SEQUENTIAL INTERCEPT MAPPING

BOONE COUNTY

Final Report, 2018

Prepared by: Region 1 Planning Council

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CHAPTER 1: INTRODUCTION

The purpose of this report is to provide a summary of the activities of the Boone County Behavioral Health Task Force relative to the *Sequential Intercept Mapping* exercises held in Boone County, Illinois between May 2017 and October 2018. The meetings were hosted by the Boone County Health Department and Boone County Government, with the Region 1 Planning Council providing staff to coordinate the effort. This multidisciplinary planning team was comprised of representatives from behavioral health and criminal justice agencies, as well as the members of the community-at-large. This report summarizes the activities and recommendations of the team, including:

- A brief review of the origins and background for the Task Force
- A summary of the information gathered at the meetings
- A *sequential intercept map* as developed by the group during the meetings
- An action planning matrix as developed by the group

Observations, comments, and recommendations to help Boone County achieve its goals
Recommendations contained in this report are based on information received prior to or during the Boone County Behavioral Health Task Force meetings. Additional information is provided that may be relevant to future action planning.
Background

In April 2017, the Boone County Health Department began reaching out to local partners within the County and the City of Belvidere to discuss the possibility of developing a partnership to respond to a newly released grant opportunity from the Department of Justice's Bureau of Justice Assistance entitled "The Comprehensive Opioid Abuse Site-Based Grant Program". Representatives from these organizations met to discuss the feasibility of submitting a proposal on behalf of Boone County's stakeholders; in the process, the group determined that in order to be competitive, a comprehensive assessment of the behavioral health and criminal justice systems was needed. The Region 1 Planning Council (R1PC) worked with the group and performed a review of best practices in this area. Upon completion, the R1PC presented its work to the group who then decided that the model outlined in the *Sequential Intercept Mapping* process would meet the needs of the group.

The Sequential Intercept Model, developed by Mark R. Munetz, M.D. and Patricia A. Griffin, Ph.D.,[1] has been used as a focal point for states and communities to assess available resources, determine gaps in services, and plan for community change. These activities are best accomplished by a team of stakeholders that cross over multiple systems, including mental health, substance abuse, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, peers, and family members, among others.

A Sequential Intercept Mapping is typically a one-day workshop designed to create a map that illustrates how people with behavioral health needs come into contact with and flow through the criminal justice system. Through the workshop, facilitators and participants identify opportunities for linkage to services

[1] Munetz, M., & Griffin, P. (2006). A systemic approach to the de-criminalization of people with serious mental illness: The Sequential Intercept Model. *Psychiatric Services*, *57*, 544-549.

and for prevention of further penetration into the criminal justice system. The Boone County Behavioral Health Task Force chose to adapt this model to better suit local needs and preferences. Instead of completing the entire exercise in a one-day workshop setting, the Task Force opted to conduct the information gathering activities, cross-systems mapping, and prioritization by utilizing monthly meetings and online surveys. This process was funded by the Boone County government.

The Region 1 Planning Council (R1PC) coordinated this process and provided assistance to Boone County with the following:

- Creation of a sequential intercept map indicating points of interface among all relevant local systems
- Identification of resources, gaps, and barriers in the existing systems
- Development of a strategic action plan to promote progress in addressing the criminal justice diversion and treatment needs of adults with substance abuse issues and/or mental illness

The participants in the workshops included individuals representing multiple stakeholder systems including mental health, substance abuse treatment, county jail, city and county government, consumers and the recovery community, law enforcement, courts, healthcare providers, and first responders. A complete list of participants is available in the resources section of this document. Dana Northcott from the Region 1 Planning Council facilitated the workshop sessions and prepared all corresponding reports.

Objectives of the Sequential Intercept Mapping Exercise

The *Sequential Intercept Mapping* Exercise has three primary objectives:

1. Development of a comprehensive picture of how people with behavioral health disorders flow through the Boone County criminal justice system along five distinct intercept points: Law Enforcement and Emergency Services, Initial Detention/Initial Court Hearings, Jails and Courts, Reentry, and Community Corrections/Community Support. A sixth intercept point (Intercept 0) was also discussed but was not a focus of this activity.
2. Identification of gaps, resources, and opportunities at each intercept for individuals in the target population.
3. Development of priorities for activities designed to improve system and service level responses for individuals in the target population.

The Boone County Sequential Intercept Map created during this process can be found in this report in Chapter 2.

