced a comprehensive approach to engagement in various activities leading up to the development of this Action Plan and set of Recommendations. Activities informing this Action Plan and set of Recommendations included but were not limited to the following:

- National Judicial Task Force to Examine the State Court Response to Mental Illness Leadership and developed resources
- Monthly Task Force Meetings including the Sharing of Information and Resources
- Ongoing review of relevant research, reports, and literature focused on the intersection of the justice system and behavioral health
- Task Force Member involvement and participation in justice and behavioral health related committees, commissions, etc.

- Hosting the Illinois Mental Health Summit: Improving the Court and Community Response to Persons with Mental Illness and Co-Occurring Disorders Through Compassion and Hope
- Development of the Illinois Mental Health Summit Report
- Hosting statewide Regional Council and Resource Mapping Workshops
- Completing a statewide Community Assessment modeled after the SIM and the SIMPLE Scorecard from Wayne State University's Center for Behavioral Health and Justice
- Receiving a Bureau of Justice, Justice and Mental Health Collaboration Program grant which provides resources to implement five court and mental health pilot programs, evaluation of those programs, and the potential to implement similar programs across the state
- Illinois Department of Mental Health 2008 Action Plan Review

Further, responding to the need for leadership across all branches of state government, Task Force members invested significant time and effort in promoting their work and creating awareness by presenting to numerous stakeholder groups.

While this plan serves as an initial roadmap for improving the court and community response to mental health and co-occurring disorders, it is not intended to be prescriptive or exhaustive. In the absence of a rigid model and specific requirements, stakeholders are free to take more risks, be more innovative, and discover what works best to meet the needs of their communities.

Furthermore, the action plan assumes all activities to be viewed through a lens of justice, equity, and inclusion. For ongoing information, it is suggested that Court Leadership review and implement strategies and resources made available through the Blueprint for Racial Justice. Launched in 2021 in response to action from the Conference of Chief Justices and the Conference of State Court Administrators, the Blueprint for Racial Justice is examining systemic change needed to make equality under the law a reality for all. Working with the National Center for State Courts' staff, the project is generating policies, webinars, benchcards, and other resources designed to assist court leaders with local racial justice, equity, and inclusion efforts.

The Action Plan includes recommendations specific to the following activities and Intercepts:

- Courts as Conveners and Leaders
- Training Opportunities Across Intercepts
- Awareness Across Intercepts
- Intercepts Zero and One – Community Services and Law Enforcement
- Intercept Two – Initial Detention and Court Hearings
- Intercept Three – Jails/Courts

- Intercept Four – Reentry
- Intercept Five – Community Corrections

1. Courts as Conveners and Leaders

With an estimated 70% of court-involved individuals experiencing a behavioral health disorder, courts have increasingly become the default system for addressing behavioral health needs. The rate of serious mental illness is four to six times higher in jail than in the general population, and the rate of substance use disorders is seven times higher among those in jail than in the general population. As leaders of their courts and communities, judges are in a unique position to encourage local practices aimed at improving responses to individuals with mental health and co-occurring substance use disorders.

RECOMMENDATION 1.1

The Task Force recommends review and implementation of the recommendations, as appropriate, of the National Judicial Task Force to Examine State Courts' Response to Mental Illness as approved by the Conference of Chief Justices and Conference of State Court Administrators through the Resolution and Findings and Recommendations. The Resolution urges each member of the Conferences to lead, examine, educate, and advocate for system improvements in his or her state or territory.

RECOMMENDATION 1.2

The Task Force recommends the Illinois Supreme Court support the Statewide Behavioral Health Administrator as a resource to develop and implement the statewide action plan to improve responses to individuals with behavioral health disorders.

RECOMMENDATION 1.3

The Task Force recommends that with the support of the Statewide Behavioral Health Administrator, judicially chaired Regional Councils continue to meet on a quarterly basis to encourage cross system communication, resource sharing, and further development and implementation of sequential intercept strategies.

RECOMMENDATION 1.4

The Task Force recommends the Supreme Court distribute a copy of this Action Plan, along with the Leading Change Guide for Trial Court Leaders to all Circuit Court Judges and Trial Court Administrators and encourage and empower all circuit courts to develop judicially-led interdisciplinary teams to advise and support local SIM activities and strategies.

RECOMMENDATION 1.5

The Task Force recommends the Supreme Court and Circuit Courts consider opportunities to improve court awareness and response to trauma, secondary trauma, and trauma-informed practices for Court staff, court users, and jurors.

RECOMMENDATION 1.6

The Task Force recommends Circuit Courts utilize case filing data to identify "revolving door" offenders as this population often displays multiple psychosocial risk factors, such as mental

illness, alcohol or substance use disorders, and homelessness. Once identified, courts may wish to convene a multidisciplinary Task Force to develop a more coordinated and comprehensive response to ensure treatment and break the cycle.

RECOMMENDATION 1.7

The Task Force recommends Circuit Courts collaborate with system partners to share and track data to inform system level decision making and reinforce diversion and treatment programs as viable budgetary solutions. It is recommended that the AOIC establish a desired data set for annual reporting to measure outcomes.

RECOMMENDATION 1.8

The Task Force recommends courts should examine the disproportionate impact of behavioral health conditions and associated demographics such as race, ethnicity, socio-economic status (SES), differential disability, and/or LGBTQIA+ on the overrepresentation of individuals who enter the justice system and ensure that interventions, diversions, specialized dockets, and other programming are equitably applied.

RECOMMENDATION 1.9

The Task Force recommends that the Supreme Court and Circuit Courts advocate for a comprehensive behavioral health care continuum that includes both outpatient and inpatient services as well as recovery oriented community housing.

2. Training Opportunities Across Intercepts

A key component to enhancing the court and community response to justice-involved individuals with mental health and co-occurring substance use disorders is providing access to continued training for professionals charged with providing community supervision, care, and support. This was not lost on the Task Force and resulted in a specific Recommendation along with opportunities for increased training.

RECOMMENDATION 2.1

The Task Force recommends the AOIC continuously engage with criminal justice professionals and partners to develop training programs that enhance court and community responses to justice-involved individuals with behavioral health disorders.

RECOMMENDATION 2.2

The Task Force recommends that training in implicit bias, microaggression, and other DEIA-appropriate courses be developed to increase judicial and justice professionals' cultural respectfulness and proficiency.

RECOMMENDATION 2.3

The Task Force recommends that training on behavioral health signs and symptoms, court interventions, and trauma-informed courtrooms be developed by the AOIC Judicial Education Division and made available to Court Professionals (i.e., judges, attorneys, probation officers, clerks, bailiffs, etc.)

- AOIC: How Being Trauma-Informed Improves Criminal Justice System Responses (New Train-the-Trainer opportunity coming to Illinois in 2022/2023) (Existing Facilitators)
- AOIC: Problem-Solving Court Series (Coming to Illinois in 2022/2023)
- Illinois Mental Health Task Force: Civil Mental Health Proceedings Training Serries under Development: Orders of Detention and Examination, Involuntary Inpatient and Outpatient Treatment, Power of Healthcare Attorney and Mental Health Declarations
- Judges and Psychiatrists Leaderships Initiative: Train the Trainer Program
- Future topics: Harm Reduction, Mental Health First Aid for Public Safety, others as identified
- NCSC Behavioral Health and the State Courts Education

3. Awareness Across Intercepts

Public awareness of the prevalence and impact of behavioral health disorders on the justice system is key to enhancing partnerships and responses.

RECOMMENDATION 3.1

The Task Force recommends the Supreme Court and Circuit Courts conduct outreach and education of local, regional, and statewide stakeholders regarding behavioral health and justice intercepts as an ongoing priority.

RECOMMENDATION 3.2

The Task Force recommends courts should actively collect and review race and ethnicity data to identify inequitable practices and to monitor progress in achieving equity. This analysis should extend to diversion to treatment, related placements, mental health evaluation referrals, and diagnostic outcomes.

RECOMMENDATION 3.3

The Task Force recommends AOIC Staff and Circuit Court professionals participate on relevant multidisciplinary committees, councils, task forces, etc. to provide a court-focused voice across systems, as the court system is the largest source of referrals to the behavioral health system.

RECOMMENDATION 3.4

The Task Force recommends utilizing the Task Force webpage as a transparent and central outlet of relevant resources so court and criminal justice professionals can easily obtain supporting information.

4. Intercepts Zero and One – Community Services and Law Enforcement

Court professionals' knowledge of current behavioral health resources, trends, systemic issues, and ongoing advocacy of best practices is vital to providing justice-involved individuals with an optimal opportunity to live stable and healthy lifestyles within the community.

RECOMMENDATION 4.1
The Task Force recommends that information about helplines such as 988, Call4Calm, and the Opioid and Other Substance Helpline be made available to the public at all court facilities.

RECOMMENDATION 4.2
The Task Force recommends the Supreme Court and Circuit Courts advocate for ongoing development of Certified Community Behavioral Health Clinics and increased access to Forensic Assertive Community Treatment.

RECOMMENDATION 4.3
The Task Force recommends the Supreme Court and Circuit Courts advocate for ongoing development of supportive treatment housing.

RECOMMENDATION 4.4
The Task Force recommends continued expansion and inclusion of Peer Support Specialists and/or individuals with lived experience in early intercept strategies.

RECOMMENDATION 4.5
The Task Force recommends Court and Criminal Justice support of strategies identified within the State Overdose Action Plan.

5. Intercept Two: Initial Detention and Court Hearings
Intercept 2 involves people with mental health and co-occurring substance use disorders who have been arrested and are going through intake, booking, and an initial hearing with a judge. At Intercept 2 there are many opportunities for early identification and diversion from further penetration into the criminal justice system.

RECOMMENDATION 5.1
The Task Force recommends the Supreme Court and Circuit Courts promote Collaborative Case Flow Management as a critical strategy of a collaborative court and community effort to promote person-centered justice for individuals with behavioral health needs.

RECOMMENDATION 5.2
The Task Force recommends county jail implementation of Jail Data Link to identify individuals with mental health disorders who have previously been involved in Illinois Department of Human Services, Division of Mental Health services.

RECOMMENDATION 5.3
The Task Force recommends developing and strengthening partnerships between Circuit Courts, the Office of Statewide Pretrial Services, and Illinois Department of Health and Human Services to enhance pretrial supervision practices and outcomes through alternative pathways to diversion and treatment.

RECOMMENDATION 5.4

The Task Force recommends consideration of embedding Recovery Support Navigators/ Community Behavioral Health Liaisons into circuit courts to meet with individuals who display indications of behavioral health needs.

6. Intercept Three: Jails/Courts

Intercept 3 involves people with behavioral health disorders who are held in jail before and during their trials and includes court-based diversion programs that allow the criminal charge to be resolved while taking care of the defendant's behavioral health needs in the community and/or providing services that prevent the worsening of a person's mental or substance use symptoms during their incarceration.

RECOMMENDATION 6.1

The Task Force recommends State Court develop a partnership with the DHS DMH Forensic Services Director to further develop alternative competency to stand trial strategies to eliminate practices of warehousing individuals in jails while awaiting competency restoration.

RECOMMENDATION 6.2

The Task Force recommends increasing utilization of assisted outpatient treatment (AOT) as a form of civil commitment that authorizes the judicial system to commit eligible individuals with severe psychiatric disorders to mental health intervention in the community.

RECOMMENDATION 6.3

The Task Force recommends courts, providers, and advocates encourage the use of psychiatric advance directives (PAD) and incorporate the provisions of an individual's PAD into relevant court orders.

RECOMMENDATION 6.4

The Task Force recommends continued implementation and assurance of problem-solving court best practices though the Supreme Court of Illinois Problem-Solving Court Standards and Certification process.

RECOMMENDATION 6.5

The Task Force recommends Circuit Courts recognize telebehavioral health interventions and best practices as an approach to expanding access and capacity for treatment of behavioral health disorders.

RECOMMENDATION 6.6

The Task Force recommends local engagement in the DHS SUPR, Health Management Associates (HMA) Learning Collaborative for county teams interested in standing up or expanding medication-assisted recovery (MAR) programs in their jails and to support continued recovery support in the community post-release.

7. Intercept Four: Reentry

At Intercept 4, people plan for and transition from jail or prison back into the community which demands strong partnerships in place to provide seamless access to medication, treatment, housing, health care coverage, and services from planning for release, the moment of release, and throughout their reentry.

RECOMMENDATION 7.1

The Task Force recommends enhancement of cross-sector partnerships and communication to strengthen support and resources for people who are being released from incarceration and often need care for behavioral health, housing, transportation, and other supportive services to reduce the impact of social and environmental factors that affect an individual or entire community's health status. (Social Determinants of Health (SDOH).

RECOMMENDATION 7.2

The Task Force recommends inclusion of Peer Support services to help people plan for reentry from local jails and state prisons through identification of safe housing, resource linkage, and learn about causes that could lead back to the justice system.

RECOMMENDATION 7.3

The Task Force recommends increased jail in-reach programs to identify, engage, and support individuals at the highest risk of returning to homelessness, overdose, and perhaps reincarceration post discharge.

8. Intercept 5: Community Corrections

People under correctional supervision are on probation or parole and require support from criminal justice agencies and community-based behavioral health, mental health, or social service programs. Throughout the Regional Council and Resource Mapping Workshops, access to safe and affordable housing was referenced as the resource most needed to support public health and safety goals.

RECOMMENDATION 8.1

The Task Force recommends community supervision providers utilize screening and assessment tools to determine how to respond to violations most effectively to influence positive behavioral change.

RECOMMENDATION 8.2

The Task Force recommends the use of smaller and specialized behavioral health disorder caseloads to provide support that keeps their clients on the path to recovery, increases connections to services and appointments, and reduces the chance of violations and jail stays**.**

RECOMMENDATION 8.3

The Task Force recommends Circuit Courts explore opportunities to increase community housing options for individuals under corrections supervision.

External Funding Support to Lead Change

External funding support for Leading Change efforts may be found at local, state, and/or federal levels. No matter the funder, the search for external funding support starts with developing a compelling impact statement with stakeholders then conceptualizing a successful implementation and operational plan. Having these conversations and engaging in program/project development activities prior to identifying funding sources is crucial to developing need-based vs. funding driven programming and solutions.

To accomplish these goals, AOIC proposes to utilize Justice and Mental Health Collaboration Program (JCMHP) funding to expand the reach of the Task Force by providing funding to local courts to expand and enhance evidence-based interventions to divert individuals with MI/CMISUD from the justice system.

Potential Funding Opportunities

- Association of Community Mental Health Authorities of Illinois
- Illinois Criminal Justice Information Authority
- Illinois Department of Human Services
- Certified Recovery Support Specialist Success Program
- Bureau of Justice Assistance
- Comprehensive Opioid, Stimulant, and Substance Abuse Program
- SAMHSA

Moving Forward/Next Steps

As the Illinois Task Force, with support from the Illinois Supreme Court, Illinois Circuit Courts, and various justice and behavioral health partners move to effectuate national and statewide efforts to lead, examine, educate, and advocate, proposed next steps include the following actions:

- Present this Action Plan to Illinois Conference of Chief Judges.
- Distribute a message from the Supreme Court which encourages all Chief Judges and Trial Court Administrators to convene and lead efforts in their circuits and communities through operationalizing the template set forth in the National Task Force: Leading Change Guide for Trial Court Leaders: Improving the Court and Community's Response to Mental Health and Co-Occurring Disorders and using established Resources and Publications to inform efforts.
- In partnership with the National Center for State Courts, host a statewide online seminar to promulgate the Action Plan content.
- Engage Trial Court Administrators through outreach efforts.

- Present this Action Plan to justice professionals and partners and seek their engagement.
- Promote the Action Plan Recommendations and provide technical assistance.
- Seek continuous funding opportunities to pilot, implement, and sustain the Action Plan recommendations.

Courts are in a unique position to lead change by following the recommendations and using the resources developed by the National Judicial Task Force to Examine State Courts' Response to Mental Illness and this Action Plan to bring communities together to communicate, collaborate, and make a difference for individuals with mental health needs with compassion and hope.

Appendix A

The National Diversion Landscape[20]

The National Judicial Task Force to Examine State Courts' Response to Mental Illness conducted a survey over a six-month period in 2021 to better understand the availability and utilization of adult behavioral health diversion practices in each state. The survey targeted State Court Administrators/State Court Behavioral Health Administrators in each state and territory. Forty of fifty-six (71.4%) states and territories responded to the survey, providing unprecedented insight into adult behavioral health diversion and deflection practices in the US state court criminal justice system.

The survey examined states' continuum of care including the availability and utilization of a range of programs and services (continuum of care) for the ideal behavioral health system, ideal behavioral health crisis system, pre-arrest diversion and deflection, pre-adjudication diversion, and post-adjudication diversion. Results of the survey indicated several trends including the following.

Ideal Behavioral Health System

- States were most likely to have outpatient mental health and substance use disorder treatment, followed by cognitive behavioral therapy, and intensive outpatient substance use disorder treatment. States were least likely to have assertive community treatment, and certified peer support.
- When it came to secondary behavioral health services and other supports, states were most likely to have medication assisted treatment, supported housing, case management teams, and recovery supports. States were least likely to have use of psychiatric advance directives, assisted outpatient treatment, and co-location of behavioral health and other services.
- Although the services noted were available states, respondents noted that many services were not widely accessible across their state, especially in rural areas; there were often waiting lists; a shortage in the behavioral health workforce; lack of services for those in need of the highest level of care such as Forensic Assertive Community Treatment (FACT); case management services; and peer lead services such as Club Houses.
- When asked if telehealth had improved access to services, most states reported that due to the pandemic, teleservices were approved and/or increased; and although many states also noted that telehealth services overcome barriers such as transportation, employment, and sometimes waitlists, there is not a clear picture that jurisdictions will continue to utilize teleservices.

[20] NCSC (2022). National Diversion Landscape: Continuum of Behavioral Health Diversions Survey Report. https://www.ncsc.org/__data/assets/pdf_file/0022/77143/National-Diversion-Landscape.pdf

Ideal Behavioral Health Crisis System

- States were most likely to have 24-hour crisis lines, acute psychiatric hospital units, and crisis stabilization units. States were least likely to have living room/peer run crisis centers, crisis residential services, and partial or day hospitals.
- Courts have recognized the need to develop collaborations, programs, and linkages to crisis services for those individuals who are likely to become justice involved. States identified the need for crisis stabilizations, mobile crisis teams, and partnerships with community behavioral health providers.

Pre-Arrest Deflection and Diversion

- States were most likely to have police response/CIT training and mobile crisis teams. States were least likely to have co-responder teams and identification of high utilizers.
- Similar challenges were identified in this area including behavioral health workforce shortages, appropriate services for pre-arrest diversion, access to services across the state, and lack of housing/supported housing.

Pre-Adjudication Diversion

- States were most likely to have prosecutor-led diversions, pretrial release resources, treatment courts, and recovery peer specialists. States were least likely to have data matching between the jail and behavioral health providers, court liaisons/navigators, and structured warm handoffs between the jail and community providers.
- When asked about assessments, states were most likely to have assessments for substance use disorders, followed by mental health, and criminogenic risk. Assessments were more likely to be done by pretrial staff than jail staff. States were least likely to have assessments for trauma utilized for pre-adjudication diversion programs.
- When asked about challenges, states identified the need for data to support programs, court liaisons/navigators, not enough services for diversion, and difficult to ensure equal access to diversion options.

Post-Adjudication Diversion

- States were most likely to have treatment courts and alternative to incarceration sentencing. States were least likely to have specialized behavioral health community supervision caseloads and benefits enrollment.
- Identified challenges included housing, lack of services in rural communities, and lack or transition planning.