BOONE COUNTY SEQUENTIAL INTERCEPT MAP

INTERCEPT 1 Law Enforcement

- Training for Jail Staff
- Rosecrance Crisis Hotline
- Drop-In Centers
- Dispatch 911
  1 center operated by county
- Local Law Enforcement
  Police and County Sheriff
- Multiple Fire Departments / Paramedics/ EMS
- Ambulance
- Local Hospitals
  Walk-aways
  Distance a barrier
- Triage Center
  Voluntary: 8 beds
- Detox Services
  Requires med clearance
- Referrals to mental health by EMS providers

INTERCEPT 2 Initial Detention/Initial Court Hearings

- NAMI
- Referral to Pre-Trial Supervision
- Referrals to Deferred Prosecution
- Initial Court Hearing
- Appearance Ticket
- Initial Detention
  - Brief screening Between initial detention and first Appearance: Med, MH, Suicide

INTERCEPT 3 Jail / Courts

- Restoration Services
- Unfit to Stand Trial
- Fitness Evaluations
- Fit to Stand Trial
- Specialty Court
  Sheriff; State's Attorney; Psychiatrist, Private Attorneys, Probation; Coordinators; Case Managers; Public Defenders
  - Drug Court
  - Emerging: Mental Health, Vets Court
- Jail
  150 maximum capacity
  90 currently
  2500 per year
  - In-Jail substance Abuse/MH Screening— AA/NA meetings
  - In-Jail Rx Assisted Therapy

INTERCEPT 4 Reentry

- Illinois Department of Corrections/ Reentry
  Sharing information with jails?
  Looking at risk assessment and case management
  - Warm handoffs
  - Field Services Parole
- Jail Reentry Services
  Sharing information with jails
  - Bridge Supply of Medications = 7 days
  - Peer Support Linkage (info/ Referral packet)

INTERCEPT 5 Community Corrections

- State of Illinois Parole
- Referrals to Behavioral Health
- Remedies
- Rosecrance Intensive OP
- Probation Officers
  Specialized Units; Surveillance, Gender— Specific Services; DWI, DV, Sex Offender, Compliance
  - LSI-R
- MH Probation Officer Training

INTERCEPT 0: Community Resources

- System-wide Mental Assessment Response Teams
- EAP Employee Assistance Programs
- Crisis Care Teams
- Law Enforcement / Fire Dept
- Remedies
- 12 Step Community
- Rosecrance Crisis Hotline
- Community Service Providers
- Certified Community Behavioral Health (BCHD)
- Rosecrance
- Serial Inebriate Programs
- Probation Officers
- Detox Services

*Blue denotes services located outside Boone County, typically in Rockford

CHAPTER 2: SEQUENTIAL INTERCEPT MAP & NARRATIVE

BOONE COUNTY SEQUENTIAL INTERCEPT MAP NARRATIVE

This narrative reflects information gathered during the Sequential Intercept Mapping exercises. It provides a description of local activities at each intercept point, as well as gaps and opportunities identified at each point. This narrative may be used as a reference in reviewing the Boone County Sequential Intercept Map. The multidisciplinary local planning team may choose to revise or expand information gathered in the activity.

The gaps and opportunities identified in this report are the result of "brainstorming" sessions and the compilation of knowledge from all stakeholders during Task Force meetings and include a broad range of input from participants. These points reflect a variety of stakeholder opinions and are therefore subjective rather than a majority consensus; however, every effort has been made to represent the conclusions of as many participants as possible.