Appendix B

Illinois Department of Mental Health 2008 Strategic Plan

PRA Action Plan: Transforming Systems and Services Recommendations

FIGURE 3: PRA RECOMMENDATIONS 1 THROUGH 8

Expand Police Crisis Intervention Teams (CIT)

Improve Coordination with Law Enforcement and Expand Crisis Stabilization

Expand Intercept 2 Diversion Options and Data Link

Improve Screening and Basis Jail Mental Health Services

Improve Unfit to Stand Trial and Not Guilty by Reason of Insanity Processes and Develop Outpatient Capacity for Restoration

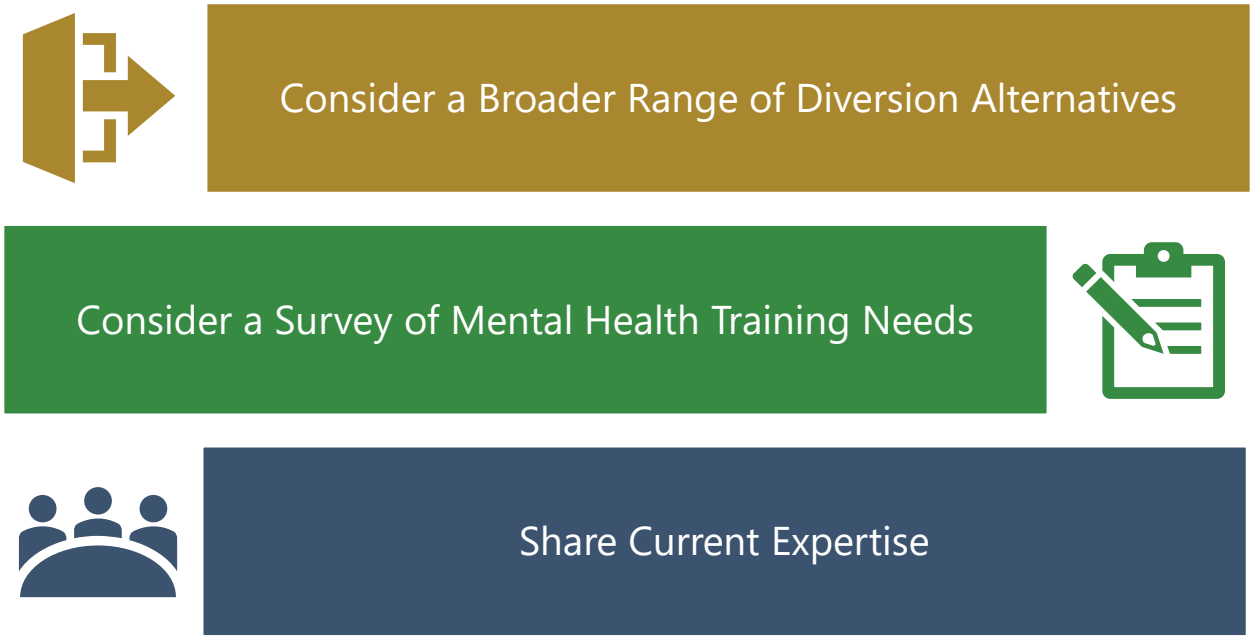
Improve Jail Transition Planning

Improve Prison Discharge Planning

Involve Parole with Community Mental Health Planning & Improve Coordination with Mental Health Service Providers

FIGURE 4: PRA RECOMMENDATIONS 9-16

FIGURE 5: PRA RECOMMENDATIONS TO THE JUDICIARY



Appendix C

Task Force Roster

Illinois Supreme Court Task Force on Improving the Court and Community Response to Mental Health and Co-Occurring Disorders

Sue Blechschmidt
President
Association of Police Social Workers

Scott Block
Statewide Behavioral Health Administrator
Administrative Office of the Illinois Courts

Stephen Brown MCW, LCSW
Director of Preventive Emergency
Medicine Department of Emergency
Medicine University of Illinois Hospital and
Health Sciences System

Bill Blundell, MPA, LCPC
Problem-Solving Court Manager
Administrative Office of the Illinois Courts

Hon. Anne M. Burke
Supreme Court Chief Justice First District
Robin Karpinski

Elizabeth Evans
Deputy Executive Director
The Kennedy Forum

Dr. Sharon Coleman
Deputy Director of Forensic and Justice
Services
DHS – Division of Mental Health

Yaacov DeLaney
Director
Justice, Equity and Opportunity Initiative
Office of Illinois Lt. Governor
Juliana Stratton

Sen. Sara Feigenholtz
Illinois Senate 6th District
Maggie O'Keefe

Gerald "Jud" DeLoss
Chief Executive Officer
Illinois Association of Behavioral Health

Mary Ann Dyar
Project Director
Adult Redeploy

Stephanie Frank LCSW
Deputy Director of Planning, Performance
Assessment and Federal Projects
DHS – Division of Substance Use
Prevention and Recovery

Kelly Gallivan-Ilarraza
Director of Problem-Solving Courts Office
of the Chief Judge
Illinois Circuit Court of Cook County

Dr. Melvin Hinton
Chief of Mental Health Services
Illinois Department of Corrections

Dan Hunt
Assistant Director-Probation Services
Administrative Office of the Illinois Courts

Alexa James MS, LCSW
Executive Director
NAMI Chicago

Joan Lodge, LCSW/LPHA
Administrator Adult Mental Health Services
Rosecrance Ware Center

Jen McGowan-Tomke, MPH
Associate Director
NAMI Chicago

Marcia M. Meis
Director
Administrative Office of the Illinois Courts

Dr. Lorrie Rickman-Jones
Vice President of Strategic Innovation and Behavioral Health
Next Level Health

Craig A. Stallings, M.S. Ed, LCPC, CADC
Senior Director
Rosecrance Inc.

Hon. Sharon M. Sullivan (Ret.)
Presiding Judge
Circuit Court of Cook County

Hon. Maureen Ward-Kirby
Circuit Judge - Circuit Court of Cook County

Hon. Kathryn Zenoff
Judge
Illinois Appellate Court Fourth District

Michelle O'Brien
Principal Court Management Consultant
National Center for State Courts

July 2022

Appendix D

Regional Workshop Participants by Discipline

The following table represents unduplicated workshop participants from all regions over the course of all five workshops. The attendees were grouped by discipline. The operationalization of each category is listed in the second table.

Disciplines	Region 1 (n=152)	Region 2 (n=212)	Region 3 (n=98)	Region 4 (n=77)	Region 5 (n=95)
Judiciary/Court Administration	5.3%	8.5%	10.2%	6.5%	5.3%
Legal	10.5%	11.3%	4.1%	7.8%	4.2%
Law Enforcement	11.2%	15.1%	5.1%	5.2%	2.1%
Jail/Detention	2.0%	0.0%	2.0%	1.3%	0.0%
Community Supervision	2.6%	13.2%	21.4%	20.8%	13.7%
Service Provider	32.9%	20.8%	19.4%	29.9%	30.5%
State Agency	10.5%	7.5%	15.3%	19.5%	21.1%
MHB/Funder	1.3%	3.3%	3.1%	1.3%	4.2%
Advocacy	8.6%	1.9%	1.0%	0.0%	6.3%
City or County Board/ Administration	2.0%	0.9%	1.0%	0.0%	0.0%
Public Health	0.7%	3.3%	0.0%	2.6%	4.2%
EMS/Fire	2.6%	1.9%	0.0%	0.0%	0.0%
Lawmaker	0.7%	0.5%	0.0%	0.0%	0.0%
VA	0.7%	0.0%	0.0%	0.0%	1.1%
Dispatch	0.0%	0.9%	0.0%	0.0%	0.0%
Treatment Courts	3.3%	3.8%	8.2%	0.0%	1.1%
Juvenile Court/Probation	2.0%	2.4%	3.1%	0.0%	0.0%
IDOC	3.3%	1.9%	4.1%	5.2%	2.1%
Education	0.0%	1.4%	1.0%	0.0%	3.2%
Community and Economic Development	0.0%	1.4%	0.0%	0.0%	0.0%
Other	0.0%	0.0%	1.0%	0.0%	1.1%

Operationalization	
Judiciary/Court Administration	Judges and court administrators and their staff
Legal	Prosecutors, defense, victim advocates and all other attorneys
Law Enforcement	Sheriffs and municipal police, co-responders and others embedded in the police departments
Jail/Detention	Juvenile and adult detention officers and officials

Community Supervision	Court services directors, chief probation officers, probation officers, pretrial officers, parole officers, and those embedded in their agencies that provide services to clients
Service Provider	Any clinical or social service provider, regardless of title, not embedded in a criminal justice agency or public health organization.
State Agency	Officials from AOIC, ICJA, and DHS/DMH/SUPR
MHB/Funder	Any person identifying as a 708, 553, or other board member, and or as a member of a funding organization such as a nonprofit to support treatment courts.
Advocacy	Those identifying with advocacy and policy organizations such as the Bar Association, Disability Advocacy Organizations, NAMI (except those identifying as direct service providers), organizations that lobby for increased access or improved/expanded behavioral health services, etc.
City or County Board/ Administration	Officials from cities, villages, towns, counties that have political or administrative oversight of the municipality's functioning.
Public Health	Those identifying as managing or providing services through a public health agency.
EMS/Fire	Emergency Medical Services and Fire Department staff, and those who train/certify them
Lawmaker	State Senators and Representatives or their staff
VA	Staff from the Veteran's Administration including service providers and VJOs.
Dispatch	9-1-1 and non-emergency dispatchers
Treatment Courts	Those identifying as coordinators or staff or treatment courts
Juvenile Court/Probation	Any person identifying as working in family or juvenile court or probation
IDOC	Staff of the Illinois Department of Corrections
Education	University and college staff who did not identify as direct service providers.
Community and Economic Development	Staff of municipal and regional community and economic development agencies
Other	Private citizens, members of the public

Appendix E

Community Assessment Survey Responses

Intercepts 0 and 1

Crisis Services

Respondents were asked about the utilization of and or need for common crisis services in their county, and what changes, if any to existing services need to be made. All core crisis services and best practices are taken from SAMHSA's National Guidelines for Behavioral Health Crisis Care.[21]

Regional Crisis Call Centers are regional 24/7 clinically staffed hub/crisis call center that provides crisis intervention capabilities (telephonic, text and chat). Such a service should meet National Suicide Prevention Lifeline (NSPL) standards for risk assessment and engagement of individuals at imminent risk of suicide and offer quality coordination of crisis care in real-time.

Crisis Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Regional Crisis Call Center					
Utilized, No Changes Needed	0	6	3	2	3
Utilized, Changes Needed	5	13	2	3	3
Not Being Utilized, Should Be Utilized	5	4	1	2	2
Not Being Utilized, Not Needed	0	0	0	0	1
Unsure	8	1	1	1	3

Across the regions, most respondents noted having a regional crisis call center. In Region 1, many of the respondents were unsure about whether the resource existed or not. For those who noted that changes were needed to the service, the changes included: adapting to the new 9-8-8 protocol; employing more staff to ensure response; staffing the lines with dedicated professional staff rather than sending calls directly to mobile crisis staff; expanding existing regional lines to be staffed 24/7/365; including online or in-person crisis reporting; better marketing/publicity for the existing service; and bringing individual crisis call lines under a comprehensive regional umbrella.

Mobile Crisis Response Teams are teams of professionals offering community-based intervention to individuals in need wherever they are; including at home, work, or anywhere else in the community where the person is experiencing a crisis.

Crisis Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Mobile Crisis Response Team					
Utilized, No Changes Needed	0	6	2	2	2
Utilized, Changes Needed	5	14	2	2	1
Not Being Utilized, Should Be Utilized	4	2	1	2	3

[21] SAMHSA (2020). National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-services-executive-summary-02242020.pdf

Crisis Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Not Being Utilized, Not Needed	1	0	0	0	2
Unsure	8	2	2	2	4

In Regions 2, 3, and 4, most respondents noted the existence and utilization of mobile crisis teams. In Regions 1 and 5, many respondents were unsure or were split on whether mobile crisis teams were utilized in their county or not. For those who noted changes were necessary, the changes included: need for teams serving all ages with Medicaid; need to have a crisis team in their county or area of the county; need for expansion and coordination to meet the Community Emergency Services and Support Act (CESSA) requirements; need to increase capacity and improving quality of services provided; need to increase follow-up capacity; need to provide municipalities and providers with direction on Program 590 services around dispatch and response areas; need to improve use of community resources over emergency rooms; need to provide in-person response rather than referral to emergency services; and need for improved interagency communication and cooperation.

Crisis Receiving and Stabilization Services offer the community a no-wrong-door access to mental health and substance use care; operating much like a hospital emergency department that accepts all walk-ins, ambulance, fire and police drop-offs, and is committed to never turning away a first responder or walk-in referral.

Crisis Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Crisis Receiving and Stabilization Services					
Utilized, No Changes Needed	0	7	2	2	1
Utilized, Changes Needed	8	10	1	3	3
Not Being Utilized, Should Be Utilized	4	4	3	1	5
Not Being Utilized, Not Needed	0	0	0	0	2
Unsure	6	3	1	2	1

All regions had respondents that noted having crisis receiving and stabilization services. However, several respondents in each region noted they were unsure about access or did not have access to such services. For those who noted changes were necessary, the changes included: need for more providers/staff to alleviate long waitlists or other barriers to access to service; need for funding and resolve conflicts in policies regarding transport to these services; need to resolve insurance limits/lack of funding for these services; need for standardized screening tools; need for transition services; need to house in neutral spaces and not in jails or hospitals; need for adequate training for staff; need for accessibility for those not experiencing suicidal/homicidal ideation; need for improved marketing/publicity for these services.

Short-Term Crisis Step-Down Facilities are a strong step-down option to support individuals who do not require inpatient care after their crisis episode. SAMHSA calls these Short-Term Residential Facilities to communicate that they are not crisis facilities as they are not required to accept all referrals. Staffing for these programs is far less intensive than a crisis receiving and stabilization facility and should minimally have a licensed and/or credentialed clinician on location for several hours each day and on call for other hours.

Crisis Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Short-Term Crisis Step-Down Facility					
Utilized, No Changes Needed	0	4	2	0	0
Utilized, Changes Needed	4	4	1	5	0
Not Being Utilized, Should Be Utilized	7	12	3	2	8
Not Being Utilized, Not Needed	0	0	0	0	1
Unsure	7	4	1	1	3

All regions except Region 5 had respondents that noted having short-term crisis step-down facilities. However, most regions' respondents noted they either did not have the service or where unsure if the service existed in their county. For those who noted they had the service but changes were necessary, the changes included: the need for better funding for step-down services; easier access to these services; re-instituting these services where they have gone defunct; better connections to safe, stable housing upon exit; more beds/availability; and having them located in closer proximity to emergency departments.

Peer-Operated Respite programs provide peer-staffed, restful, voluntary sanctuary for people in crisis, which is preferred by guests and increasingly valued in service systems. Peer respite offers a low-cost, supportive step-down environment for individuals coming out of or working to avoid the occurrence of a crisis episode.

Crisis Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Peer-Operated Respite					
Utilized, No Changes Needed	1	1	1	1	0
Utilized, Changes Needed	3	4	0	1	1
Not Being Utilized, Should Be Utilized	4	11	4	4	7
Not Being Utilized, Not Needed	1	1	0	0	1
Unsure	9	7	2	2	3

The majority of respondents noted not having or being unsure about having peer-operated respite in their counties, although at least one respondent in every region noted having peer-operated respite services. For those who noted they had the service but changes were necessary, the changes included: increased capacity and expanded hours; additional locations throughout the community/county/area; centralized referral to and from peer-operated respite; workforce development for peer support specialists; and interagency communication and cooperation.

Psychiatric Advance Directives (PADs) are a legal tool that allow persons with mental illness to state their preferences for treatment in advance of a crisis. They can serve to protect a person's autonomy and ability to self-direct care. Crisis providers are expected to always seek to understand and implement any existing PAD that has been developed by the individual during the evaluation phase and work to ensure the individual discharges from crisis care with an updated and accurate psychiatric advance directive whenever possible. PADs create a path to express treatment preferences and identify a representative who is trusted and legally empowered to make healthcare decisions on medications, preferred facilities, and listings of visitors.

Crisis Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Psychiatric Advance Directives					
Utilized, No Changes Needed	2	3	2	0	0
Utilized, Changes Needed	4	7	1	2	2
Not Being Utilized, Should Be Utilized	2	6	3	1	3
Not Being Utilized, Not Needed	0	0	0	0	2
Unsure	10	8	1	5	5

Most respondents were unsure if PADs exist in their county or believed that it does not. However, at least two respondents from every region did note that PADs do exist in their county. For those who noted they had PADs, but changes were necessary, the changes included: providing widespread education to patients and providers on patients' rights; expanding the mental health patient navigator workforce; simplifying the process to execute PADs; expand access to PADs; increase providers to provide PADs; ensure acceptance of PADs at local hospitals and service facilities.

Assisted Outpatient Treatment (AOT) is the practice of providing community-based mental health treatment under civil court commitment to treat patients with serious mental history and a history of treatment failure. AOT (also known as involuntary outpatient commitment, conditional release, and other terms) involves petitioning local courts to order individuals to enter and remain in treatment within the community for a specified period. AOT is intended to facilitate the delivery of community-based outpatient mental health treatment services to individuals with SMI that are under court order, as authorized by state mental health statute.[22]

Crisis Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Assisted Outpatient Treatment					
Utilized, No Changes Needed	1	8	4	5	1
Utilized, Changes Needed	6	8	1	3	5
Not Being Utilized, Should Be Utilized	4	3	1	0	4
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	7	5	1	0	2

Most respondents in all regions noted the availability of AOT in their counties. Approximately one quarter of respondents noted they did not have AOT, and 21% were unsure. For those who noted they had AOT but changes were necessary, the changes included: better coordination with wraparound services and allow concurrent substance use treatment; expansion of AOT in lieu of hospitalization or incarceration; increase capacity; make it more affordable and accessible; expand community outreach; formalize the process through interagency communication and cooperation; improve/ secure/expand workforce; decrease time to service initiation; more convenient locations; more secure facilities; better information sharing, marketing, and outreach; and better defined protocols.

[22] https://www.samhsa.gov/sites/default/files/grants/pdf/sm-16-11.pdf

Law Enforcement Crisis Intervention Teams Training (CIT) involves police training by mental health professionals to provide crisis intervention and act as liaisons to the mental health system. CIT training for law enforcement includes educating officers about mental illness, substance use and abuse, psychiatric medications, and strategies for identifying and responding to a crisis. CIT necessitates a strong partnership and close collaboration between the police officers and mental health programs that includes the availability of a crisis setting where police can drop off people experiencing a mental health crisis.

Crisis Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Law Enforcement Crisis Intervention Team Training					
Utilized, No Changes Needed	6	7	1	3	2
Utilized, Changes Needed	6	9	2	2	2
Not Being Utilized, Should Be Utilized	0	3	2	1	2
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	6	5	2	2	6

Nearly 60% of respondents noted their county is utilizing CIT training for law enforcement. Thirty percent noted their county is not utilizing CIT, and 12 percent were unsure. All regions noted having a CIT-trained officer. For those who noted they had CIT but changes were necessary, the changes included: more community awareness/outreach; more uniformity across departments; implementation of CIT teams that partner with/utilize clinicians; institution of performance measures and benchmarks for success; expanded training, particularly for patrol officers; more emphasis on understanding disabilities, not just de-escalation; more refresher trainings and specialized trainings for dispatch; more funding for training; train officers sooner, ideally as part of basic training; and better collaboration between CIT officers and mobile crisis response teams.