INTERCEPT I: LAW ENFORCEMENT / EMERGENCY SERVICES

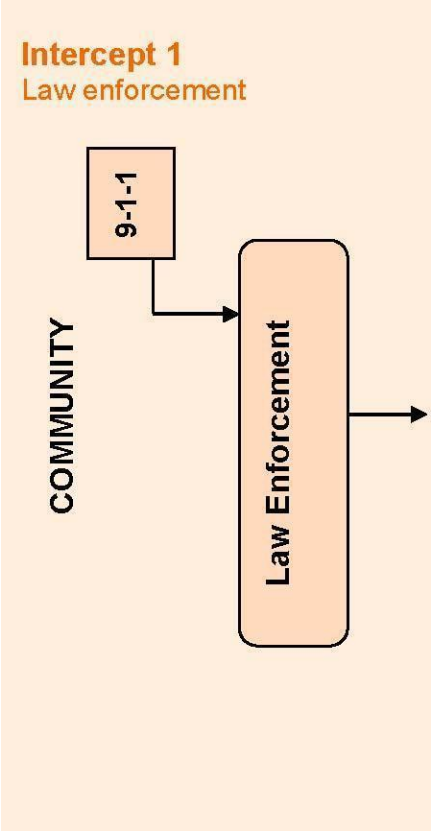


Figure 1: Intercept 1

Boone County is covered by two local law enforcement agencies, the Boone County Sheriff's Office (BCSO) and the Belvidere Police Department. Law enforcement options for responding to people with mental illness include advise, summons, arrest, transport to county jail, referral to out-of-county provider agencies, or referral to out-of-county hospital emergency departments.

Dispatch / 9-1-1

Boone County has one dispatch center, operated by the county. The 9-1-1 Center took 78,548 total calls for service in 2016, with approximately equal numbers being handled by the BCSO and the Belvidere PD. Approximately 10,000 were Fire/EMS calls. There are currently 4 Shift Supervisors and 12 Telecommunicators.

The dispatch center uses the Emergency Medical Dispatch (EMD) protocol for all calls recognizing certain types of things. All dispatchers are state certified in EMD protocols. These protocols include procedures for handling calls for medical emergencies of all kinds, including drug overdoses.

The dispatch center utilizes the Illinois Premise Alert Program, which allows those with special needs or disabilities, or their guardians, to voluntarily provide personal information to Public Safety Agencies for

emergency dissemination to police, fire, and EMS personnel. The information, which is linked to the individual's address, is stored and maintained in a secure database that is provided to first responders via the computer aided dispatch (CAD) system prior to their arrival. They have 16 dispatchers that are EMD certified, includes narcotics and mental health issues. Although this program is very helpful, one of the biggest issues is that people do not update their addresses when they move, so information is often not current, and first responders either arrive on-scene expecting someone with mental health issues that has moved since submitting the packet. Conversely, first responders often respond to an address without receiving an alert about the subject's Premise file, since the address they are dispatched to is not the address given in the Premise file (such as when the person has moved, or is at a friend or relative's house when the emergency prompting the 911 call occurs).

The typical protocol for mental health calls is for dispatchers to stay on the line until an officer arrives, although this can depend on the nature of the call. Dispatch always calls police first; an ambulance may be staged close by until an officer is on scene.

There are numerous EMS providers in Boone County, including Boone County Fire Protection District 1 (Capron Rescue Squad), North Boone County Fire Protection District 3 (Poplar Grove), and Lifeline Ambulance, and staff are not trained in Crisis Intervention Team (CIT). Capron rescue,

Law Enforcement

Boone County's two law enforcement entities, the Boone County Sheriff and Belvidere Police Department, are both housed in the Boone County Public Safety Building. This combined facility allows each department complete autonomy and independence to operate, yet allows for intergovernmental and interdepartmental cooperation and assistance. This cooperation has proven to be a great benefit in cost savings and rapid response capabilities.

Although the sheriff is authorized to enforce laws within the entire county, by professional courtesy and policy, he does not do so within individual municipalities, villages, or towns which have their own respective law enforcement agency, unless he is requested by federal or state authorities, or the authorities of any such community. The position of Sheriff is an elected office, with a four-year term. Four primary patrol shifts provide uninterrupted 24/7 coverage. Each shift consists of up to five deputies and one Sergeant. Boone County is divided into two zones for which calls are distributed by the communications center.

The Belvidere Police Department has 43 sworn officers and is responsible for responding to calls within the City limits. Police officers from both agencies have some discretion regarding pre-booking diversion, although they are typically required to book all individuals who have committed a felony or misdemeanor offense. Officers often provide transport to out-of-county emergency rooms where persons in crisis can be evaluated. Generally, police face a long wait when they bring someone for evaluation at an emergency department.