Law Enforcement Co-Responder Programs are a response to crisis where law enforcement agencies dedicate specially trained personnel and team them with clinically trained individuals to respond to mental health crises. These programs vary in design, from embedded clinical staff housed at the law enforcement agency, to dual dispatch of mobile crisis and law enforcement, to telehealth provided via the officer's tablet or laptop to the person in crisis.

Crisis Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Law Enforcement Co-Responder Program					
Utilized, No Changes Needed	4	6	1	1	0
Utilized, Changes Needed	3	10	0	2	0
Not Being Utilized, Should Be Utilized	3	4	4	2	3
Not Being Utilized, Not Needed	1	0	0	0	1
Unsure	6	4	2	3	8

Thirty-nine percent of respondents indicated that they have co-responder programs in their counties, 26% indicated they do not, and a third were unsure. All regions except Region 5 indicated having at least one co-responder model. For those who indicated they had a co-responder model but changes were needed, the changes included: more uniformity/inclusion of other law enforcement agencies; expansion of staff to better reach the entire jurisdiction;

increased capacity and geographic coverage; standard operating procedures for classifying calls; and increase response to 24 hours a day, seven days a week.

Overdose Response Teams (also called post-overdose response teams, quick response teams, rapid response teams, etc.) are an emerging strategy to meaningfully engage with people who have experienced overdose. These teams follow up with patients who have experienced an overdose within 72 hours. Teams seek to link the patient with appropriate care ranging from harm reduction services to treatment to recovery supports.[23]

Crisis Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Overdose Response Teams					
Utilized, No Changes Needed	1	3	1	0	0
Utilized, Changes Needed	4	6	0	0	1
Not Being Utilized, Should Be Utilized	4	10	3	4	5
Not Being Utilized, Not Needed	1	0	0	0	2
Unsure	8	5	3	4	4

Less than a quarter of respondents indicated that they have an opioid response team in their county. Forty-two percent indicated they do not have a team, and 35% indicated they were unsure. All regions except Region 4 had at least one respondent that noted they have an ORT in their county. For those who indicated they had an ORT but changes were needed, the changes included: better outreach/marketing/education on their existence; expansion of staff to reach all geographic areas of the jurisdiction; and increased collaboration between agencies.

Crisis Triage Centers offer in-person treatment and services to people experiencing a behavioral health emergency. These centers may offer short-term treatment, group and individual therapy, medical assessment, peer respite, medication administration and rehabilitation services, among other ongoing support options. In many counties, crisis triage centers are federally funded Certified Community Behavioral Health Clinics (CCBHCs) that provide integrated and evidence-based services to residents.[24]

Crisis Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Crisis Triage Center					
Utilized, No Changes Needed	0	4	3	0	0
Utilized, Changes Needed	3	4	0	3	2
Not Being Utilized, Should Be Utilized	7	12	2	4	6
Not Being Utilized, Not Needed	0	1	1	0	2
Unsure	8	3	1	1	2

The majority of respondents indicated that they do not have a crisis triage center in their county. Twenty-two percent indicated they are unsure if they do, and a little over a quarter indicated they do. At least two people from each Region indicated they have a crisis triage

[23] https://www.ncdhhs.gov/about/department-initiatives/opioid-epidemic/first-responders
[24] https://www.naco.org/events/somewhere-go-during-behavioral-health-emergency-crisis-triage-centers-and-behavioral-health

center in their county. For those who indicated they had a center, but changes were needed, the changes included: increasing hours and staffing to accommodate 24/7 operation; improving collaboration with law enforcement; developing standardized screening tools; decreasing response time; improving inadequate architectural layouts; and placement closer to emergency rooms/hospitals.

Brief Intervention and Treatment (BIT) refers to a brief universal screening, time-limited intervention, and referral to treatment. Success in substance use treatment has led to its use with other behavioral health issues, including anxiety and depression. Brief Intervention and Treatment is designed for primary and emergency care providers to stabilize an individual so they can be referred to more appropriate treatment.

Crisis Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Brief Intervention and Treatment					
Utilized, No Changes Needed	0	7	2	2	1
Utilized, Changes Needed	8	10	1	3	3
Not Being Utilized, Should Be Utilized	4	4	3	1	5
Not Being Utilized, Not Needed	0	0	0	0	2
Unsure	6	3	1	2	1

The majority of respondents indicated that they have BIT in their communities. Smaller percentages indicated they do not have BIT (25%) or are unsure (19%). All regions have this service. For those who indicated they had the service, but changes were needed, the changes included: better linkage to services once a need is identified; colocation of services; ability to have appointments scheduled prior to discharge; expansion to non-hospital settings; expanded availability; better advertisement of services; and improved communication and collaboration between agencies.

Substance Use Services

Respondents were asked about the utilization of and or need for common substance use disorder (SUD) services in their county and what changes, if any, to existing services need to be made.

Prevention and Early Intervention strategies can reduce the impact of substance use on communities. Prevention activities work to educate and support individuals and communities to prevent the use and misuse of drugs and the development of substance use disorders. Early intervention is the American Society of Addiction Medicine's (ASAM's)[25] lowest level (0.5) of assessed care. It includes assessment and education for individuals with risk factors related to substance abuse who do not have a confirmed substance use disorder.

Substance Use Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Prevention and Early Intervention					
Utilized, No Changes Needed	2	10	4	3	1
Utilized, Changes Needed	9	6	1	5	4

[25] https://www.aetna.com/document-library/healthcare-professionals/documents-forms/asam-criteria.pdf

Substance Use Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Not Being Utilized, Should Be Utilized	1	2	1	0	5
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	6	6	1	0	2

The vast majority (65%) of respondents indicated that prevention and early intervention services are available in their communities, 22% were unsure, and 13% indicated they do not have these services available. For those who indicated they had the service but changes were needed, the changes included: increase services for children and adolescents; increase availability; needs to be added as a Medicaid benefit; improve access by increasing services throughout the county to address transportation issues; improve collaboration across agencies; expand services to all schools; and increase staffing and funding.

Adolescent Community Reinforcement Approach (A-CRA) is behavioral intervention that aims to support adolescents and young adults with substance use disorders. The treatment aims to support adolescents' substance use recovery by encouraging positive family and peer relationships and helping adolescents engage in prosocial activities. A-CRA is rated as a promising practice because at least one study achieved a rating of moderate or high on study design and execution and demonstrated a favorable effect on a target outcome.[26]

Substance Use Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Adolescent Community Reinforcement Approach					
Utilized, No Changes Needed	1	4	3	0	0
Utilized, Changes Needed	3	2	2	2	1
Not Being Utilized, Should Be Utilized	4	5	1	1	5
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	10	13	1	5	6

The majority of respondents were unsure if A-CRA is utilized in their community, while a little over a quarter indicated that is utilized, and a little under a quarter indicated that it is not. For those who indicated they had A-CRA, but changes were needed, the changes included: re-instating A-CRA and all adolescent services that were discontinued; increasing trained staff; improving and condensing SUD certification for service delivery; and improving response to the Illinois Youth Survey.

Assessment is a process for defining the nature of the problem, determining diagnosis, and developing specific treatment recommendations for addressing the diagnosis. It is often confused with screening, which is a process for evaluating the possible presence of a particular problem. Assessment is far more involved and may involve the use of multiple screening instruments and the exploration of biological, psychological, and social factors that contribute to the issue or diagnosis. [27]

[26] https://preventionservices.acf.hhs.gov/programs/233/show
[27] https://www.ncbi.nlm.nih.gov/books/NBK83253/

Substance Use Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Assessment					
Utilized, No Changes Needed	3	13	3	6	2
Utilized, Changes Needed	8	9	2	2	6
Not Being Utilized, Should Be Utilized	2	1	1	0	2
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	5	1	1	0	2

Very few respondents were unsure (13%) or indicated they do not have assessment services in their county (9%). Those who indicated they had assessment services (78%) were fairly evenly split between being satisfied with assessment services offered and believing they needed changes. Indicated changes included: reducing the wait time for assessment; expanding hours and availability of assessments to meet the population's needs, including nights and weekends; recalibrating assessments so individuals are not over-assessed; integrating substance use and mental health at the state level so agencies do not have to silo their care based on billing and oversight; providing assessments to persons while in custody; improving accessibility to service (location, times and days available, modalities); expanding services to those not in the criminal justice system; and addressing funding restrictions and staffing shortages.

Outpatient Treatment (OP) is ASAM Level 1.0 community-based care. For adults, it is fewer than nine hours of services per week, and fewer than six for adolescents. Outpatient care is generally reserved for persons who have no significant withdrawal risks, no or stable biomedical conditions or complications, no or stable emotional/behavioral/cognitive conditions or complications, are ready for recovery but need strategies to strengthen that readiness, are able to maintain abstinence or control their use with minimal support and have a supportive environment and adequate coping skills.

Substance Use Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Outpatient Treatment					
Utilized, No Changes Needed	3	11	3	5	3
Utilized, Changes Needed	9	11	4	3	7
Not Being Utilized, Should Be Utilized	1	1	0	0	1
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	5	1	0	0	1

Nearly all respondents indicated that they have outpatient level of care in their communities. Four percent indicated they do not, and 10% indicated they were unsure. For those who indicated changes were necessary to their outpatient treatment, the changes included: expand capacity and have more facilities/places for treatment; immediate availability/reduction of wait times; more affordable options for low income and underinsured patients; increase in staff paneled for private insurance; increase in non-traditional community-based treatment; increase/improve utilization of evidence-based curricula; address transportation challenges;

improve reimbursement rates; increase access to integrated treatment and options for other complex cases; stabilize the workforce; and improve quality assurance.

Intensive Outpatient Treatment (IOP) is ASAM level 2.1 community-based care. For adults, it is nine or more hours of services per week, and six or more for adolescents. IOP is reserved for those patients with minimal withdrawal risk, no or non-distracting biomedical conditions, mild emotional/behavioral/cognitive conditions or complications, require a structured treatment program due to variable engagement, have a high likelihood of relapse without close monitoring and support, and who have coping skills despite an unsupportive environment.

Substance Use Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Intensive Outpatient Treatment					
Utilized, No Changes Needed	5	12	3	4	3
Utilized, Changes Needed	6	10	3	3	3
Not Being Utilized, Should Be Utilized	1	1	1	1	4
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	6	1	0	0	2

Nearly all respondents indicated that they have IOP available in their communities. Twelve percent indicated they do not, and 13% indicated they were unsure. For those who indicated they had IOP but changes were needed, the changes included: better education for the justice system on what IOP entails; increase availability; increase/improve utilization of evidence-based curricula; more options for low income and un- or under-insured patients; more flexibility in services; address transportation issues; increase access to integrated treatment options for co-occurring disorders; increase reimbursement rates; and address staffing shortages and training issues.

Day Treatment is ASAM level 2.5 partial hospitalization services. It provides 20 or more hours of service per week. Day treatment is reserved for those who are at moderate risk of severe withdrawal, have no or non-distracting biomedical conditions, mild to moderate emotional/behavioral/cognitive conditions or complications, have poor treatment engagement and need near-daily structured programming, have a high likelihood of relapse without near daily monitoring and support, and have an unsupportive environment but can cope with structure and support.

Substance Use Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Day Treatment					
Utilized, No Changes Needed	2	6	1	1	0
Utilized, Changes Needed	8	6	0	4	1
Not Being Utilized, Should Be Utilized	1	7	3	2	4
Not Being Utilized, Not Needed	0	0	1	0	1
Unsure	7	5	2	1	6

Forty-two percent of respondents indicated that they have day treatment services in their communities, 28% do not, and 30 were unsure. For those who indicated changes were needed in their day treatment services, the changes included: increase availability, particularly for low income, un- and under-insured populations; more facilities to offer this treatment level; expand

eligibility and capacity; develop peer-run day treatment such as recovery community organizations and recovery cafes; and increase communications to providers and patients on this level of service.

Residential Treatment (Non-Medical) is ASAM level 3.1 clinically managed low-intensity residential services. It provides 24-hour structure with available personnel and at least five hours of clinical service per week. Non-medical residential treatment is reserved with those for no to stable withdrawal, no or stable biomedical conditions, no or minimal emotional/behavioral/cognitive conditions or complications, are open to recovery but need a structured environment, understands relapse but needs more structure, and whose environment is dangerous to their recovery and need 24-hour structure.

Substance Use Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Residential Treatment (Non-Medical)					
Utilized, No Changes Needed	1	4	2	1	3
Utilized, Changes Needed	9	8	2	5	2
Not Being Utilized, Should Be Utilized	2	9	3	1	4
Not Being Utilized, Not Needed	0	0	0	0	1
Unsure	6	3	0	1	2

Seventeen percent of participants were unsure if they have non-medical residential treatment services in their community, 29% indicated they do not, and 54% indicated they do have the service available. For those who indicated changes were necessary, the changes included: expedite referrals from the emergency room so they don't need to be sent home; improve access for low income and un- and under-insured patients; improve insurance coverage/allowance of this service; expand capacity to reduce wait times; allow/expand use of medication assisted treatment while in treatment; improve parity of Medicaid rates; increase availability for juvenile placements; and address staffing shortages and transportation issues.

Inpatient Treatment (Non-Medical) is ASAM level 3.3 clinically managed population-specific high-intensity residential services and 3.5 clinically managed high-intensity residential services. Level 3.3 provides 24-hour care with trained counselors and treatment for those with cognitive and other impairments. Level 3.5 provides similar care for those without cognitive impairments. Both levels serve patients who are at a minimal to manageable withdrawal level, have no or stable biomedical conditions, whose environment is dangerous to their recovery, and need highly structured 24-hour care. Level 3.3 patients have mild to moderate emotional/behavioral/ cognitive conditions or complications and need interventions to stay engaged in treatment and prevent relapse. Level 3.5 patients require a 24-hour setting for stabilization of their emotional/ behavioral/cognitive needs, have significant difficulty with treatment, and need skills to prevent continued use.

Substance Use Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Inpatient Treatment (Non-Medical)					
Utilized, No Changes Needed	1	4	2	1	2
Utilized, Changes Needed	8	8	1	4	3

Substance Use Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Not Being Utilized, Should Be Utilized	3	10	3	2	4
Not Being Utilized, Not Needed	0	0	0	0	1
Unsure	6	2	1	1	2

About half of respondents indicated that they have non-medical inpatient services in their communities. A third indicated they do not, and 17% were unsure. For those who indicated their inpatient treatment services needed changes, the changes included: more co-occurring and integrated treatment options; reduce wait times/immediate access; expand capacity; allow/expand use of medication assisted treatment while in care; increase availability to low income, un- and under-insured populations; increase parity for Medicaid rates; increase adolescent treatment beds/facilities; and address the staffing and transportation issues.

Inpatient Treatment (Medical) is ASAM level 3.7 medically monitored intensive inpatient services and level 4.0 medically managed intensive inpatient services. Both levels provide 24-hour nursing care with physician availability. Level 4.0 provides 24-hour counselor availability while Level 3.7 provides 16-hour per day counselor availability. Level 3.7 is reserved for those with a manageable to high risk for withdrawal, requires 24-hour medical monitoring and a 24-hour structured setting for emotional/behavioral/cognitive conditions. It is for patients who have low interest in treatment, need motivational strategies, have challenges controlling use at less intensive levels of care, and whose environment is dangerous to their use, and require a 24-hour structured setting. Level 4.0 serves those who are at high withdrawal risk and need full hospital resources. These patients have severe or unstable emotional/behavioral/cognitive challenges. Domains 4-6 are not utilized to determine level of care for Level 4.0.

Substance Use Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Inpatient Treatment (Medical)					
Utilized, No Changes Needed	1	2	4	1	0
Utilized, Changes Needed	7	5	1	3	4
Not Being Utilized, Should Be Utilized	2	12	2	3	6
Not Being Utilized, Not Needed	0	0	0	0	1
Unsure	8	5	0	1	1

Thirty-six percent of respondents indicated their communities do not have medical inpatient treatment, while 38% do have it available, and 22% were unsure. For those who indicated that their medical inpatient treatment was in need of changes, the changes included: access for low income and un- and under-insured patients; increased access for those on Medicaid and parity for Medicaid rates; increase in capacity/number of beds available; availability of services outside of the hospital setting; availability of co-occurring treatment; more convenient locations; address issues with staffing and transportation; improve quality of services provided; and provide more follow-up services.

Ambulatory Detox is reserved for patients who are experiencing mild to moderate withdrawal and is considered outpatient withdrawal monitoring. For those at Level I, outpatient service is

monitored at predetermined levels, while those at Level II receive medically monitored day hospital care from licensed and credentialed nurses.

Substance Use Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Ambulatory Detox					
Utilized, No Changes Needed	0	3	2	0	0
Utilized, Changes Needed	7	3	1	2	3
Not Being Utilized, Should Be Utilized	2	11	2	3	5
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	9	7	2	3	4

Thirty percent of respondents indicated that they have ambulatory detox services in their communities, one third do not, and 36% were unsure. For those who indicated changes were needed for their ambulatory detox services, the changes included: increase capacity/availability; increase access for low-income, un- and under-insured patients; parity for Medicaid rates; access to transportation; and address the staffing issues.

Inpatient/Medical Detox is reserved for patients who are experiencing moderate to severe withdrawal. There are three levels of medical detox including clinically managed residential for moderate withdrawal requiring 24-hour support, medically monitored inpatient withdrawal management that is for severe withdrawal requiring 24-hour nursing care and physician visits as needed; and medically managed intensive inpatient withdrawal management that is for severe, unstable withdrawal requiring 24-hour nursing care and daily physician visits.

Substance Use Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Inpatient/Medical Detox					
Utilized, No Changes Needed	2	6	2	0	0
Utilized, Changes Needed	7	5	1	2	2
Not Being Utilized, Should Be Utilized	2	10	3	5	6
Not Being Utilized, Not Needed	0	0	0	0	2
Unsure	7	3	1	1	2

Thirty-nine percent of participants have inpatient/medical detox available in their communities, 41% do not, and 20% were unsure. For those who indicated that changes were needed for their inpatient/medical detox services, the changes included: increase access and improve availability; parity for Medicaid rates; allow/increase use of medication assisted treatment; increase capacity; and address staffing and transportation issues.

Medication-assisted treatment (MAT) is the use of medications in combination with counseling and behavioral therapies to provide a "whole-patient" approach to the treatment of substance use disorders. The prescribed medication operates to normalize brain chemistry, block the euphoric effects of alcohol and opioids, relieve physiological cravings, and normalize body functions without the negative and euphoric effects of the substance used.[28]

[28] https://www.samhsa.gov/medication-assisted-treatment

Substance Use Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Medication Assisted Treatment					
Utilized, No Changes Needed	3	11	4	5	1
Utilized, Changes Needed	9	11	1	3	5
Not Being Utilized, Should Be Utilized	1	1	1	0	3
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	5	1	1	0	3

More than three quarters of respondents reporting having Medication Assisted Treatment available in their communities, less than 10% do not, and 14% were unsure. For those who indicated changes were needed to the service, the changes included: the need to educate hospitals and treatment agencies so they will allow patients on MAT in their programs; waiving the 30 person per prescriber limit for suboxone; offering MAT in non-healthcare settings that also offer treatment and social services; allowing Medicaid to cover MAT through SUPR agencies and not just through hospitals and FQHCs; offering financial incentives for physicians and APRNs to work in this field; better training for clinicians with lived experience to overcome biases against using MAT for treatment; increased access to MAT while incarcerated and upon reentry; require treatment in addition to MAT; expand options and programs, including for alcohol and meth; expand the workforce—address staffing shortages; and address transportation issues.

Other Harm Reduction Programs. Harm reduction is an approach that emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission, improve the physical, mental, and social wellbeing of those served, and offer low-threshold options for accessing substance use disorder treatment and other health care services. Harm reduction services save lives by being available and accessible in a matter that emphasizes the need for humility and compassion toward people who use drugs. Harm reduction plays a significant role in preventing drug-related deaths and offering access to healthcare, social services, and treatment. These services decrease overdose fatalities, acute life-threatening infections related to unsterile drug injection, and chronic diseases such as HIV/HCV. These harm reductions services include overdose reversal, linkage to HIV and viral hepatitis protection and vaccines, fentanyl test strips, needle exchange programs, safer smoking kits, etc.[29]

Substance Use Service	Region (n=18)	Region (n=24)	Region (n=7)	Region (n=8)	Region (n=12)
Other Harm Reduction Programs					
Utilized, No Changes Needed	1	4	2	1	1
Utilized, Changes Needed	8	6	2	2	1
Not Being Utilized, Should Be Utilized	1	10	0	2	6
Not Being Utilized, Not Needed	1	0	1	0	1
Unsure	7	4	2	3	3

Forty percent of respondents indicated that they have other harm reduction programs available in their communities, 32% do not, and 28% were unsure. For those who indicated they had services, but changes were needed, the changes included: greater access to clean needles, fentanyl strips

[29] https://www.samhsa.gov/find-help/harm-reduction

and sobering centers; expansion of street outreach programs and organizations; better availability in rural and less populated areas; and expansion of these services in general.

Brief Intervention and Referral is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur. Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment. Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change. Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.[30]

Substance Use Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Brief Intervention and Referral					
Utilized, No Changes Needed	3	7	1	2	1
Utilized, Changes Needed	5	7	1	4	3
Not Being Utilized, Should Be Utilized	2	3	2	1	4
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	8	7	3	1	4

Forty-nine percent of respondents indicated that they have access to brief intervention and referral services in their communities, 17% do not, and a third were unsure. For those who indicated changes were needed to their existing service, the changes included: extending the service to local police/CIT units; covering the service through Medicaid; expanding services to more providers; advertising the service for community awareness; and ensuring that all emergency rooms and primary care physicians are trained and utilizing the service.

Peer Recovery Support Services (PRSS) are designed and delivered by people who have experienced both substance use disorder and recovery. PRSS may include peer mentoring, peer-led support groups, peer-led classes and seminars, assistance with transportation or accessing community services, and peer-managed recovery centers, sports leagues, and sober activities and supports.[31]

Substance Use Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Peer Recovery Support Services					
Utilized, No Changes Needed	2	11	2	2	3
Utilized, Changes Needed	7	7	2	5	2
Not Being Utilized, Should Be Utilized	3	2	1	1	4
Not Being Utilized, Not Needed	0	0	0	0	1
Unsure	6	4	2	0	2

[30] https://www.samhsa.gov/sbirt

[31] https://store.samhsa.gov/sites/default/files/d7/priv/sma09-4454.pdf

Sixty-two percent of respondents indicated that they have PRSS available in their communities, 17% do not, and 20% were unsure. For those who indicated changes were needed to their available PRSS, the changes included: expansion of services to local police/CIT units; making PRSS a standard Medicaid benefit; workforce development including professionalizing PRSS through certification, having more locations for that education process, and salary parity for peers; ensuring that these positions and staff are not taken advantage of—give them a pathway to higher paying positions; expansion of these services to increase access; making peer support available 24/7; and addressing transportation issues.

Substance Use Case Management focuses on the whole individual and stresses comprehensive assessment, service planning, and service coordination to address multiple aspects of a patient's life. Case management enhances the scope of treatment and recovery by providing the patient with a single point of contact for multiple health and social services systems, patient advocacy, and patient-focused linkages and monitoring.[32]

Substance Use Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Substance Use Case Management					
Utilized, No Changes Needed	1	11	5	4	4
Utilized, Changes Needed	9	6	1	4	2
Not Being Utilized, Should Be Utilized	2	2	0	0	3
Not Being Utilized, Not Needed	0	0	0	0	1
Unsure	6	5	1	0	2

Sixty-eight percent of respondents indicated that they have substance abuse case management services in their communities, 12% did not and 20% were unsure. For those who indicated changes were needed for services in their area, the changes included: increasing availability of the service in an outpatient setting; ensuring case planning and goal setting are utilized; adding this as a Medicaid covered service for SUPR providers; improving communication between the treatment agency and justice system; expanding the workforce and availability; and addressing transportation issues.

Outreach Services refers to recovery-oriented service delivery designed to offer evidence-based interventions to patients in the community. Similar to A-CRA noted above, these interventions are provided in patients' homes or other places they may be. This may include anything from harm reduction strategies to case management and PRSS to outpatient treatment.[33]

Substance Use Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Outreach Services					
Utilized, No Changes Needed	3	8	3	4	2
Utilized, Changes Needed	5	6	0	3	3
Not Being Utilized, Should Be Utilized	3	3	2	0	3
Not Being Utilized, Not Needed	0	0	0	0	1

[32] https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4215.pdf
[33] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6987469/

Substance Use Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Unsure	7	7	2	1	3

Fifty-four percent of respondents indicated that they have outreach services in their communities, 17% did not, and 29% were unsure. For those who indicated changes were necessary, the changes included: expanding outreach services to local police/CIT units; making outreach and engagement services standard Medicaid services for SUPR providers; educating the community on these services; improving collaborations for outreach; increasing outreach workforce; and expanding outreach services.

Medical Services refers to concurrent medical treatment for co-occurring chronic and acute medical needs while in treatment. It includes psychiatric care and medication monitoring, care for HCV and HIV and other infectious diseases and conditions; and having substance use services as part of integrated care or a "health home."[34]

Substance Use Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Medical Services					
Utilized, No Changes Needed	3	7	3	5	3
Utilized, Changes Needed	7	7	2	1	3
Not Being Utilized, Should Be Utilized	2	2	1	1	3
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	6	8	1	1	3

Fifty-nine percent of respondents indicated that they have medical services tied to substance use treatment in their communities, 13% did not, and 28% were unsure. For those who indicated changes were needed to their medical services, the changes included: doing more medical outreach rather than making patients come to clinics and increasing co-location in non-traditional settings; increasing use of social workers to manage social determinants of health; making patient navigators a standard offering to patients to help navigate the system and advocate for themselves; ensuring providers understand mental health; expanding services and availability; and addressing transportation issues.

Co-Occurring or Integrated Treatment coordinates mental and substance use interventions by linking people to other providers who can deliver individualized and personalized services to treat the physical and emotional aspects of mental and substance use disorders. There are three models for delivering care for co-occurring disorders: coordinated, co-located, and fully integrated. With integrated care, a more complete recovery is possible.[35]

Substance Use Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Co-Occurring or Integrated Treatment					
Utilized, No Changes Needed	0	10	3	3	2
Utilized, Changes Needed	8	8	0	4	3

[34] https://www.ncbi.nlm.nih.gov/books/NBK424848/

[35] https://www.samhsa.gov/co-occurring-disorders

Substance Use Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Not Being Utilized, Should Be Utilized	3	4	3	0	4
Not Being Utilized, Not Needed	0	0	0	0	1
Unsure	7	2	1	1	2

Fifty-nine percent of respondents indicated that they have co-occurring or integrated treatment services in their communities, 22% do not, and 20% were unsure. For those who indicated changes were necessary, the changes included: expanding integrated care to all MH and SUD treatment agencies; integrating SUPR and DMH at the state level to encourage integrated rather than siloed treatment; expanding the workforce and training; and ensuring that integrated residential treatment is covered by Medicaid.

Recovery Housing is an intervention that is specifically designed to address the recovering person's need for a safe and healthy living environment while supplying the requisite recovery and peer supports. There are four levels of care in recovery housing. Level I includes Oxford Houses and typical residents are those who identify as being in recovery. They have no on-site staff and are peer to peer support. Level II includes sober living homes and is for those who are in stable recovery but want more structure and accountability. They have a resident house manager that holds house meetings and mutual support groups. Level III is for those who wish to have moderately structured daily schedule and life skill supports. They have a paid house manager, administrative support, certified PRSS staff, and on-site life skills training and PRSS. Level IV includes therapeutic communities and for those who require clinical oversight or monitoring. They have paid licensed or credentialed staff and provide on-site clinical services, mutual support groups, life-skills training, and PRSS.[36]

Substance Use Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Recovery Housing					
Utilized, No Changes Needed	0	5	1	1	0
Utilized, Changes Needed	8	8	1	4	4
Not Being Utilized, Should Be Utilized	2	8	4	2	4
Not Being Utilized, Not Needed	1	0	0	0	1
Unsure	7	3	1	1	3

Forty-six percent of respondents indicated that they have recovery housing services available in their communities, 32% do not, and 22% were unsure. For those who indicated changes were needed to their housing services, the changes included: ensuring that housing is available in safe neighborhoods; Medicaid allowing more long-term stays; the need for more structured (higher level) homes; rental assistance; more housing altogether, but women specific housing as well; and expanding the workforce.

Relapse Prevention is a skills-based, cognitive-behavioral approach that requires patients and their clinicians to identify situations that place the person at greater risk for relapse—both internal experiences (e.g., positive thoughts related to substance use or negative thoughts

[36] https://www.samhsa.gov/sites/default/files/housing-best-practices-100819.pdf

related to sobriety that arise without effort, called "automatic thoughts") and external cues (e.g., people that the person associates with substance use). Then, the patient and clinician work to develop strategies, including cognitive (related to thinking) and behavioral (related to action), to address those specific high-risk situations. With more effective coping, the patient develops increased confidence to handle challenging situations without alcohol and other drugs (i.e., increased self-efficacy).[37]

Substance Use Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Relapse Prevention					
Utilized, No Changes Needed	3	8	2	3	1
Utilized, Changes Needed	7	8	0	4	3
Not Being Utilized, Should Be Utilized	1	3	3	0	4
Not Being Utilized, Not Needed	0	0	0	0	1
Unsure	7	5	2	1	3

Fifty-seven percent of respondents indicated that they have relapse prevention services in their communities, 17% did not, and 26% were unsure. For those who indicated changes were necessary for their existing services, the changes included: the need for rapid treatment entry upon relapse; more and expanded programming; development of recovery community organizations to do this work; expansion of the use of peers to do this work; and addressing transportation and staffing issues.

Self-Help Support Groups can aid recovery from substance use disorders and facilitate personal growth through self-exploration and peer support. Although these groups are not a part of professional treatment, they can provide a rich source of support for recovery and complement other treatment. Mutual self-help groups provide a forum and opportunity for individuals in recovery to connect with others who have similar experiences and goals, allowing them to build relationships within a substance-free support network. These groups are typically free, anonymous, and easily accessible; as such, these groups can be readily available over the long-term trajectory of recovery. Mutual self-help groups include a variety of programs, with 12-step programs (e.g., Alcoholics Anonymous, AA; or Narcotics Anonymous, NA) and Self-Management and Recovery Training (SMART Recovery) being the most common ones.[38] These groups may be in person or virtual. Courts requiring defendants to attend self-help groups must ensure secular options are available, as groups based on 12-step programs have a religious/spiritual component.

Substance Use Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Self-Help Support Groups					
Utilized, No Changes Needed	3	14	5	3	5
Utilized, Changes Needed	7	8	1	5	4
Not Being Utilized, Should Be Utilized	1	1	1	0	0
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	7	1	0	0	3

[37] https://www.recoveryanswers.org/resource/relapse-prevention-rp/

[38] https://www.va.gov/WHOLEHEALTHLIBRARY/tools/recovery-based-mutual-self-help-groups.asp

Eighty percent of respondents indicated that they have self-help groups in their communities, 4% did not, and 16% were unsure. For those indicating changes were needed to their existing self-help groups, the changes included: needing secular alternatives to AA/NA; increased number and type of groups available, particularly on nights and weekends; mor funding and investments in the development of groups and pro-social networks, especially for the formerly incarcerated; and addressing issues with transportation.

Aftercare Services, sometimes referred to as 'continuing care' are structured care to help the patient continue the progress they have made after completing a level of care. Aftercare planning begins in that highest level of care and focuses on what the patient will need to support their recovery, prevent relapse, and help achieve their goals. An aftercare plan includes activities, interventions, and resources to help a recovering person cope with triggers, stress, and cravings that they may face when treatment is over. Each patient's aftercare plan will vary based upon their own needs.[39]

Substance Use Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Aftercare Services					
Utilized, No Changes Needed	1	11	3	3	0
Utilized, Changes Needed	7	9	2	5	3
Not Being Utilized, Should Be Utilized	1	1	1	0	5
Not Being Utilized, Not Needed	0	0	0	0	1
Unsure	9	3	1	0	3

Sixty-four percent of respondents indicated that they have aftercare services in their communities, 13% do not, and 23% are unsure. For those who indicated changes were needed to their aftercare services, the changes included: doing aftercare planning rather providing a list of resources; utilizing case management for transitions between levels of care; staff to manage linkages between hospitals, residential, and correctional settings to treatment in the community; increased funding; direct scheduling through electronic health records to expedite appointments upon facility exit; dedicated staff at treatment agencies who are on call for scheduling purposes; expanding the workforce; employing cognitive behavioral treatment methods within a structured program that does follow-up; having counselors available on nights and weekends; extending these services through recovery community organizations; and addressing transportation issues.

Mental Health Services

Respondents were asked about the utilization of and or need for common mental health services in their county, and what changes, if any to existing services need to be made.

Early Identification and Intervention requires early and periodic screening, diagnosis, and treatment for genetic, behavioral, and environmental risk factors mental health disorders. Research indicates that intervening early can interrupt the negative course of some mental illnesses and may, in some cases, lessen long-term disability. New understanding of the brain science indicates that early identification and intervention can sharply improve outcomes and that

[39] https://americanaddictioncenters.org/addiction-treatment-aftercare

longer periods of abnormal thoughts and behavior have cumulative effects and can limit capacity for recovery.[40]

Mental Health Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Early Identification and Intervention					
Utilized, No Changes Needed	1	7	2	3	0
Utilized, Changes Needed	6	11	2	4	1
Not Being Utilized, Should Be Utilized	4	1	2	0	5
Not Being Utilized, Not Needed	0	0	0	0	1
Unsure	7	5	1	1	5

Fifty-four percent of respondents indicated that they have early identification and intervention services in their communities, 19% do not, and 28% were unsure. For those who indicated changes were necessary to the services, the changes included: expansion of child and adolescent mental health services; expansion of first episode psychosis programs along with more publicity and messaging; expanding college campus capacities to screen and provide treatment to students; build capacity to meet the need; improving elementary school level identification and response; combining this with stigma work; expand screening to primary care; expand screening to correctional facilities; and address workforce issues.

Mental Health Evaluation is an examination used to ascertain whether or not a patient is functioning on a healthy psychological, social, or developmental level. A mental health assessment can also be used to aid diagnosis of some neurological disorders, specific diseases, or possible drug abuse. These assessments are carried out by licensed, credentialed clinicians, and include a mental status exam, review of patient history, and written and verbal tests, and may include a physical examination and clinical tests such as an MRI or CT scan.[41]

Mental Health Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Mental Health Evaluation					
Utilized, No Changes Needed	1	11	2	6	0
Utilized, Changes Needed	12	12	4	2	6
Not Being Utilized, Should Be Utilized	2	0	1	0	3
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	3	1	0	0	3

Eighty-one percent of respondents indicated that they have mental health evaluation services available in their communities, 9% did not, and 10% were unsure. For those who indicated changes were necessary, the changes included: immediate access to evaluation services; reducing wait times; use of a trauma-informed assessment rather than the IM CANS which is required for

[40] https://www.amhca.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=2ca60afe-8be0-af27-2ad9-7100b61ad636&forceDialog=1

[41] https://www.encyclopedia.com/medicine/encyclopedias-almanacs-transcripts-and-maps/mental-health-assessment

Medicaid; expand this service beyond emergency rooms and have them available 24/7; expand hours of operation and locations; screen uninsured patients for Medicaid and facilitate enrollment on the spot, rather than turning patients away; use an actual diagnostic assessment rather than the IM CANS; improve access for Medicaid patients and children; and build capacity and the workforce.

Outpatient Treatment is community-based treatment for mental health that generally involves less than six hours a week for adolescents and less than 9 hours a week for adults. It may include individual counseling or therapy and group counseling or therapy. Other services such as psychiatry and medication monitoring may also be included. Outpatient services are intended to reduce psychiatric symptoms and promote adaptive functioning. These services are designed to help people live independently as they stabilize and move toward recovery.

Mental Health Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Outpatient Treatment					
Utilized, No Changes Needed	2	12	3	6	1
Utilized, Changes Needed	12	11	4	2	7
Not Being Utilized, Should Be Utilized	2	0	0	0	2
Not Being Utilized, Not Needed	0	0	0	0	1
Unsure	2	1	0	0	1

Eighty-seven percent of participants indicated that they have outpatient mental health services available in their communities, 6% do not, and 6% were unsure. For those who indicated changes were needed in outpatient services, the changes included: reducing wait times for program entry; improving the workforce and reduce turnover through salary parity and improved technology; expand the workforce; reduce Medicaid required documentation; create misdemeanor assisted outpatient therapy; screen uninsured patients for Medicaid and facilitate enrollment on the spot, rather than turning patients away; provide system navigators; build capacity; address transportation issues; and increase reimbursement rates.

Intensive Outpatient Treatment provides similar services to outpatient treatment but is more robust. Adolescent patients receive at least six hours per week of service, and adult patients receive at least nine hours per week. Those who need more structure may be stepped up to partial hospitalization, receiving 20 to 35 hours of service a week. Patients often attend structured groups three to five times a week.[42]

Mental Health Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Intensive Outpatient Treatment					
Utilized, No Changes Needed	5	5	2	4	1
Utilized, Changes Needed	8	13	3	2	3
Not Being Utilized, Should Be Utilized	3	4	2	1	5
Not Being Utilized, Not Needed	0	0	0	0	1
Unsure	2	2	0	1	2

[42] https://www.nami.org/Blogs/NAMI-Blog/April-2020/The-Value-of-Structured-Outpatient-Treatment

Two thirds of respondents indicated that they have intensive outpatient services in their communities, 23% do not, and 10% were unsure. For those who indicated changes were necessary for their services, the changes included: reduce wait times and make treatment more readily available; create a misdemeanor AOT program; screen uninsured patients for Medicaid and facilitate enrollment on the spot, rather than turning patients away; improve Medicaid and insurance coverage; expand availability on nights and weekends and expand to more locations; provide system navigators; provide services outside of the hospital setting; build capacity; address transportation issues; and increase reimbursement rates.

Inpatient Treatment may also be referred to as hospitalization. Inpatient treatment generally involves a one- to 30-day stay in a psychiatric unit or at a psychiatric hospital to treat an acute phase of mental illness.[43]

Mental Health Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Inpatient Treatment					
Utilized, No Changes Needed	2	3	2	2	0
Utilized, Changes Needed	12	11	3	3	5
Not Being Utilized, Should Be Utilized	2	7	2	1	5
Not Being Utilized, Not Needed	0	1	0	0	1
Unsure	2	2	0	2	1

Sixty-two percent of respondents indicated that they have inpatient treatment available in their communities, 28% do not, and 10% were unsure. For those who noted changes were necessary in the treatment available, the changes included: expand availability for involuntary commitment—patients are often 'stabilized' in emergency rooms and discharged only to return later the same day; improve insurance coverage/managed care for inpatient services; improve discharge planning and reentry services; ensure psychological evaluations are completed on patients in inpatient treatment; make inpatient treatment available based on need and not dependent on insurance coverage; increase the number of beds available statewide; expand inpatient services for adolescents and children; increase facilities in local communities; and address the workforce shortage.