Law enforcement generally has the following options for disposition when dispatched to calls involving persons with mental illness in crisis:

- Boone County Jail
- Hospital E.R. (the majority of Boone County's residents are serviced in Winnebago County Emergency Rooms) for medical clearance and referral to Rosecrance or other behavioral health treatment providers. These providers do not respond until medical clearance is completed. The hospital does toxicology screens to rule out drug-induced symptoms vs. mental illness. A considerable amount of time is spent by officers waiting for medical clearance (This can take up to 4-6 hours if they are transported to Rockford). Although the amount of time spent can be less if officers are able to utilize SwedishAmerican in Belvidere, severity typically dictates the site. In addition, even when officers are able to send people here, they often end up needing to go to Rockford if SwedishAmerican is unable to provide a high enough level of service, costing even more time.
- Refer or transport directly to Rosecrance Triage Center: Mulberry Center has not been used as much in the past due to a lack of knowledge about the resource. According to Task Force participants, another reason people are not taken there is because of the need for medical clearance, so often individuals are sent straight to the ER.
- Home, with or without advice and referrals

For children in crisis, schools are staffed with a School Resource Officer (SRO); there are currently 2 SROs that work in District 100 schools. One of these is assigned to the county's schools and one is assigned to the City of Belvidere's schools. The City of Belvidere and the school district pay for the SROs with 70% being funded by District 100 and 30% being funded by the City.

Crisis Services

Rosecrance, the region's largest nonprofit behavioral health treatment provider has a number of centers offering crisis services in the region, but none are located in Boone County. Rosecrance's crisis services include detox, residential substance abuse treatment, and mental health crisis residential services through the Rosecrance Mulberry Center (also known as the Triage Center). In addition, Rosecrance offers mental health and substance abuse assessments, as well as medically assisted treatment (MAT) for substance abuse (including Vivitrol and Buprenorphine). Services offered include traditional and intensive outpatient substance abuse counseling services and multiple levels of outpatient mental health services. There are also residential programs for substance abuse and mental health treatment. The Triage Program and the Crisis Residential Unit are closely linked mental health programs that are offered under one roof, designed to provide an immediate response to individuals experiencing a psychiatric crisis. The goal of these programs is to avoid unnecessary hospitalization or incarceration of individuals in crisis by providing rapid assessment, stabilization and referral to the appropriate level of care. While some Triage clients go home with follow-up services at the Rosecrance Ware Center and others are referred for hospitalization, many are seamlessly moved to a short-term placement in the Rosecrance Crisis Residential Unit.

The Triage Center is a Medicaid covered service; it is also covered by many private insurance plans. Although some local dollars are used to support the service, none of these are currently provided through Boone County or Belvidere, since the services are often difficult to access for Boone County clients. The Triage Program has capacity for up to 7 people and Crisis Residential has 16 beds. Rosecrance Mulberry Center is the only center of its kind in the Northern Illinois region outside the Chicago Metro area. Triage

cares for an average 75 individuals per month. The program is open to the general public from 8AM – 12AM daily but has expanded the hours of operation to offer on-call services 24 hours a day to accommodate law enforcement referrals. The goal of this expansion is to increase diversion from the criminal justice system into behavioral health treatment. The average length of stay in Crisis Residential is 9 days. There are no shelters in Boone County and generally limited beds for crisis or transitional care for individuals with severe mental illness or in behavioral health crisis.

Hospitals / Emergency Rooms/Inpatient Psychiatric Centers

Currently, the closest inpatient state psychiatric hospital is in Elgin, more than an hour away. This has been the situation since 2012, when the State of Illinois' budget cuts closed a number of larger inpatient psychiatric hospitals, including the 76-bed H. Douglas Singer Mental Health Center in Rockford.[2] Singer was responsible for admissions from 23 northwestern counties – including Boone County- and saw 607 admissions 2010 and 485 admissions in FY 2011. Finally, in a 2012 report from the State Health Facilities and Services Review Board, it was determined that if Singer closed: the services they provided would cease to exist within 45 minutes travel time of the facility, and; there would be a negative impact on health care services in this service area. Although these factors led to the classification of the closure as noncompliant with discontinuation criteria, Singer was ultimately closed anyway.[3]

Despite the increase in the number of former Singer patients referred to the community's remaining behavioral health providers there was no corresponding increase in funding. This funding gap left providers scrambling to provide more with less on an already strained budget and resulted in an increased number of mentally ill individuals entering Emergency Departments and the criminal justice system. The remaining people were referred to distant hospitals across the state or did not receive services at all when placements could not be made.

Today, Elgin Mental Health Center is the mental health inpatient treatment provider for adults from a state-defined geographic catchment area (the 14 county Northern Illinois region, including Boone County) and works closely with the community mental health agencies and community hospital psychiatric units in its region. Since space is very limited, these beds are primarily used to care for "forensic patients" who have been found "not guilty by reason of insanity", and for persons found "unfit to stand trial" but who are required by Illinois law to remain confined to a mental hospital for a defined period of time, leaving others in need of hospitalization without an appropriate alternative.

Detoxification

There is no detox facility in Boone County; individuals are screened and often are referred, with a long wait and no transitional services. The closest detox facility is in Rockford at the Rosecrance Harrison

[2] http://www.chicagobusiness.com/article/20120830/NEWS03/120839993/in-brief-closing-rockford-mental-health-center-bad-for-patients-state-report-says

[3] http://www.idph.state.il.us/about/hfpb/Sept12sbr/19.%2012-060%20Singer%20Mental%20Health.pdf

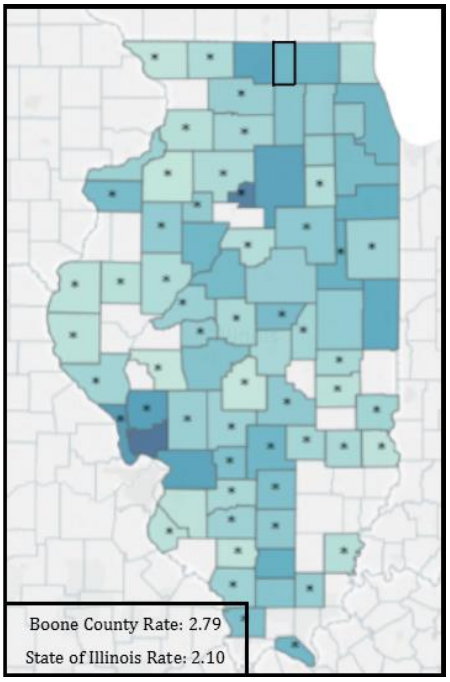


Figure 2: Fatal Opioid Overdoses Per 10,000 Population (Source: IDPH)

Campus. There are a number of admission criteria that must be met before a person can be admitted. Rosecrance cannot accept severely intoxicated persons until they reach a certain threshold of intoxication, typically under medical supervision in the ER. When these individuals are brought in by law enforcement, this requirement often prolongs officers' wait time at the ER.

According to the Illinois Department of Public Health (IDPH) listing, Boone County's only in-county opioid treatment options consist of two Physician prescribers of buprenorphine.

Opioid Overdoses

The United States is in the midst of a public health emergency and Boone County has been impacted as much, if not more, than many of its peer communities. The opioid crisis as it is now called has placed a tremendous burden on officials across the country to develop new, innovative solutions to deal with the onslaught of overdoses and the growing burden of addiction in communities. Despite having some of the worlds highest spending on medical care, a 2017 report from the Centers for Disease Control (CDC) reports that drug overdoses have now overtaken unintentional injury as the leading cause of death among adults under 50. It also showed that the U.S. experienced a decline in life expectancy for the 2nd year in a row in 2016. To lend perspective, the last time life expectancy declined for a year was in 1993, at the height of the AIDS epidemic. The last time it fell for 2 years in a row was in 1962-1963 as a result of a record number of influenza deaths, prior to widespread use of the influenza and pneumonia vaccines (people often die from pneumonia after being infected first with the flu, which makes people more susceptible to other illnesses). Based on provisional death numbers, officials fear this trend may continue another year: the last time a 3-year drop was seen was in 1918, during the Spanish flu pandemic.[4] Further, this drop in life expectancy is not being seen around the world, suggesting this is not a drop from "natural" causes.

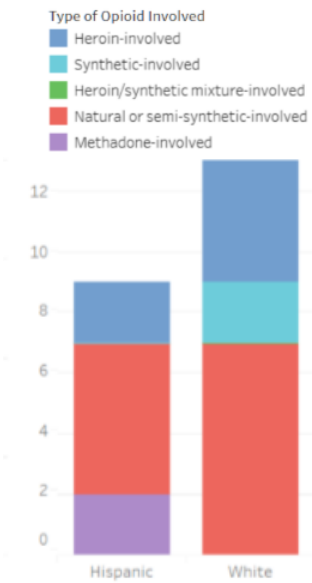


Figure 3: Ethnicity, Boone County Overdose Victims (Source: IDPH)

The State of Illinois has been affected more than most states by the opioid epidemic. In fact, the state experienced an statistically significant increase in its overdose death