Residential Treatment centers provide long-term care once the acute phase has passed, if the patient continues to be unready to return to the community. Residential treatment is considered a step down from hospitalization.[44]

Mental Health Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Residential Treatment					
Utilized, No Changes Needed	1	2	1	1	0
Utilized, Changes Needed	9	8	1	3	4
Not Being Utilized, Should Be Utilized	5	9	5	2	6
Not Being Utilized, Not Needed	0	2	0	0	1

[43] https://www.sandstonecare.com/blog/inpatient-mental-health-faqs
[44] ibid

Mental Health Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Unsure	3	3	0	2	1

Forty-three percent of respondents indicated that they have residential treatment centers in their communities, 43% did not, and 13% were unsure. For those who indicated residential treatment services changes were needed, the changes included: increase options for patients with developmental or cognitive delays; address workforce issues through pay parity and reduced workloads; ensure parity for mental health treatment so insurance is unable to deny payment; expand access through more facilities in more communities; expand access for children and adolescents; ensure care is integrated; and do more outreach.

Psychiatry is the branch of medicine focused on the diagnosis, treatment, and prevention of mental, emotional, and behavioral disorders. Psychiatrists use a variety of treatments—including various forms of psychotherapy, medications, psychosocial interventions, and other treatments (such as electroconvulsive therapy or ECT), depending on the needs of each patient. Psychiatrists differ from psychologists in that they are medical doctors who are able to prescribe medication and treatment.[45]

Mental Health Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Psychiatry					
Utilized, No Changes Needed	4	4	4	3	1
Utilized, Changes Needed	10	19	3	5	6
Not Being Utilized, Should Be Utilized	1	0	0	0	4
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	3	1	0	0	1

Eighty-six percent of respondents indicated that they have psychiatry services available in their communities, 7% did not, and 7% were unsure. For those who indicated changes were needed, the changes included: increase communication from psychiatric providers; provide continuity of care across psychiatric providers when patients move levels of care or change providers; have shared database for psychiatric providers/prescribers; ensure psychiatric services follow evidence-based practices; use fewer psychotropics for children; provide supports to CIT units; increase the number and types of prescribers to address long waitlists and reduce costs; increase capacity; provide incentives for people to enter the field and build capacity; increase CMHC and Medicaid reimbursement rates for parity; and increase availability/use of telepsych services.

Medication and Medication Monitoring refers to a psychiatrist, primary care physician, or APN under the supervision of a psychiatrist monitoring the effectiveness and limitations of prescribed psychotropic medications. Many medications require blood testing to monitor whether the patient is within therapeutic ranges for the prescribed medication, others have a danger of toxicity

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or development of debilitating physical reactions/side effects. Patients must be monitored not just for efficacy, but to minimize these side effects and potentially life-threatening reactions.[46]

Mental Health Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Medication and Medication Monitoring					
Utilized, No Changes Needed	1	5	4	4	1
Utilized, Changes Needed	8	18	2	3	4
Not Being Utilized, Should Be Utilized	4	0	0	0	4
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	5	1	1	1	3

Seventy-two percent of respondents indicated that they have medication and medication monitoring services in their communities, 12% do not, and 16% were unsure. For those who indicated changes were needed, the changes included: increase capacity; put better processes in place for missed appointments; improve Medicaid reimbursement rates; increase housing for those who struggle with medication compliance; increase staff and the number of appointments to ensure no essential monitoring is missed; provide more options for the un- and under-insured; address transportation issues; and ensure integrated care.

Mental Health Case Management provides coordination, support, and advocacy for patients with multiple needs and who require assistance in obtaining them including mental health, vocational, educational, child welfare, and other community services. Mental health case managers work intimately with their patients to develop treatment plans that are properly targeted at the patient's needs. This involves a thorough assessment of the patient's psychosocial triggers, strengths, and personal needs.[47]

Mental Health Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Mental Health Case Management					
Utilized, No Changes Needed	2	9	4	4	2
Utilized, Changes Needed	9	14	2	3	5
Not Being Utilized, Should Be Utilized	4	0	0	0	3
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	3	1	1	1	2

Seventy-eight percent of respondents indicated that they have mental health case management services in their communities, 10% did not, and 12% were unsure. For those who indicated changes were needed, the changes included: expand the workforce, ensure salary parity, and increase capacity; remove the 200 hour/year limit from Medicaid; and ensure rate parity for Medicaid.

Intensive Case Management (ICM) is a community-based package of care aiming to provide long-term care for severely mentally ill people who do not require immediate hospitalization. It consists of management of the mental health problem and the rehabilitation and social support

[46] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2014933/

[47] https://www.mhaonline.com/faq/what-is-a-mental-health-manager

needs of the patient over an indefinite period of time by a team of people who have a fairly small group of clients (fewer than 20). Twenty-four-hour help is offered, and clients are seen in a non-clinical setting.[48]

Mental Health Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Intensive Case Management					
Utilized, No Changes Needed	1	8	5	3	0
Utilized, Changes Needed	7	12	0	2	3
Not Being Utilized, Should Be Utilized	5	1	1	0	6
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	5	3	1	3	3

Fifty-nine percent of respondents indicated that they have ICM services in their communities, 19% do not, and 22% were unsure. For those who noted ICM changes were needed, the changes included: provide assistance with transportation; ensure Medicaid rate parity; provide more services in more geographic locations; and build capacity, develop workforce, and ensure salary parity.

Assertive Community Treatment (ACT) is a very specialized model of treatment/service delivery in which a multidisciplinary team assumes ultimate accountability for a small, defined caseload of seriously mentally ill adults and becomes the single point of responsibility for that caseload. While encompassing a full range of case management activities, ACT is not just an intensive form of assertive case management; it is a unique treatment model in which the majority of mental health services are directly provided internally by the ACT program in the client's regular environment.[49]

Mental Health Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Assertive Community Treatment					
Utilized, No Changes Needed	0	7	2	3	0
Utilized, Changes Needed	5	7	0	0	0
Not Being Utilized, Should Be Utilized	6	6	3	1	6
Not Being Utilized, Not Needed	0	1	0	0	0
Unsure	7	3	2	4	6

Thirty-five percent of respondents indicated that they have ACT in their communities, 33% do not, and 32% were unsure. For those who indicated changes were needed to their ACT services, the changes included: expanded capacity; expedited access; quality assurance; and allowing Medicaid reimbursement at fair rates.

Wellness Recovery Action Plan (WRAP®) Facilitation is a process to assist patients in identifying tools to keep them well and create action plans to put into practice in their everyday lives. WRAP® is an evidence-based practice used worldwide by people dealing with mental health or general health challenges. WRAP® is an education process, not therapy. Every WRAP®

[48] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6472672/

[49] https://www.dhs.state.il.us/page.aspx?item=30471

includes principles of wellness, learning skills and strategies for wellness, understanding triggers, recognizing when wellness begins to get off track, creating a crisis plan, developing a wellness toolbox, plans for utilizing peer support, and ways to recover after a crisis. As an EBP, WRAP® facilitators must be trained according to IDHS and WRAP® standards.[50]

Mental Health Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Wellness Recovery Action Plan (WRAP®) Facilitation					
Utilized, No Changes Needed	1	4	4	1	0
Utilized, Changes Needed	3	8	0	2	2
Not Being Utilized, Should Be Utilized	4	7	2	2	4
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	10	5	1	3	6

Thirty-six percent of respondents indicated that they have WRAP® services in their communities, 28% do not, and 36% were unsure. For those who indicated changes in their WRAP® service were necessary, the changes included the need for more WRAP® services and facilitation trainers.

Family Counseling and Services refers to any services provided to a patient with mental illness that includes their biological and chosen families. This may include family counseling or case management, separate counseling for family members, support groups, educational classes/ groups, etc.

Mental Health Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Family Counseling and Services					
Utilized, No Changes Needed	5	8	3	4	2
Utilized, Changes Needed	8	11	3	4	5
Not Being Utilized, Should Be Utilized	1	5	0	0	4
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	4	0	1	0	1

Seventy-seven percent of respondents indicated that they have family counseling and services available in their communities, 14% do not, and 9% were unsure. For those who noted changes were needed in these services, the changes included: increase capacity; reduce wait times; address transportation issues; expand the workforce; provide services in more areas; and reduce stigma about treatment.

Drop-In Counseling and Centers may include drop-in counseling as offered at many colleges and universities, for instance, or drop-in centers. Drop-in counseling provides first-come, first-served professional counseling during given hours/days. Drop-In Centers are generally peer-run programs providing a central location for self-help, advocacy, and education. They offer a safe, supportive environment for socializing and networking to address feelings of isolation. The centers are generally open to any person in mental health recovery.

[50] https://www.dhs.state.il.us/page.aspx?item=88013

Mental Health Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Drop-In Counseling and Centers					
Utilized, No Changes Needed	2	2	2	0	1
Utilized, Changes Needed	7	7	0	3	2
Not Being Utilized, Should Be Utilized	5	10	4	3	5
Not Being Utilized, Not Needed	0	0	0	0	1
Unsure	4	5	1	2	3

Thirty-eight percent of respondents indicated that they have drop-in services in their communities, 40% do not, and 22% were unsure. For those who indicated changes were necessary to their drop-in services, the changes included: expand hours of availability to 24/7, expand availability in more communities and areas, and address staffing and transportation issues.

Peer Support Services encompass a range of activities and interactions between people who have shared similar experiences of having mental illness. Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders. Illinois provides a certification for recovery support specialists to ensure competency.[51]

Mental Health Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Peer Support Services					
Utilized, No Changes Needed	0	5	3	3	1
Utilized, Changes Needed	8	12	1	4	4
Not Being Utilized, Should Be Utilized	3	4	2	1	3
Not Being Utilized, Not Needed	1	0	0	0	1
Unsure	6	3	1	0	3

Fifty-nine percent of respondents indicated that they have Peer Support Services for mental health in their communities, 22% do not, and 19% were unsure. For those who indicated changes were needed, the changes included: expansion of services and locations; salary parity; ensuring the positions and staff are not taken advantage of—give them a pathway to higher paying positions; workforce expansion and expansion of the training centers; quality assurance; and ensuring peer services are known in the community.

Outreach Services deliver care and support to the population in their homes or other settings, such as public spaces or on the streets. Community outreach services often constitute mobile clinicians or teams that provide counseling, medication support, prevention, etc. to marginalized populations that would not otherwise have access to them.[52]

Mental Health Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Outreach Services					
Utilized, No Changes Needed	1	7	2	3	0

[51] https://www.illinoismentalhealthcollaborative.com/consumers/crss/CRSS-Model-April-2018.pdf
[52] https://apps.who.int/iris/rest/bitstreams/1350314/retrieve

Mental Health Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Utilized, Changes Needed	8	7	1	4	4
Not Being Utilized, Should Be Utilized	3	4	3	0	5
Not Being Utilized, Not Needed	1	0	0	0	1
Unsure	5	6	1	1	2

Fifty-four percent of respondents indicated that they have outreach services in their communities, 25% do not, and 22% were unsure. For those who indicated changes were needed, the changes included: expand outreach services to those with transportation issues or other reasons they cannot get to a provider; expand to more areas of the county/community; expand the workforce; increase capacity and reimbursement rates; ensure co-occurring services are available; and ensure services are coordinated across agencies and systems.

Supportive Housing is a highly effective strategy to reduce homelessness that combines affordable housing with intensive coordinated services to help people struggling with chronic physical and mental health issues maintain stable housing and receive appropriate health care.[53]

Mental Health Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Supported Housing					
Utilized, No Changes Needed	1	2	2	0	0
Utilized, Changes Needed	8	13	1	5	3
Not Being Utilized, Should Be Utilized	5	6	3	2	6
Not Being Utilized, Not Needed	0	0	0	0	1
Unsure	4	3	1	1	2

Fifty-one percent of respondents indicated that they have supportive housing in their communities, one third do not, and 16% were unsure. For those who indicated changes were needed, the changes included: need for more housing specifically for those with mental illness or autism; need to expand services and providers; need easier access to housing; need to institute 'housing first'; and need to create a central access point.

Supported Employment is an approach to vocational rehabilitation for people with serious mental illness that emphasizes helping them obtain competitive work in the community and providing the supports necessary to ensure their success in the workplace. The overriding philosophy of supported employment is the belief that every person with a serious mental illness is capable of working competitively in the community if the right kind of job and work environment can be found. The primary goal of supported employment is not to change consumers but to find a natural "fit" between consumers' strengths and experiences and jobs in the community.[54]

Mental Health Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Supported Employment					
Utilized, No Changes Needed	1	6	2	1	1

[53] https://www.dhs.state.il.us/page.aspx?item=30361

[54] https://store.samhsa.gov/sites/default/files/d7/priv/buildingyourprogram-se_0.pdf

Mental Health Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Utilized, Changes Needed	5	11	1	6	3
Not Being Utilized, Should Be Utilized	5	4	3	1	4
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	7	3	1	0	4

Fifty-four percent of respondents indicated that they have supported employment, 25% do not, and 22% were unsure. For those who indicated changes were needed, the changes included: expand services and providers; include options for those with felony records; increase services for those with mental illness, most of the services are for those with developmental disabilities; increase capacity; and advertise and promote to recruit more employers.

Medical Services refers to concurrent medical treatment for co-occurring chronic and acute medical needs while receiving mental health treatment. It includes things such as psychiatric care and medication monitoring, seizure management, care for medical conditions caused or exacerbated by mental health medications, fetal alcohol assessment and treatment, and treating other co-occurring medical or treatment needs as part of integrated care.[55]

Mental Health Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Medical Services					
Utilized, No Changes Needed	3	7	3	6	2
Utilized, Changes Needed	7	12	2	2	5
Not Being Utilized, Should Be Utilized	0	3	1	0	3
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	8	2	1	0	1

Seventy-one percent of respondents indicated that they have medical services available to patients in their community, 10% do not, and 17% were unsure. For those who indicated changes were needed, the changes included: doing more medical outreach rather than making patients come to clinics and increasing co-location in non-traditional settings; increasing use of social workers to manage social determinants of health; expanding the workforce with more psychiatrists, APNs and telehealth; ensuring retention of psychiatric/medical staff; building capacity by expanding services and availability; reducing silos through integrated care; increasing providers in rural areas; and enhancing stakeholder collaboration.

Co-Occurring or Integrated Treatment coordinates mental and substance use interventions by linking people to other providers who can deliver individualized and personalized services to treat the physical and emotional aspects of mental and substance use disorders. There are three models for delivering care for co-occurring disorders: coordinated, co-located, and fully integrated. With integrated care, a more complete recovery is possible.[56]

[55] https://ontario.cmha.ca/documents/the-relationship-between-mental-health-mental-illness-and-chronic-physical-conditions/

[56] https://www.samhsa.gov/co-occurring-disorders

Substance Use Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Co-Occurring or Integrated Treatment					
Utilized, No Changes Needed	0	5	2	4	2
Utilized, Changes Needed	7	14	2	4	3
Not Being Utilized, Should Be Utilized	3	5	2	0	4
Not Being Utilized, Not Needed	0	0	0	0	1
Unsure	8	0	1	0	2

Sixty-two percent of respondents indicated that they have co-occurring or integrated treatment services in their communities, 22% do not, and 16% were unsure. For those who indicated changes were necessary, the changes included: integrate SUPR and DMH at the state level to encourage integrated rather than siloed treatment; provide training to providers on other types of co-occurring disorders aside from substance use; build capacity by expanding the workforce and training; ensure fidelity to evidence-based treatment models; and expand integrated care to all MH and SUD treatment agencies.

Complementary Services

Respondents were asked about the utilization of and/or need for common complementary services in their county and what changes, if any, to existing services needed to be made.

Anger Management treatment helps an angry person recognize the self-defeating negative thoughts that lie behind anger flare-ups. Patients work with a mental health professional to learn how to manage stressful life circumstances more successfully. Most programs utilize a cognitive behavioral approach.[57]

Complementary Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Anger Management					
Utilized, No Changes Needed	3	10	3	5	0
Utilized, Changes Needed	6	8	2	2	4
Not Being Utilized, Should Be Utilized	1	0	2	0	5
Not Being Utilized, Not Needed	0	0	0	1	0
Unsure	8	6	0	0	3

Sixty-two percent of respondents indicated that they have anger management treatment available in their communities, 13% do not, and 25% were unsure. For those who indicated changes were necessary, the changes included: allow this service to be offered within CMHCs; reduce silos and allow blended counseling; reduce cost to consumer; expand capacity, services, providers; increase communication/awareness on who offers these services; and provide court ordered treatment.

Batterer Intervention Treatment is court mandated treatment for those convicted of domestic violence related offenses. In Illinois, offenders are statutorily required to attend 26 weeks of group treatment through an IDHS approved partner abuse intervention provider.

[57] https://www.psychguides.com/anger-management/treatment/

Complementary Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Batterer Intervention Treatment					
Utilized, No Changes Needed	4	10	3	3	0
Utilized, Changes Needed	4	7	2	1	3
Not Being Utilized, Should Be Utilized	2	1	2	0	4
Not Being Utilized, Not Needed	0	0	0	1	0
Unsure	8	6	0	3	5

Fifty-four percent of respondents indicated that they have batterer intervention treatment in their communities, 13% did not, and 32% were unsure. For those who indicated changes were needed, the changes included: more and dedicated funding; the need to utilize a cognitive behavioral model; availability of programs for women, youth, and family violence; and expanded capacity and service providers.

Benefit Enrollment/Adjustment Assistance is generally performed by navigators. Navigators play a vital role in helping consumers prepare applications to establish eligibility and enroll in coverage through the Marketplace and potentially qualify for an insurance affordability program. They also provide outreach and education to raise awareness about the Marketplace and refer consumers to health insurance ombudsman and consumer assistance programs when necessary.[58]

Complementary Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Benefit Enrollment/Adjustment Assistance					
Utilized, No Changes Needed	3	11	3	4	1
Utilized, Changes Needed	8	9	2	4	5
Not Being Utilized, Should Be Utilized	2	2	1	0	2
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	5	2	1	0	4

Seventy-two percent of respondents indicated that they have benefit navigators in their communities, 10% did not, and 17% were unsure. For those who indicated changes were needed, the changes included: increased support from DHS for enrollment rather than it falling to the provider; reduce processing time; make navigators more easily available; need to pass the Medicaid Reentry Act to limit inmate exclusion; allow justice system partners access to status of coverage; providers need to verify purported coverage and assist in application if uninsured; expand capacity and funding; more/better bilingual assistance; include disability (SSI/SSDI); and expand to more communities and rural areas.

Childcare refers to both direct childcare at licensed providers and childcare location/cost assistance through the Illinois Child Care Resource and Referral Agencies.[59]

Complementary Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Childcare					

[58] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/assistance
[59] https://www.ccrrn.com/

Complementary Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Utilized, No Changes Needed	1	6	4	2	1
Utilized, Changes Needed	6	11	1	4	6
Not Being Utilized, Should Be Utilized	1	2	1	0	3
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	10	5	1	2	2

Sixty-one percent of respondents indicated that they have childcare services in their communities, 10% did not, and 29% were unsure. For those who noted changes were needed, the changes included: accessible and affordable childcare within the average wage; assistance programs that cover the full cost of childcare; increase infant care; provide childcare for nights, overnights, and weekends; provide bilingual care; provide care for children with special needs; provide emergency childcare for children older than six; timely state assistance payments; and ensure providers meet state care guidelines.

Cognitive Behavioral Treatment for Criminal Thinking refers to manualized, evidence-based interventions for justice-involved individuals who score high on the criminal attitudes/ orientation and criminal associates/companions domains of their risk assessment. These interventions include programs like Moral Reconation Therapy (MRT), Thinking for a Change (T4C), and Reasoning and Rehabilitation.