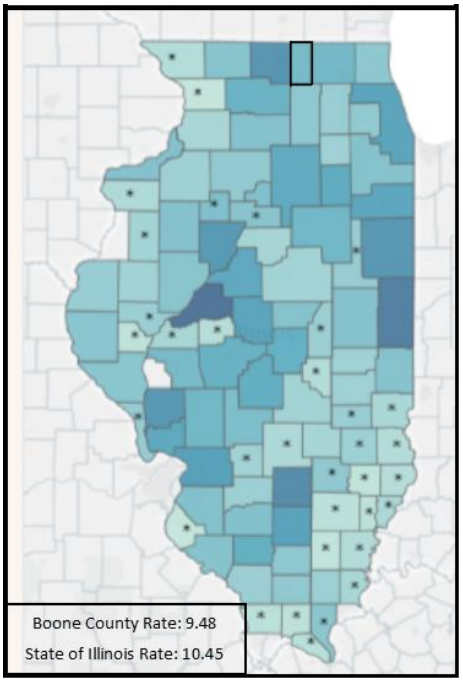


Figure 4: Non-Fatal Overdoses Per 10,000 Population (Source: IDPH)

[4] http://core-rems.org/u-s-life-expectancy-declining-do-opioid-overdose-deaths-play-a-role/

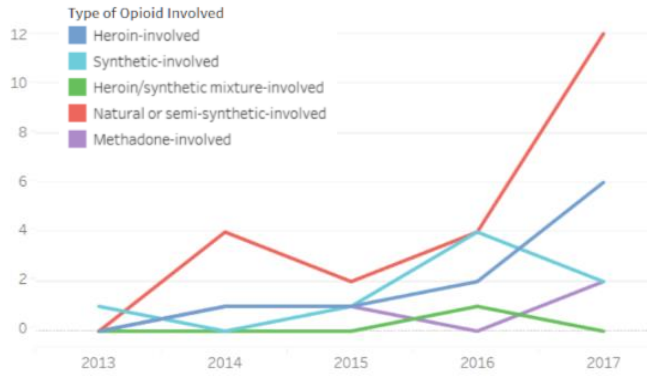


Figure 5: Boone County Overdose Incidence by Opioid (Source: IDPH)

rate in both 2015 and 2016. That increase was even more significant in 2016: whereas Illinois placed 19th among states for greatest increase in death rate in 2015, it jumped to 9th highest of all states in 2016. It is unclear whether this trend will continue in the coming years.[5]

Despite the state's rapidly increasing overdose rate, Boone County still has above average rates on some important indicator related to opioid overdoses. For example, Boone County's non-fatal opioid overdose rate per 100,000 population for 2017 was 94.8, slightly less than the 104.5 statewide, but the fatal overdose rate was 27.9 compared to only 21.0 statewide. The County's non-fatal heroin overdose rate per 100,000 was 65.4, again slightly lower than Illinois' 70.7 but it's fatal overdose rate was 11.2 compared to only 8.8 statewide. These numbers are fairly similar to the states but when broken down, it appears that although there are fewer overdoses overall, they are fatal more often. In addition, young adults appear to be disproportionately affected, even more so than throughout the state. For example, the number of nonfatal overdoses among 15-34 year olds nearly doubled from 2015 to 2016, and increased an additional 25% in 2017, hitting an all-time high of 29.

Further analysis of Illinois Department of Public Health (IDPH) data shows that the increase in natural or semi-synthetic opioid deaths is also troubling (overdose deaths in which a natural opioid such as morphine and/or a semi-synthetic opioid such as oxycodone was reported as the cause of death). From 2015 to 2016, the number of deaths from natural or semi-synthetic opioids doubled. In 2017, that number tripled to six times that of 2015. This same trend was seen in heroin deaths, with only 1 heroin death in Boone County in 2015, 2 in 2016 and 6 in 2017, six times as many. If the national fear that overdoses will continue to rise is realized in Boone County, the results will be devastating.[6]

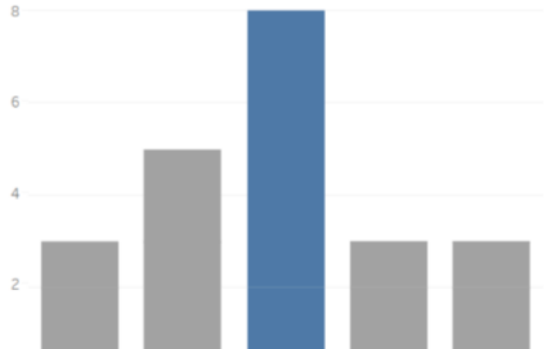


Figure 6: 2017 Boone County Age Breakdown of Overdose Victims (Source: IDPH)