Complementary Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Cognitive Behavioral Treatment for Criminal Thinking					
Utilized, No Changes Needed	2	11	3	5	0
Utilized, Changes Needed	3	8	1	2	5
Not Being Utilized, Should Be Utilized	3	0	3	0	3
Not Being Utilized, Not Needed	1	0	0	0	0
Unsure	9	5	0	1	4

Fifty-eight percent of respondents indicated that they have criminal thinking interventions in their communities, 14% do not, and 28% were unsure. For those who noted changes were needed, the changes included: assess fidelity to the program model; offer service to all qualifying offenders, not just treatment court participants; increase the number of groups to avoid waitlists; and provide more services and closer availability.

DUI Services are mandated by statute for any person arrested for driving under the influence of drugs or alcohol. The defendant must undergo an alcohol and drug evaluation prior to sentencing and may be required to adhere to the recommendations and have driving restrictions as part of the sentencing. Recommendations vary from minimal risk (completion of 10 hours DUI risk education) to high risk (completion of a minimum of 75 hours of substance use treatment and compliance with their aftercare plan).[60]

[60] https://www.dhs.state.il.us/page.aspx?item=44177

Complementary Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
DUI Services					
Utilized, No Changes Needed	5	15	5	6	2
Utilized, Changes Needed	4	6	1	2	7
Not Being Utilized, Should Be Utilized	1	0	1	0	1
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	8	3	0	0	2

Seventy-seven percent of respondents indicated that they have DUI services in their communities, 4% did not, and 19% were unsure. For those who noted changes were needed, the changes included: needs to be more affordable; DUI services should not be siloed away from substance abuse treatment—the dual nature of the assessments and recommendations is confusing to defendants; there is confusion surrounding Secretary of State procedures involving DUI assessment; all components should be streamlined; need more non-driving transportation options, as many services are not walkable; expand capacity and locations for services; need more mandatory counseling and intervention services in lieu of fines, fees, and jail; and need to address workforce issues.

Education/GED Preparation Services refers to assistance with diploma completion, TABE testing, GED preparation, assistance with college application, entry, and support; and any other education-related services that may be available.

Complementary Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Education/GED Preparation Services					
Utilized, No Changes Needed	4	13	4	7	5
Utilized, Changes Needed	5	6	1	1	3
Not Being Utilized, Should Be Utilized	1	0	1	0	0
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	8	5	1	0	4

Seventy-one percent of respondents indicated that they have educational services available in their communities, 3% did not, and 26% were unsure. For those who indicated changes were necessary, the changes included: increased capacity and availability; more satellite locations for community colleges and more offerings at those satellites; better marketing/communication about programming; and improved collaboration between education, justice, and treatment organizations on how to engage in supports.

Family Preservation Services are short-term, family-focused services designed to assist families in crisis by improving parenting and family functioning while keeping children safe. The scope of these services vary widely, but generally include in-home services for intact families (those without children in substitute care).[61]

[61] https://www.childwelfare.gov/topics/supporting/preservation/

Complementary Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Family Preservation Services					
Utilized, No Changes Needed	3	6	3	3	1
Utilized, Changes Needed	6	6	1	3	4
Not Being Utilized, Should Be Utilized	2	2	2	0	2
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	7	10	1	2	5

Fifty-two percent of respondents indicated that they have family preservation services in their communities, 12% do not, and 36% were unsure. For those who indicated changes were necessary, the changes included: ensure DCFS follow-up on calls or services for families; expand services for parents for housing and employment; increase capacity to reduce wait times; provide earlier access to services before it becomes a crisis or requires removal of children; reduce the stigma for needing this service; allow other providers that do not require DCFS involvement; and address workforce issues.

Job Skills Training refers to any service that improves employability, from activities at the local workforce development office to trade school, to participation in DORS programs.

Complementary Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Job Skills Training					
Utilized, No Changes Needed	4	11	3	2	3
Utilized, Changes Needed	5	10	2	4	2
Not Being Utilized, Should Be Utilized	2	0	1	0	4
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	7	3	1	2	2

Two thirds of respondents indicated that they have job skills training in their communities, 9% do not, and 22% were unsure. For those who indicated that changes were needed, the changes included: expand capacity and types of programming; provide flexibility in length, modality, time, and days for offerings; provide offerings for different skill levels; provide more outreach and community education on programs; provide more for adults and dislocated workers; and provide more locations/availability.

Life Skills Groups are utilized to educate, teach, and train participants on psychological and behavioral skills that enable them to deal effectively with the demands and challenges of life. This may include problem-solving, social skills, or practical skills such as budgeting and cooking.

Complementary Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Life Skills Groups					
Utilized, No Changes Needed	2	6	3	2	2
Utilized, Changes Needed	5	9	2	4	2
Not Being Utilized, Should Be Utilized	3	2	1	0	4
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	8	7	1	2	3

Fifty-four percent of respondents indicated that they have life skills groups in their communities, 15% do not and, 30% were unsure. For those who indicated changes were needed, the changes included: pairing life skills with job training and trauma-related content; expanding availability to those who don't have a mental health diagnosis; expanding capacity and availability; extending hours and being more financially accessible; follow life skills model with fidelity; provide life skills on an outpatient basis or out of a recovery community organization; and address workforce issues.

Sex Offender Evaluation and Treatment generally refers to statutorily mandated assessment and intervention for offenders convicted of a sex offense. However, they may also be utilized with non-justice involved persons as well. The requirements for these evaluations and treatment are outlined in statute.[62]

Complementary Services	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Sex Offender Evaluation and Treatment					
Utilized, No Changes Needed	1	6	4	5	0
Utilized, Changes Needed	4	7	1	2	1
Not Being Utilized, Should Be Utilized	1	5	1	0	4
Not Being Utilized, Not Needed	0	0	0	0	1
Unsure	12	6	1	1	6

Forty-five percent of respondents indicated that they have these services in their communities, 17% do not, and 38% were unsure. For those who indicated changes were needed, the changes included: increase providers; address affordability issues; include in a mental health framework under one payment structure; avoid sending to jail rather than community supervision with treatment; providers should follow SOMB criteria; improve court communication with providers; include polygraphs; do a risk assessment during assessment; make providers more accessible, need more and closer options; address workforce and transportation issues.

Shoplifter, Bad Check, and Other Diversion Programs refer to prosecution-led diversion programs for specific charges. Defendants are offered a dismissal of charges upon successful completion of educational programs related to their charges.

Complementary Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Shoplifter, Bad Check, and Other Diversion Programs					
Utilized, No Changes Needed	1	4	1	3	0
Utilized, Changes Needed	4	5	1	2	1
Not Being Utilized, Should Be Utilized	1	5	2	0	5
Not Being Utilized, Not Needed	0	0	0	0	2
Unsure	12	10	3	3	4

Thirty-two percent of respondents indicated that they have prosecutor-led diversion programs in their communities, 22% do not, and 46% were unsure. For those who indicated changes were needed, the changes included: reducing subjectivity of who qualifies for the programs; making

[62] https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=3431&ChapterID=24

them more affordable; increasing capacity/availability; and adding additional diversion programs.

Parenting Classes are designed to help parents provide a healthy physical and emotional environment for their children.

Complementary Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Parenting Classes					
Utilized, No Changes Needed	3	13	4	7	2
Utilized, Changes Needed	6	9	2	1	6
Not Being Utilized, Should Be Utilized	1	0	1	0	2
Not Being Utilized, Not Needed	1	0	0	0	1
Unsure	7	2	0	0	1

Seventy-seven percent of respondents indicated that they have parenting classes in their communities, 9% do not, and 14% were unsure. For those who indicated changes were needed, the changes included: should be streamlined into one-stop reentry programming; need classes specific to court-ordered needs; need increased capacity, availability, and providers; need to be more structured and have homework; need to expand services to more areas.

Temporary Housing for Those Experiencing Homelessness includes emergency shelters, transitional shelters, rapid re-housing, permanent supportive housing, hotel vouchers, single-room occupancy, transitional living, and many other options.

Complementary Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Temporary Housing for Those Experiencing Homelessness					
Utilized, No Changes Needed	1	6	2	1	0
Utilized, Changes Needed	8	9	3	4	4
Not Being Utilized, Should Be Utilized	4	6	2	2	5
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	5	3	0	1	3

Fifty-five percent of respondents indicated that they have temporary housing for persons experiencing homelessness in their communities, 28% do not, and 17% were unsure. For those who identified needed changes, those changes included: more capacity/availability to meet increasing demand; re-opening shelters that have closed during the pandemic; improving shelter conditions to increase safety; reduce wait times through increased capacity; time incarcerated 90 days or more does not count toward homelessness for HUD; additional investment in temporary housing is needed for those released from incarceration; shelters are often full; many homelessness services require religious service participation; many shelters do not allow families or couples to stay together (children go with mother); lack of interim housing placements; there is a lengthy intake process and it can be quite bureaucratic; include job placement assistance; reduce restrictions for shelter stays; have more options in more places; and address the workforce issue.

Transportation Assistance includes entities providing free or reduced transportation for persons in need (bus passes, ride-share or taxi vouchers, van or small bus services, car ownership programs, peer assistance, etc.).

Complementary Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Transportation Assistance					
Utilized, No Changes Needed	0	5	2	2	3
Utilized, Changes Needed	5	13	2	6	5
Not Being Utilized, Should Be Utilized	4	3	2	0	1
Not Being Utilized, Not Needed	0	0	0	0	1
Unsure	9	3	1	0	2

Sixty-two percent of respondents indicated that they have transportation assistance available in their communities, 16% do not, and 22% were unsure. For those who indicated needed changes, those changes included: insurance benefits vary and can create conflicts such as getting a minor to a therapy visit when a parent is at work; need a mechanism for providers to replenish public transit cards; make Medicaid transportation benefits more explicit and less difficult to navigate; give patients a means to communicate with drivers in real time; increased use of ride-share credits/vouchers; increase funding for these services; improve quality and accessibility of these services; additional times and routes; more reliable services; options for evenings after bus lines shut down; climate controlled and wheelchair accessible shelters; make rural transit services more accessible to families and people in recovery; reduce stigma surrounding the need for transportation assistance; and address the workforce issue.

Trauma Specific Assessment and Treatment requires specific, evidence-based tools and processes. Trauma screening involves determining if someone has a trauma history (e.g., ACES, CATS), while trauma assessment (e.g., TSI-2, PCL/-C, combined with clinical observation) examines the presence and severity of trauma-related symptoms. Trauma specific treatment refers to treatment to specifically address trauma symptoms present. Depending on the type and severity, treatments may include short term programs like Seeking Safety, Dialectical Behavior Therapy or Trauma Focused CBT, or more intensive or long-term treatments such as EMDR, trauma-focused cognitive processing therapy, or medications.

Complementary Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Trauma Specific Assessment and Treatment					
Utilized, No Changes Needed	0	7	1	4	2
Utilized, Changes Needed	6	8	0	3	5
Not Being Utilized, Should Be Utilized	4	4	2	0	1
Not Being Utilized, Not Needed	0	0	0	0	1
Unsure	8	5	4	1	3

Fifty-two percent of respondents indicated that they have these services available in their communities, 17% do not, and 30% were unsure. For those indicating needed changes, those changes included: more culturally relevant trauma assessments and treatments; need to adopt

trauma-informed practices; better identification of services and use of resources; improve screening processes; and expand workforce to increase capacity and availability.

Traumatic Brain Injury Services are provided to individuals who have experienced a brain injury and have ongoing symptoms or complications. TBI has been linked to poor impulse control, aggressive behaviors, deficits in attention span, and higher risks for substance use disorders. Symptoms often negatively impact behavior within corrections and contribute to increased recidivism rates. The prevalence of TBI within the corrections population is very high.[63]

Complementary Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Traumatic Brain Injury Services					
Utilized, No Changes Needed	2	3	1	1	2
Utilized, Changes Needed	3	9	0	0	0
Not Being Utilized, Should Be Utilized	1	7	2	2	5
Not Being Utilized, Not Needed	0	0	0	0	1
Unsure	12	5	4	5	4

Thirty percent of respondents indicated that they have TBI services available in their communities, 26% do not, and 44% were unsure. For those who indicated necessary changes, those changes included: expansion of services; more comprehensive services; increased case management and resources; support groups for patient and families/caretakers; pediatric services; and more availability in more parts of the area.

Victim Services and Treatment address the needs of victims of violent crime. Victimization may result in physical injury and/or psychological stress. Victim service providers may address these impacts of violence through a variety of services based on victim need.[64]

Complementary Service	Region 1 (n=18)	Region 2 (n=24)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=12)
Victim Services and Treatment					
Utilized, No Changes Needed	3	7	4	2	3
Utilized, Changes Needed	6	13	0	3	3
Not Being Utilized, Should Be Utilized	1	1	1	0	3
Not Being Utilized, Not Needed	0	0	0	0	1
Unsure	8	3	2	3	2

Sixty-four percent of respondents indicated that they have these services in their communities, 10% do not, and 26% were unsure. For those indicating needed changes, those included: more services in addition to those provided by the SAO or domestic violence agencies; more restorative justice courts; increased capacity and availability; more social workers/clinicians responding with law enforcement; referring victims to counseling and other resources; more advocacy for victims; reduce the stigma associated with victimization; and expand the workforce.

[63] https://psychology.du.edu/tbi

[64] https://icjia.illinois.gov/researchhub/articles/victim-need-report-service-providers-perspectives-on-the-needs-of-crime-victims-and-service-gaps

Intercepts 2 and 3

Pretrial Services

Respondents were asked about the utilization of and or need for common pretrial practices in their county, and what changes, if any to existing practices need to be made.

Motivational Interviewing and Goal Setting (MI) is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion. As an evidence-based practice its four fundamental processes are engaging, focusing, evoking, and planning. MI is an essential skill for pretrial officers in building rapport and helping move defendants engage in supervision and move through the stages of change.[65]

Pretrial Services	Region 1 (n=5)	Region 2 (n=18)	Region 3 (n=8)	Region 4 (n=6)	Region 5 (n=6)
Motivational Interviewing and Goal Setting					
Utilized, No Changes Needed	0	1	1	3	1
Utilized, Changes Needed	0	3	1	0	0
Not Being Utilized, Should Be Utilized	2	4	0	1	2
Not Being Utilized, Not Needed	0	2	0	1	1
Unsure	3	8	6	1	2

Twenty-three percent of respondents indicated that MI is being practiced by pretrial in their communities, 30% said it is not, and 47% were unsure. For those indicating change is needed, those changes included: wanting to know how long individuals are being met with and what follow-up is being done and making MI standard with regular training for staff.

Validated Pretrial Risk Assessment and Impartial Universal Screening are critical functions of pretrial services agencies, as outlined in NAPSA standard 3.1(b)(ii). The pretrial services agency should complete investigations on all defendants charged with a criminal offense who are in custody at the time of their initial court appearance and eligible for bail consideration according to controlling statute. Pretrial service agencies must also assess a defendant's likelihood of future court appearance and arrest-free behavior pending adjudication. NAPSA Standards recommend that agencies make these assessments using an actuarial risk assessment, preferably validated to the agency's local defendant population. Pretrial services agencies should adopt an "adjusted actuarial" approach to drafting bail recommendations that include mitigating and aggravating factors such as substance use disorder, mental health needs, residency requirements, and other factors that might impede future court appearances.[66]

Pretrial Services	Region 1 (n=5)	Region 2 (n=18)	Region 3 (n=8)	Region 4 (n=6)	Region 5 (n=6)
Validated Pretrial Risk Assessment and Impartial Universal Screening					
Utilized, No Changes Needed	1	5	3	5	2

[65] https://motivationalinterviewing.org/understanding-motivational-interviewing
[66] https://drive.google.com/file/d/1edS2bltwfNROieGeu1A6qKIuTfzqop92/view

Pretrial Services	Region 1 (n=5)	Region 2 (n=18)	Region 3 (n=8)	Region 4 (n=6)	Region 5 (n=6)
Utilized, Changes Needed	0	6	0	0	0
Not Being Utilized, Should Be Utilized	1	0	0	0	2
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	3	7	5	1	2

Just over half of respondents indicated that universal screening by pretrial services with a validated assessment is being done in their communities, 7% said it is not, and 42% were unsure. For those indicating needed changes, those changes included: adding assessments to focus on specific needs; sharing assessments with providers; and also assessing alcohol and drug use as well as mental health.

Verification of Interview Information and Criminal History Checks are critical functions of pretrial services agencies, as outlined in NAPSA standard 3.1(b)(i). To help determine a defendant's likelihood of court appearance and arrest-free behavior and to identify release conditions, if any, needed to foster these outcomes, a pretrial agency should complete a standardized investigation. A pretrial services agency's background investigation should include at the least a criminal records check (preferably national) that notes adjudications and pending cases, the defendant's current status with the justice system (probation, parole, pretrial status, etc.), and previous willful failures to appear, as well as verification of information from the pretrial interview. At a minimum, information obtained from a defendant that contributes to the risk assessment calculation or final recommendation should be verified.[67]

Pretrial Services	Region 1 (n=5)	Region 2 (n=18)	Region 3 (n=8)	Region 4 (n=6)	Region 5 (n=6)
Verification of Interview Information and Criminal History Checks					
Utilized, No Changes Needed	1	7	4	4	3
Utilized, Changes Needed	0	3	0	2	0
Not Being Utilized, Should Be Utilized	1	0	0	0	2
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	3	8	4	0	1

Forty-five percent of respondents indicated that pretrial services is utilizing these activities in their communities, 7% said they are not, and 37% said they were unsure. For those indicating needed changes, those changes included: needing time to verify information; need for universal verification; and the need to verify information contained in NCIC and local criminal histories.

Presentation of Recommendations Based Upon Risk Level is covered under NAPSA Standard 4.5(a). The pretrial services agency should prepare for the Court, prosecution, and defense counsel a written report that summarizes results from its background investigation, criminal history search, and validated risk assessment. The report should include a recommendation for appropriate conditions to address identified court appearance and public safety-related risk factors.[68]

[67] ibid
[68] ibid

Pretrial Services	Region 1 (n=5)	Region 2 (n=18)	Region 3 (n=8)	Region 4 (n=6)	Region 5 (n=6)
Presentation of Recommendations Based Upon Risk Level					
Utilized, No Changes Needed	1	5	3	3	2
Utilized, Changes Needed	0	5	0	2	0
Not Being Utilized, Should Be Utilized	0	1	0	0	2
Not Being Utilized, Not Needed	0	0	0	1	0
Unsure	4	7	5	0	2

Forty-nine percent of respondents indicated that this standard is being followed in their communities, 9% said it is not, and 42% were unsure. For those who indicated changes were needed, the changes included: pretrial recommendations; consistency in presentation and consideration; and judges willing to base decisions on risk assessment/levels.

Proactive Reminders of Court Dates and Deadlines. Notification to defendants of upcoming court appearances is a proven way to improve court appearance rates.172 Notification may include telephone calls, email, or text messaging. If an agency employs multiple methods for court notification, the defendant should determine the best method of contact. Regardless of the system used, court notifications should include the date and time of the next scheduled court appearance, the court address and, if available, the judge's name and courtroom.[69]

Pretrial Services	Region 1 (n=5)	Region 2 (n=18)	Region 3 (n=8)	Region 4 (n=6)	Region 5 (n=6)
Proactive Reminders of Court Dates and Deadlines					
Utilized, No Changes Needed	1	3	4	4	1
Utilized, Changes Needed	1	3	0	1	0
Not Being Utilized, Should Be Utilized	0	3	1	1	3
Not Being Utilized, Not Needed	0	1	0	0	1
Unsure	3	8	3	0	1

Forty-two percent of respondents indicated that pretrial services utilize proactive reminders in their communities, 23% said they do not, and 35% were unsure. For those who indicated changes were needed, the changes included extending the communication to family members and significant other and adding text and email messaging to regular mail.