Availability of NARCAN in the Community

Narcan is the brand name for naloxone, an opioid antagonist medication used to reverse the effects of opioid overdose. When someone overdoses on an opioid drug like heroin or prescription painkillers, the drug depresses the respiratory and central nervous systems, disrupting breathing and potentially leading to death. The naloxone molecules reverse overdose by binding more strongly to the receptors in the brain to which opioid drugs attach. The naloxone literally pushes the drug molecules out of their position

[5] https://www.cdc.gov/drugoverdose/data/statedeaths.html
[6] https://idph.illinois.gov/OpioidDataDashboard/

on the receptor, reversing the opioid effects and allowing the individual to start breathing normally again. Naloxone is non-addictive, and does not produce a euphoria. In fact, it does not produce any effect if the individual has no opioids in his or her system. Naloxone can be administered via injection (directly into the muscle, vein or under the skin), but is also available in a nasal spray, making people with only limited training capable of administering it safely. The effects wear off in 20 to 90 minutes.

The statewide Illinois Naloxone Standing Order authorizes trained, licensed pharmacists and overdose education and naloxone distribution (OEND) programs to dispense naloxone to anyone who requests it for the use of reversing a potential opioid overdose, even if they do not have an individual prescription for the medication. The order was issued by the Chief Medical Officer of the Illinois Department of Public Health on September 7, 2017 and is renewed annually.

There are currently five pharmacies in Boone County that carry NARCAN. Of these, two (Snyders Pharmacy in Poplar Grove and Shopko Pharmacy in Belvidere) do not carry NARCAN but are able to order it and fill prescriptions when requested. The other three (Walgreens, Walmart and O'Briens & Dobbins Pharmacies, all in Belvidere) keep NARCAN stocked on their shelves. Of those three, Walgreens and Walmart, utilize the Illinois Naloxone Standing Order and do not require a prescription for purchase.

The Boone County Sheriff's Department, the Belvidere Police Department and the Belvidere Fire Department carry NARCAN on them when working and have been trained in its administration. Local EMS (Capron Rescue Squad, Lifeline, SwedishAmerican and OSF Ambulances) also typically have NARCAN available to treat overdose victims.

The Illinois Department of Human Services (IDHS), Division of Alcoholism and Substance Abuse (DASA) established the Drug Overdose Prevention Program (DOPP) in 2010. The purpose of the DOPP is to reduce the number of deaths in Illinois by training and educating first responders to an overdose. First responders may include law enforcement officers, school nurses, bystanders, friends and family members of heroin or other opioid dependent persons. Training for first responders includes information on methods that can reduce overdose fatalities, including the administration of Naloxone.

IDHS/DASA provides training for 'Enrolled Programs' that then train multiple sites within their communities to administer Naloxone. 'Enrolled Programs' include substance use disorder treatment programs, community-based organizations, hospitals, and local health departments, and health care providers. As of the Spring of 2017, thirty-four counties (34) in the state, representing 87 percent of the population, include an Enrolled Program. All 102 counties have access to federally-funded training and Naloxone through an assigned program partner funded from one of two programs: the Illinois Department of Human Services Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths (PDO), awarded by the Department of Health and Human Services (HHS) Center of Substance Abuse Prevention/Substance Abuse and Mental Health Services Administration (CSAP/SAMHSA), or; the State Targeted Response to the Opioid Crisis Grant (O-STR) program funded through the SAMHSA's 21st Century Cures Act.

Boone County is covered by the $16 million O-STR program. The County's assigned program partner is Human Service Center of Peoria, Inc. (HSC) Although HSC is not located in Boone County, they collaborates with the Jolt Foundation, Chestnut Health Systems, Robert Young Center, and Sinnissippi Centers to support an expansion of Naloxone distribution and education and outreach across

several counties throughout the northern and central portion of the state. Of these collaborating agencies, Sinnissippii Centers has been working directly with Boone County since Summer 2018 to offer free NARCAN trainings to the public. Using the Illinois Naloxone Standing Order, grant funds cover the purchase of Naloxone nasal spray that is made available to the public provided people undergo a brief training with one of their grant-funded staff. In addition starting in 2018, once someone has been trained, they can in turn choose to train additional people in a "Train-the-Trainer" model. Once an individual is trained, they are given a supply of NARCAN and allowed to administer it freely to anyone in need. There is no limit on how much NARCAN a person can receive; once they are trained then they can receive as many kits as they need.