Accountable and Appropriate Supervision of Defendants Released. The goal of pretrial monitoring, supervision, and support is to promote court appearance, public safety, and compliance with court-ordered conditions. Monitoring, supervision, and support should include: the least restrictive interventions needed to promote pretrial success; notification of upcoming court appearances; assignment to pretrial specific monitoring or supervision staff and communication with assigned staff to report circumstances that may affect the defendant's reporting to court as required, public safety or compliance to court-ordered conditions; monitoring defendants' compliance with court-ordered conditions, including addressing initial compliance or infractions of court-ordered conditions administratively; informing the court of new arrests or defendant conduct that may warrant a modification of bail; recommending lower or

[69] ibid

higher levels of supervision when appropriate; and facilitating the return to court of defendants who miss scheduled court dates. Pretrial supervision should be individualized to a defendant's assessed risk level and risk factors and based on the least restrictive conditions necessary to reasonably assure the defendant's future court appearance and arrest-free behavior.[70]

Pretrial Services	Region 1 (n=5)	Region 2 (n=18)	Region 3 (n=8)	Region 4 (n=6)	Region 5 (n=6)
Accountable and Appropriate Supervision of Defendants Released					
Utilized, No Changes Needed	1	3	4	6	1
Utilized, Changes Needed	0	5	0	0	3
Not Being Utilized, Should Be Utilized	0	1	0	0	1
Not Being Utilized, Not Needed	0	1	0	0	0
Unsure	4	8	4	0	1

Fifty-three percent of participants indicated that this standard is being followed in their communities, 7% said it is not, and 40% were unsure. For those indicating needed changes, the changes included: the need for dedicated pretrial officers rather than probation staff who also do pretrial supervision; more probation staff; increased staffing for pretrial; and more frequent court dates or check-ins with pretrial services.

Electronic Monitoring and GPS are often utilized as conditions of release in domestic violence and stalking cases to ensure victim safety and have been used as an alternative to pretrial jail detention.

Pretrial Services	Region 1 (n=5)	Region 2 (n=18)	Region 3 (n=8)	Region 4 (n=6)	Region 5 (n=6)
Electronic Monitoring/GPS					
Utilized, No Changes Needed	1	3	5	5	4
Utilized, Changes Needed	2	4	0	0	0
Not Being Utilized, Should Be Utilized	0	1	0	1	1
Not Being Utilized, Not Needed	0	1	0	0	0
Unsure	2	9	3	0	1

Fifty-six percent of respondents indicated that pretrial services utilize electronic monitoring or GPS in their communities, 9% said they do not, and 35% were unsure. For those who indicated needed changes, the changes included: range of options from home confinement to GPS; improve communication with stakeholders; and address violations.

SCRAM, Soberlink, and Other Alcohol Monitoring are often used as a condition of release for cases involving alcohol-related charges and when alcohol use is an aggravating factor in risk to appear. Judges may order alcohol monitoring as a condition of release, but the pretrial services agency may determine type and other specifics.

Pretrial Services	Region 1 (n=5)	Region 2 (n=18)	Region 3 (n=8)	Region 4 (n=6)	Region 5 (n=6)
SCRAM/Soberlink/Other Alcohol Monitoring					

[70] ibid

Pretrial Services	Region 1 (n=5)	Region 2 (n=18)	Region 3 (n=8)	Region 4 (n=6)	Region 5 (n=6)
Utilized, No Changes Needed	0	5	3	3	2
Utilized, Changes Needed	0	5	0	2	0
Not Being Utilized, Should Be Utilized	0	1	0	1	2
Not Being Utilized, Not Needed	0	0	0	0	1
Unsure	5	7	5	0	1

Forty-seven percent of respondents indicated that pretrial services utilize alcohol monitoring in their communities, 12% said they do not, and 42% were unsure. For those who indicated needed changes, the changes included: affordable services and treatment; need for more training for officer supervising these cases; and more accountability for violations,

Drug Testing is often utilized as a condition of release for cases involving drug charges and when substance use is an aggravating factor in risk to appear. Judges may order drug testing, but the pretrial services agency may determine frequency.

Pretrial Services	Region 1 (n=5)	Region 2 (n=18)	Region 3 (n=8)	Region 4 (n=6)	Region 5 (n=6)
Drug Testing					
Utilized, No Changes Needed	2	5	5	5	4
Utilized, Changes Needed	0	3	0	1	0
Not Being Utilized, Should Be Utilized	0	1	0	0	1
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	3	8	3	0	1

Fifty-eight percent of respondents indicated that pretrial services utilize drug testing in their communities, 5% said they do not, and 35% were unsure. For those who indicated needed changes, the changes included the need for more available testing sites and observed testing.

Victim Safety Management. Jurisdictions should establish procedures to ensure the rights of victims are recognized at the pretrial stage. The rights afforded victims should include, but are not limited to, notification of all pretrial hearings, all bail decisions, conditions of release related to the victim's safety, the defendant's release from custody, and instructions on seeking enforcement of release conditions. Release orders should include, in writing, the prohibitions against threats, force, or intimidation of witnesses, jurors and officers of the court, obstruction of criminal investigations and retaliation against a witness, victim or informant.[71]

Pretrial Services	Region 1 (n=5)	Region 2 (n=18)	Region 3 (n=8)	Region 4 (n=6)	Region 5 (n=6)
Victim Safety Management					
Utilized, No Changes Needed	1	1	3	4	0
Utilized, Changes Needed	0	2	0	1	0
Not Being Utilized, Should Be Utilized	0	1	0	0	4
Not Being Utilized, Not Needed	0	1	0	0	0
Unsure	4	13	5	1	2

[71] ibid

Twenty-eight percent of respondents indicated that victims' safety is managed during the pretrial process, 14% indicated they are not, and 58% were unsure. For those who indicated needed changes, the changes included the need for more services and better communication between the State's Attorney's Office Victim Witness program and pretrial services.

Follow-Up Reviews of Defendants Unable to Meet Conditions of Release. The prosecutor, defense, or pretrial services agency may request a hearing to consider changes to a defendant's release or detention status, including reduction of supervision for positive behavior or to address an alleged violation of conditions of release, willful failure to appear in court or an arrest on a new offense.[72]

Pretrial Services	Region 1 (n=5)	Region 2 (n=18)	Region 3 (n=8)	Region 4 (n=6)	Region 5 (n=6)
Follow-Up Reviews of Defendants Unable to Meet Conditions of Release					
Utilized, No Changes Needed	1	2	4	3	2
Utilized, Changes Needed	0	3	0	2	0
Not Being Utilized, Should Be Utilized	0	1	0	0	2
Not Being Utilized, Not Needed	0	1	0	0	0
Unsure	4	11	4	1	2

Forty percent of respondents indicated that this standard is being followed in their communities, 9% said it is not, and 51% were unsure. For those indicating needed changes, the changes included: more immediate hearings; more follow-up reviews; use of pretrial supervision rather than conditions of release with no support; and finding and keeping tabs on noncompliant individuals.

Objective Assessment of Pretrial Misconduct is covered in NAPSA Standard 3.5(d). A defendant's continued release pretrial should depend on the defendant's record of court appearance, arrest-free behavior, and compliance to court-ordered conditions. Courts may revise or revoke a defendant's release status if it finds clear and convincing evidence that the defendant violated a condition or conditions of release or willfully failed to appear for a scheduled court appearance or probable cause for a new rearrest and that no condition or combination of conditions will reasonably assure future court appearance or public safety. These findings must be made following a formal court hearing and the Court's decision made in writing.[73]

Pretrial Services	Region 1 (n=5)	Region 2 (n=18)	Region 3 (n=8)	Region 4 (n=6)	Region 5 (n=6)
Objective Assessment of Pretrial Misconduct					
Utilized, No Changes Needed	1	4	3	3	1
Utilized, Changes Needed	0	2	0	1	0
Not Being Utilized, Should Be Utilized	1	2	0	0	3
Not Being Utilized, Not Needed	0	1	0	1	0
Unsure	3	9	5	1	2

[72] ibid
[73] ibid

Thirty-five percent of respondents indicated that this standard is being followed in their communities, 19% said it is not, and 46% said they were unsure. For those indicating needed changes, the changes included immediacy of response.

Performance Measures and Reporting to Stakeholders. Jurisdictions should engage in performance measurement and feedback of pretrial system practices. Jurisdictions should establish strategic goals and objectives that reflect their mission, consistent with maximizing release rates, court appearance, and public safety. Pretrial services agencies, at a minimum, should measure appearance rate, safety rate, concurrence rate, success rate, and pretrial detainee length of stay. Although the pretrial services agency should take the lead in collecting, compiling, and reporting of data, not all the metrics are reflective solely of the agency's performance, but rather are an indication of the jurisdiction's performance in relation to its goals concerning pretrial release. All metrics should be used to measure progress, track trends, and expose discrepancies between stated goals and actual practices. Performance measurements should be shared with stakeholders and used to inform decisions and drive policy.

Pretrial Services	Region 1 (n=5)	Region 2 (n=18)	Region 3 (n=8)	Region 4 (n=6)	Region 5 (n=6)
Performance Measures and Reporting to Stakeholders					
Utilized, No Changes Needed	0	1	3	1	1
Utilized, Changes Needed	0	2	0	0	0
Not Being Utilized, Should Be Utilized	0	1	0	3	2
Not Being Utilized, Not Needed	0	1	0	0	0
Unsure	5	13	5	2	2

Nineteen percent of respondents indicated that their jurisdiction measure pretrial performance and report to stakeholders, 16% said they do not, and 63% were unsure. The only noted change needed was the need to report out to stakeholders on a regular basis.

Intercepts 4 and 5

Probation

Respondents were asked about the utilization of and or need for common probation services and best practices in their county, and what changes, if any to existing services need to be made.

Motivational Interviewing and Goal Setting (MI) is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion. As an evidence-based practice, its four fundamental processes are engaging, focusing, evoking, and planning. MI is an essential skill for probation officers in building rapport and helping defendants engage in supervision and move through the stages of change.[74]

Pretrial Services	Region 1 (n=2)	Region 2 (n=11)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=7)
Motivational Interviewing and Goal Setting					

[74] https://motivationalinterviewing.org/understanding-motivational-interviewing

Pretrial Services	Region 1 (n=2)	Region 2 (n=11)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=7)
Utilized, No Changes Needed	0	5	4	5	2
Utilized, Changes Needed	0	3	0	0	4
Not Being Utilized, Should Be Utilized	0	0	0	1	0
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	2	3	3	2	1

Sixty-six percent of respondents indicated that probation utilizes MI in their communities, 3% said they do not, and 31% were unsure. For those that indicated needed changes, the changes included: utilization of the tool during daily interactions; ongoing advanced training; more trainers and trainings; increased communication with treatment providers; expansion of use beyond treatment courts; and addressing staffing issues so probation officers have the time to utilize MI.

Validated Risk Assessment. Risk/Need assessments should be actuarial measures that have been tested and retested proving valid and reliable for a variety of probationer populations. They should reliably predict a probationer's likelihood of reoffending and should distinguish what level of care a probationer will need. Assessment tools are most reliable when probation officers are formally trained to administer the tools. In Illinois, all probationers must be assessed with the Adult Risk Assessment (ARA) upon intake and then reassessed every six months or when major changes occur.

Probation Services	Region 1 (n=2)	Region 2 (n=11)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=7)
Validated Risk Assessment					
Utilized, No Changes Needed	0	5	3	4	1
Utilized, Changes Needed	0	1	0	0	2
Not Being Utilized, Should Be Utilized	0	0	0	1	0
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	2	5	4	3	4

Forty-six percent of respondents indicated that probation in their jurisdictions utilize validated risk assessment, 3% said they do not, and 51% were unsure. For those indicating needed changes, the changes included: validating the assessment tool for the local population; expanding use beyond drug court; and using a different risk assessment for drug court participants.

Case Planning Based on Risk Assessment with Integrated Treatment and Service Goals. Case planning is a cornerstone of community supervision. Effective case planning is based on the validated assessment of probationer's risk of reoffending and criminogenic needs. The case plan should also incorporate the probationer's strengths to ensure that an intervention does not disrupt or interfere with protective factors (i.e., the factors that are correlated with positive behavior, such as employment and family relationships). Case plan goals should also incorporate and support goals from treatment and service plans from providers. Compliance with the case plan increases when the probationer is involved in developing their own plans, and the case plan should be adjusted regularly to reflect changes in circumstances and achieved goals.

Probation Services	Region 1 (n=2)	Region 2 (n=11)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=7)
Case Plan based on Risk Assessment with Integrated Treatment and Service Goals					
Utilized, No Changes Needed	1	5	5	2	3
Utilized, Changes Needed	0	3	0	1	3
Not Being Utilized, Should Be Utilized	0	0	0	1	0
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	1	3	2	4	1

Sixty-six percent of respondents indicated that probation services utilize case planning in their jurisdictions, 3% said they do not, and 31% were unsure. For those indicating needed changes, the changes included: the need to follow this best practice; reviewing case plans at each probation visit; sharing plans with clients and providers; expanding use of this practice beyond treatment courts; utilizing case planning with more consistency; and the need for increased communication between probation and service/treatment providers.

Prioritized Supervision for Higher Risk Probationers. Most risk assessments break out probationer scores into high-, moderate- and low-risk categories (although some have intermediate categories such as high-moderate) so the assessor is provided information on the degree of supervision and intervention the probationer will need to have the best chance at rehabilitation. This is important, as the level of supervision and service should be proportional to the level of risk and need. Low-risk probationers have traditionally received the bulk of services and attention, as they are often the most cooperative with intervention. Yet delivering intensive supervision and programming to low-risk probationers can disrupt already established prosocial behaviors, activities, or relationships. Focusing resources on those with the greatest needs and likelihood to reoffend has been shown to have the highest cost-benefit ratio.

Probation Services	Region 1 (n=2)	Region 2 (n=11)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=7)
Prioritized Supervision for Higher Risk Probationers					
Utilized, No Changes Needed	1	4	5	4	4
Utilized, Changes Needed	0	2	0	0	1
Not Being Utilized, Should Be Utilized	0	1	0	1	0
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	1	4	2	3	2

Sixty percent of respondents indicated that probation services prioritize supervision and services for high-risk probationers in their jurisdictions, 6% said they do not, and 34% were unsure. For those indicating needed changes, the changes included the need for more resources such as anger management, DBT, and CBT for high-risk clients and expanding this practice beyond treatment courts.

Interventions Targeted to Criminogenic Needs Per Risk Assessment. Interventions should target factors that predict a justice-involved person's likelihood to commit crime that can be changed. There are eight central criminogenic factors that are widely accepted as the most important contributors to recidivism: criminal history, antisocial personality patterns, pro-criminal attitudes, antisocial associates, unstable family relationships, unstable employment or

education, a lack of prosocial recreational activities, and substance abuse. Most risk assessments score each of these factors, also called domains, to help guide the assessor in determining which areas are in greatest need of intervention and tailoring interventions to the individual and their abilities/needs. Readiness to change, reasons for change, developmental level, learning style, language, and culture are all important factors to consider.

Probation Services	Region 1 (n=2)	Region 2 (n=11)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=7)
Interventions Targeted to Criminogenic Needs Per Risk Assessment					
Utilized, No Changes Needed	0	4	4	4	2
Utilized, Changes Needed	0	2	0	1	3
Not Being Utilized, Should Be Utilized	0	1	0	0	0
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	2	4	3	3	2

Fifty-seven percent of respondents indicated probation services utilizes targeted interventions in their jurisdictions, 3% said they do not, and 40% were unsure. For those who indicated needed changes, the changes included: creating and utilizing more in-house interventions; ongoing training for probation staff at all levels; expanding this practice beyond treatment courts; and ensuring probation officers are aware of all resources available to them.

Positive Reinforcement. Behavior modification has been well-researched, and consensus shows that reinforcement works better than punishment. Higher successful probation completion rates are achieved when incentives–or rewards–are used in proportionally higher numbers than sanctions. Research suggests that a ratio of four rewards to every sanction produces the best results.

Probation Services	Region 1 (n=2)	Region 2 (n=11)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=7)
Positive Reinforcement					
Utilized, No Changes Needed	1	5	4	5	2
Utilized, Changes Needed	0	2	0	1	4
Not Being Utilized, Should Be Utilized	0	1	0	1	0
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	1	3	3	1	1

Sixty-eight percent of respondents indicated that probation utilizes positive reinforcement in their jurisdictions, 6% said they did not, and 26% were unsure. For those indicating needed changes, the changes included: more and more frequent positive reinforcement; expanding use beyond treatment courts; increased funding for incentives; the need to focus more on small successes; and addressing the staffing issues so probation officers can focus on best practices.

Appropriate Sanctions. Using sanctions to respond to noncompliance with supervision requirements is an effective strategy to modify and reinforce behavior. Supervision strategies that use both sanctions and rewards are most effective at modifying behavior. Noncompliant behavior is most likely to be reduced when sanctions are clearly articulated and consequences are swift, certain, consistent, and used sparingly. To best ensure that sanctions and rewards are

used in a consistent and swift manner, many probation agencies use a matrix or grid to inform their responses to behavior. Structured grids provide officers with guidance on the appropriate, proportionate, and graduated reinforcement of a behavior.

Probation Services	Region 1 (n=2)	Region 2 (n=11)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=7)
Appropriate Sanctions					
Utilized, No Changes Needed	1	3	5	4	1
Utilized, Changes Needed	0	4	0	1	4
Not Being Utilized, Should Be Utilized	0	1	0	1	0
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	1	3	2	2	2

Sixty-six percent of respondents indicated that probation utilizes appropriate sanctions in their jurisdictions, 6% said they do not, and 29% were unsure. For those indicating needed changes, the changes included: utilizing sanctions more often and more formally; utilizing options other than jail; enhancing the grid to include therapeutic responses and not just punishment; expanding the continuum of appropriate sanctions; expanding this practice beyond treatment courts; having uniform probation sanctions for specific violations; and reinstituting administrative sanctions.

Electronic Monitoring and GPS includes home confinement and cellular bracelet devices that track movement. They are often utilized in domestic violence and stalking cases to ensure victim safety, for frequent absconders, as a curfew monitor, and have been used as an alternative to jail sanctions.

Probation Services	Region 1 (n=2)	Region 2 (n=11)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=7)
Electronic Monitoring/GPS					
Utilized, No Changes Needed	1	5	5	5	3
Utilized, Changes Needed	0	2	0	0	1
Not Being Utilized, Should Be Utilized	0	1	0	0	1
Not Being Utilized, Not Needed	0	0	0	1	0
Unsure	1	3	2	2	2

Sixty-three percent of respondents indicated that these monitoring tools are utilized by probation in their jurisdictions, 9% said they are not, and 29% were unsure. For those indicating needed changes, the changes included more focused response to EM/GPS violations and updating the technology for these systems.

SCRAM, Soberlink, and Other Alcohol Monitoring devices are often used for cases involving alcohol related charges and when alcohol use is a major risk factor for probationer success. Judges may order alcohol monitoring as a condition of probation, or it may be added later as a sanction or monitoring tool.

Probation Services	Region 1 (n=2)	Region 2 (n=11)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=7)
SCRAM, Soberlink, and Other Alcohol Monitoring					
Utilized, No Changes Needed	1	5	4	3	1
Utilized, Changes Needed	0	3	0	1	2
Not Being Utilized, Should Be Utilized	0	0	0	1	2
Not Being Utilized, Not Needed	0	0	0	1	0
Unsure	1	3	3	2	2

Fifty-seven percent of respondents indicated that these monitoring tools are utilized by probation in their jurisdictions, 11% said they are not, and 31% were unsure. For those indicating needed changes, the changes included: use more often; use for more than DUI-related offenses; and address workforce issues to allow time for monitoring these devices.

Drug Testing. Drug and alcohol testing is an effective monitoring strategy for probationers with a history of illicit drug use or a substance abuse disorder and is used by the most effective and cost-efficient programs. Evidence-based testing helps identify those probationers who need more intensive interventions and holds probationers accountable. Testing should only be conducted on individuals who are assessed as having a substance abuse issue. If the probationer is not diagnosed as a substance abuser, monitoring, or treating the probationer for substance abuse may be counterproductive. It is critical that a probation agency's drug and alcohol testing process follow evidentiary standards and best practices and produce accurate results in an expeditious timeframe that allows probation officers to address continued drug or alcohol use.

Probation Services	Region 1 (n=2)	Region 2 (n=11)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=7)
Drug Testing					
Utilized, No Changes Needed	1	4	6	5	4
Utilized, Changes Needed	0	3	0	1	2
Not Being Utilized, Should Be Utilized	0	1	0	0	0
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	1	3	1	2	1

Seventy-four percent of respondents indicated that probation is utilizing drug testing in their jurisdictions, 3% said they are not, and 23% were unsure. For those indicating needed changes, the changes included: returning to pre-pandemic level testing; allowing probation to determine frequency of testing rather than blanket orders from plea agreements or the courts; randomizing testing and testing according to level of use/need; reducing the amount of testing as probationers get more sober time; focusing on skills to reduce relapse rather than trying to catch probationers; providing more options for facilities that observe testing; increasing consistency; expanding this practice beyond treatment courts; and testing regular probationers more often.

Victim Safety Management. Victim-centered policies, protocols, and training are essential to proactively engaging crime victims and survivors and identifying and meeting their most

important needs. APPA recommends that probation partner with victim assistance to identify and address victim safety needs through collaborative safety planning prior to an offender's release to the community, provide effective victim safety and protection strategies, and utilize technologies that strengthen offender supervision and increase victim safety.[75]

Probation Services	Region 1 (n=2)	Region 2 (n=11)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=7)
Victim Safety Management					
Utilized, No Changes Needed	0	3	4	0	1
Utilized, Changes Needed	0	3	0	0	0
Not Being Utilized, Should Be Utilized	0	1	0	3	4
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	2	4	3	5	2

Thirty-one percent of respondents indicated that probation is utilizing victim safety management in their jurisdictions, 23% said they are not, and 46% were unsure. For those indicating needed changes, the changes included expanding this activity to probation.

Performance Measures and Reporting to Stakeholders. This process involves collecting data, analyzing it for patterns and facts, making inferences, and utilizing those inferences to guide decision-making. Performance assessments should be used to examine overall effectiveness of specific interventions or activities, probation programs, entire departments, or at the system level to examine collaborations between agencies, evaluate multi-agency initiatives, or do system mapping to address service gaps. Transparency regarding performance through regular sharing of results with stakeholders and the community helps build trust and confidence.

Probation Services	Region 1 (n=2)	Region 2 (n=11)	Region 3 (n=7)	Region 4 (n=8)	Region 5 (n=7)
Performance Measures and Reporting to Stakeholders					
Utilized, No Changes Needed	1	2	3	1	2
Utilized, Changes Needed	0	3	1	0	3
Not Being Utilized, Should Be Utilized	0	0	0	2	0
Not Being Utilized, Not Needed	0	0	0	0	0
Unsure	1	6	3	5	2

Forty-six percent of respondents indicated that probation utilizes these activities in their jurisdictions, 6% said they do not, and 49% were unsure. For those indicating needed changes, the changes included: sharing results with stakeholders; being able to determine what data is useful to stakeholders; expanding departments' ability to measure performance; making changes based upon performance measure results; addressing the limitations AOIC places on sharing information with stakeholders; instituting stakeholder meetings; and expanding performance measurement beyond treatment courts and grant-funded programs.

[75] http://www.appa-net.org/eweb/docs/appa/pubs/PHVIPPRR.pdf

SIMPLE Scorecard

The Center for Behavioral Health and Justice at Wayne State University created the SIMPLE (Sequential Intercept Model Practices Leadership, and Expertise) Scorecard to assess county-level behavioral health and justice collaborations. The scorecard is an evidence-based strategic planning tool that can be used to drive behavioral health and criminal legal system change at a county level. NCSC adapted the Scorecard's comprehensive list of practices, originally designed for interviews and observation, into a survey format for this assessment. Respondents were asked to consider their county's policies and activities and answer to the best of their knowledge. The results were then compiled for each responding county and scored according to the Scorecard's guidance. When answers from respondents for a county contradicted one another, the key stakeholder response (stakeholder whose position directly worked in the area questioned) was taken. If a key stakeholder was unclear, the point was given if the majority of stakeholders answered appropriately.

Point	Question	Operationalization
Outside Grant	Did the county have a grant to help behavioral health services in criminal/legal settings?	Counties that received any federal, state, or foundation grant funding within the last five years received a point.
County Funding	Did the county, sheriff's office, or law enforcement agency pay for a public behavioral health position?	Counties that had funded behavioral health positions in one or more agency received a point. For-profit mental health services in jails and existing positions like health department directors did not count.
Millage	Did the county pass a millage to support behavioral health programming?	Counties that had passed a special tax/millage whose proceeds were dedicated to behavioral health services received a point.
CMH SUD	Is the community mental health organization authorized to bill Medicaid for substance use disorder services beyond its designated 10% carveout?	Counties who indicated more than 10% of SUD services are billed by CMHs received a point.
ACT	Did the county have an Assertive Community Treatment (ACT) program?	Counties who indicated the presence of a currently operating ACT program received a point.
Police Training	Are at least 20% of patrol officers trained in CIT or 50% trained in at least 8 hours of ILETSB-approved behavioral health training?	Counties who indicated that their law enforcement officers were trained at the appropriate thresholds received a point.

Point	Question	Operationalization
Police Coding of MH Calls	Do officers categorize mental health calls in police reports and is the prevalence of those calls more than 1% of total calls?	Most respondents were unsure about the total percentage of calls. Counties whose LEOs had the ability to code their reports received a point.
Police Referrals to Treatment	Does law enforcement directly refer persons in mental health crises to Community Mental Health or another provider?	Counties who indicated a mechanism for direct law enforcement referrals to treatment during crisis calls received a point.
Dispatch of Trained Officers	Does dispatch know which officers have received behavioral health training and send them to appropriate crises?	Counties who indicated that dispatch is aware AND dispatches trained officers received a point.
Co-Responder Model	Does the county have a co-responding unit of law enforcement and a mental health clinician to either respond to real time crises or follow up after mental health related incidents?	Counties who indicated a co-responding unit of either type received a point.
Alternative Drop-Off	Does the county have an alternative law enforcement drop-off center other than the jail or emergency departments?	Counties who indicated at least one alternative drop-off location in their jurisdictions received a point.
Evidence-Based Screening	Does the jail use empirically validated screening instruments to identify behavioral health concerns during the booking process?	Counties had to meet both parts of this (empirically validated and at booking) to receive a point.
Diversion	Does the county have a program designed to divert pretrial detainees who show signs of mental illness?	Counties received a point if any program that advocated for early release during pretrial status was mentioned.
Jail-CMH Data Matching	Does the county have a mechanism to match CMH client lists with jail bookings on a regular basis?	Counties received a point if they both matched bookings (generally with Jail DataLink) and did so on a regular basis and not just occasionally.
Jail Meetings	Does the jail have regularly scheduled interdisciplinary meetings to address behavioral health and criminal justice issues for jail case coordination?	Counties who had regularly scheduled interdisciplinary meetings quarterly or more frequently received a point.
Not for Profit Jail Provider	Does the county contract third party not-for-profit providers for jail behavioral health programming?	Counties whose jail contracted with nonprofits or had their own behavioral health staff received a point.

Point	Question	Operationalization
Jail Clinician	Does the jail have dedicated clinician(s) whose primary place of work is in the jail?	Counties who had at least one clinician who spent the majority of their time working in the jail received a point.
Jail SUD Services	Does the jail offer substance use disorder therapeutic services beyond self-help groups?	Counties who provided any clinical SUD service in the jail (including MAT other than vivitrol) received a point.
MOUD Continuation	Does the jail offer either Methadone or Buprenorphine for continuation?	Counties who offered these medications to any inmate who was already taking them received a point.
MOUD Induction	Does the jail offer either Methadone or Buprenorphine for induction?	Counties who offered these medications to any inmate to qualified for the service received a point.
Circuit Court to Prison	Were under 20% of circuit court dispositions sent to prison?	Most respondents did not know this statistic. The researchers looked it up when possible. Counties received a point if the verified percent was under 20% or if the majority of respondents indicated it was under 20% when not verifiable.
Treatment Court	Does the county have a treatment court other than a drug or sobriety court?	Counties received a point if they indicated any treatment court aside from DUI and drug courts.
Data Sharing	Do stakeholders believe HIPAA or 42CFR Part 2 are barriers to care coordination in the jail upon release?	Counties received a point if respondents indicated confidentiality laws were not a barrier.
Release Time	Does the county have a daytime release policy?	Counties received a point if their regular release times were between 5am and 7pm.
Psych Medications	Are people who receive psychotropic medications in jail routinely released with a prescription or supply?	Counties received a point if this was a regular part of jail practice.
Discharge Planning	Is discharge planning/care coordination a standard process in jail-based mental health services?	Counties received a point if both a discharge plan and care coordination were standard.
Medicaid Reactivation	Is Medicaid reactivation a part of a standard release process?	Counties received a point if Medicaid reactivation was automatic upon release.
Specialty Probation	Does the county have specialty probation officers for people with behavioral health needs?	Counties received a point if they had specialized units or officers who received specialized training.
CMH-Probation Collaboration	Does probation have formal, regularly scheduled meetings and referral systems with community mental health?	Counties received a point if there were any formalized systems, including treatment courts.

Point	Question	Operationalization
Champion	Does the county have a behavioral health and justice champion, defined as someone who can move a project along regardless of boundaries or institution.	Counties received a point if a champion was named.
Resistance to Change	Does leadership welcome change, work through data sharing barriers, or take on new behavioral health and justice matters?	Counties received a point if they reported slight or no resistance.
Strategic Planning	Does the county have regular strategic planning meetings to address behavioral health and justice issues?	Counties received a point if regular strategic planning was indicated.
Performance Measurement	Does the county regularly measure justice and behavioral health performance?	Counties received a point if at least one of the following performance measures was noted: ▪ Prevalence of justice-involved persons with serious mental illness. ▪ Dispositions for justice-involved persons with SMI. ▪ Recidivism for justice-involved persons with mental illness ▪ Connections to treatment for justice-involved persons with serious mental illness
Networking	Do mental health staff/supervisors regularly network with their counterparts in other counties?	Counties received a point if networking occurred at least annually.
Evaluation Experience	Has the county had a recent evaluation?	Counties received a point if they noted an evaluation within the last 3 years.
Boundary Spanner	Does the county have a boundary spanner, defined as someone who knows both the justice and behavioral health systems intimately?	Counties received a point if they indicated an expert in both systems or an expert in one system learning the other system.

Simple Scorecards by Region

Region 1

Intercept	Simple Scorecard Point	Region 1 Cook
Leadership	Champion	✓
	No Resistance to Change	
	Strategic Planning	✓
Expertise	Measure Own Outcomes	✓
	Networking	✓
	Evaluation Experience	✓
	Boundary Spanner	✓
Intercept 0	Outside Grant	✓
	County Funding	✓
	Millage	✓
	CMH SUD	□
	ACT	✓
Intercept 1	Police Training	✓
	Police Coding of MH Calls	✓
	Police Referrals to Treatment	✓
	Dispatch Sends Trained Law Enforcement	✓
	Co-Responder Model	✓
	Alternative Drop Off	✓
Intercept 2	Evidence-Based Screening	✓
	Diversion	✓
	Jail-CMH Data Matching	✓
	Jail meetings	✓
Intercept 3	Not for Profit Jail Provider	✓
	Jail Clinician	✓
	Jail SUD Services	✓
	MOUD Continuation	✓
	MOUD Induction	✓
	Low Circuit Court to Prison	
	Specialty Court	✓
Intercept 4	No Data Sharing Issues	
	Release Time	
	Psych Medications	
	Discharge Planning	
	Medicaid Reactivation	
Intercept 5	Specialty Probation	
	CMH-Probation Collaboration	

Region 2

Intercept	Simple Scorecard Point	Region 2										
		Boone	DeKalb	DuPage	Kane	Kankakee	Kendall	Lake	McHenry	Whiteside	Will	Winnebago
Leadership	Champion		✓	✓					✓		✓	✓
	No Resistance to Change	✓	✓				✓					✓
	Strategic Planning	✓	✓	✓	✓				✓			✓
Expertise	Measure Own Outcomes		✓	✓				✓	✓		✓	✓
	Networking		✓	✓	✓		✓	✓	✓	✓		✓
	Evaluation Experience		✓	✓	✓				✓	✓		✓
	Boundary Spanner		✓	✓	✓				✓	✓		✓
Intercept 0	Outside Grant	✓	✓	✓	✓		✓				✓	✓
	County Funding	✓	✓	✓	✓				✓	✓	✓	✓
	Millage		✓				✓		✓	✓		✓
	CMH SUD	✓	✓	✓			✓		✓	✓		✓
	ACT		✓	✓					✓			✓
Intercept 1	Police Training		✓	✓	✓		✓		✓			
	Police Coding of MH Calls		✓				✓					✓
	Police Referrals to Treatment	✓	✓	✓	✓					✓		✓
	Dispatch Sends Trained Law Enforcement				✓							✓
	Co-Responder Model	✓	✓	✓	✓				✓			✓
	Alternative Drop Off			✓	✓			✓				✓
Intercept 2	Evidence-Based Screening			✓				✓	✓			✓
	Diversion			✓	✓				✓			✓
	Jail-CMH Data Matching											✓
	Jail meetings								✓			✓
Intercept 3	Not for Profit Jail Provider			✓						✓		
	Jail Clinician			✓	✓				✓			✓
	Jail SUD Services			✓	✓		✓	✓	✓	✓		✓
	MOUD Continuation			✓	✓		✓		✓			
	MOUD Induction				✓		✓					
	Low Circuit Court to Prison						✓		✓			
	Specialty Court			✓	✓	✓	✓	✓	✓			✓
Intercept 4	No Data Sharing Issues									✓		✓
	Release Time			✓		✓			✓	✓		
	Psych Medications											
	Discharge Planning				✓							
	Medicaid Reactivation				✓							
Intercept 5	Specialty Probation			✓				✓	✓			✓
	CMH-Probation Collaboration							✓	✓			✓

Region 3

Intercept	Simple Scorecard Point	Region 3						
		Ford	Livingston	Marshall	McLean	Peoria	Rock Island	Tazewell
Leadership	Champion	☐			✓			✓
	No Resistance to Change	☐					✓	
	Strategic Planning	☐			✓			✓
Expertise	Measure Own Outcomes	✓			✓	✓	✓	
	Networking	☐		✓				✓
	Evaluation Experience	☐			✓			
	Boundary Spanner	☐				✓	✓	✓
Intercept 0	Outside Grant	☐			✓			
	County Funding	☐			✓		✓	
	Millage	☐		✓	✓		✓	
	CMH SUD	✓		✓	✓		✓	✓
	ACT	☐				✓		
Intercept 1	Police Training	✓		✓	✓			
	Police Coding of MH Calls	☐						
	Police Referrals to Treatment	☐			✓	✓		✓
	Dispatch Sends Trained Law Enforcement	☐			✓			
	Co-Responder Model	☐				✓		
	Alternative Drop Off	☐			✓	✓	✓	
Intercept 2	Evidence-Based Screening	☐			✓			
	Diversion	☐			✓	✓		✓
	Jail-CMH Data Matching	☐				✓		
	Jail meetings	☐			✓			
Intercept 3	Not for Profit Jail Provider	☐	✓	✓	✓			✓
	Jail Clinician	☐			✓	✓		
	Jail SUD Services	☐	✓		✓			
	MOUD Continuation	☐						
	MOUD Induction	☐						
	Low Circuit Court to Prison	✓		✓				
	Specialty Court	✓	✓		✓	✓		✓
Intercept 4	No Data Sharing Issues	✓	✓		✓	✓		
	Release Time	✓			✓			
	Psych Medications	☐						
	Discharge Planning	☐			✓			
	Medicaid Reactivation	☐						
Intercept 5	Specialty Probation	☐	✓		✓			✓
	CMH-Probation Collaboration	☐						

Region 4

Intercept	Simple Scorecard Point	Region 4				
		Adams	Hancock	Macon	Montgomery	Sangamon
Leadership	Champion			✓		
	No Resistance to Change	✓	✓	✓		
	Strategic Planning					✓
Expertise	Measure Own Outcomes	✓		✓		✓
	Networking				✓	✓
	Evaluation Experience					✓
	Boundary Spanner					✓
Intercept 0	Outside Grant	✓				✓
	County Funding		✓		✓	✓
	Millage				✓	
	CMH SUD	✓	✓	✓	✓	
	ACT			✓		✓
Intercept 1	Police Training					✓
	Police Coding of MH Calls					✓
	Police Referrals to Treatment	✓		✓		✓
	Dispatch Sends Trained Law Enforcement					✓
	Co-Responder Model	✓				✓
	Alternative Drop Off			✓		✓
Intercept 2	Evidence-Based Screening	✓				✓
	Diversion					✓
	Jail-CMH Data Matching					✓
	Jail meetings					✓
Intercept 3	Not for Profit Jail Provider	✓			✓	
	Jail Clinician					✓
	Jail SUD Services	✓		✓		✓
	MOUD Continuation					
	MOUD Induction					
	Low Circuit Court to Prison		✓	✓	✓	
	Specialty Court	✓		✓		✓
Intercept 4	No Data Sharing Issues		✓	✓		
	Release Time	✓			✓	✓
	Psych Medications					
	Discharge Planning					✓
	Medicaid Reactivation					
Intercept 5	Specialty Probation	✓	✓			✓
	CMH-Probation Collaboration	✓				✓

Region 5

Intercept	Simple Scorecard Point	Region 5							
		Clay	Clinton	Crawford	Jackson	Jefferson	Madison	Richland	St. Clair
Leadership	Champion								✓
	No Resistance to Change					✓	✓		✓
	Strategic Planning				✓				✓
Expertise	Measure Own Outcomes		✓		✓		✓	✓	✓
	Networking		✓				✓	✓	✓
	Evaluation Experience						✓		✓
	Boundary Spanner				✓				✓
Intercept 0	Outside Grant		✓	✓	✓	✓			✓
	County Funding				✓				
	Millage								✓
	CMH SUD		✓		✓		✓		✓
	ACT						✓		
Intercept 1	Police Training					✓	✓		
	Police Coding of MH Calls				✓	✓			
	Police Referrals to Treatment								
	Dispatch Sends Trained Law Enforcement								✓
	Co-Responder Model				✓				
	Alternative Drop Off								
Intercept 2	Evidence-Based Screening								
	Diversion					✓	✓		
	Jail-CMH Data Matching								
	Jail meetings								
Intercept 3	Not for Profit Jail Provider								
	Jail Clinician								
	Jail SUD Services								
	MOUD Continuation						✓		
	MOUD Induction								
	Low Circuit Court to Prison		✓	✓		✓	✓		
	Specialty Court						✓		
Intercept 4	No Data Sharing Issues								
	Release Time		✓	✓		✓		✓	
	Psych Medications								
	Discharge Planning								
	Medicaid Reactivation								
Intercept 5	Specialty Probation			✓			✓		
	CMH-Probation Collaboration						✓		