Data/Information Sharing for Crisis Services and Law Enforcement

Task Force Participants reported that there are currently no mechanisms by which medical, public health and/or behavioral health providers can exchange patient information for the purpose of case management or service provision.

Intercept I Gaps

Although Boone County's proximity to Winnebago County can make Boone County's behavioral health needs appear relatively minor, when adjusted for population, it becomes clear that this is not the case. For example, although Boone County's number of Primary Opioid Treatment Admissions is lower than that of neighboring counties, when measures that account for population size are examined, such as the rate of Primary Opioid Admissions per 1,000 population, we see that Boone County's rate is comparable to Winnebago and Cook Counties[7].

Another gap identified is the narrow admission criteria which requires a finding of "imminent danger or inability to care for self or others" for admission under the State's involuntary commitment statute. This restrictive definition often makes placement difficult when individuals are not willing to get help. Task Force participants report a consistent lack of options for individuals that fall short of this threshold. This gap is related to another obstacle, the lack of in-county crisis beds. Voluntary admissions do not follow the previously referenced statutory criteria and are available in the manner of a medical hospital admission. Unfortunately, the past decade has seen a decrease in the number of inpatient beds for both voluntary and involuntary commitment, as previously described in reference to Singer.

A common theme in any human service-related assessment of Boone County is that of transportation as a gap. Boone County's proximity to Rockford, a mid-sized metropolitan area, means that social service and medical providers often opt to operate out of the larger urban city. Unfortunately, Boone County, like most rural areas, does not have the same robust public transportation system that Rockford does and people often struggle to access services. In the event of a mental health crisis involving first-responders, this usually means that the burden to transport the individual in crisis falls on them. This translates to diminished ability to respond to other emergencies and a drain on resources.

Overly restrictive confidentiality and privacy laws (HIPAA) that impede better integration of services, coordination of response and data sharing among partners represent another gap. There are currently no

[7]The Opioid Crisis in Illinois

formal data sharing mechanisms between mental health and public safety systems. As a result, police, jail, and treatment providers are not aware of person's interactions with systems outside their own. This gap in information sharing has also created a situation where there is currently no accurate measurement of the true need for services.

Additional Intercept 1 gaps identified by the Task Force include:

- Time involved between police officer and hospital before cleared for crisis intervention
- Need CIT training for officers on all shifts, 24/7 operations
- Need for procedures that allow streamlining of initial contact with people in behavioral health crisis to reduce time for police involvement
- Lack of services for mentally ill/substance abusers without health insurance
- Need for education/outreach to improve familiarity with crisis/detox services (to improve law enforcement referrals and increase diversion from jail)
- Need more resources and opportunities to involve families, support systems in crisis response

INTERCEPT I OPPORTUNITIES

- Develop additional services for clients that are difficult to engage and don't meet criteria for involuntary hospitalization other than jail
- Develop crisis stabilization bed capacity within Boone County
- Explore telehealth options to leverage existing resources for provision of behavioral health crisis services, such as implementing video/Skype crisis services to connect clinical staff to first responders during crisis calls
- Enhance existing process to inform officers if pending call has a history of mental illness or violence
- Train all officers and dispatchers in crisis intervention and ensure 24/7 availability
- Develop data sharing agreements to increase access between agencies
- Create more robust data collection system to get better assessment of gaps and opportunities system wide
- Streamline initial contact to decrease time spent by law enforcement on calls for people in behavioral health crisis
- Increase utilization of existing crisis services
- Further examination of the jail/law enforcement/treatment provider information sharing approach used in other localities

RECOMMENDATIONS:

HEALTHCARE SYSTEM BASED TELEHEALTH POOLS

Boone County could work with neighboring counties/cities to explore the development of telehealth resources for hospitals and urgent care settings that would be operated by the healthcare system for their affiliates. In this scenario, if a patient presented at a local (rural) provider without dedicated on-site resources for mental health, telehealth would be used to support the local provider in providing appropriate intervention and stabilization. This model could provide immediate services at any number

of rural health/service locations on an as-needed basis. By sharing the resource in a pool, no one locality would have to bear the full financial burden of supporting a full-time behavioral health clinician but would have greatly improved access to one as necessary.

Some key advantages to this model would be greater familiarity between host/remote staff than might be expected in a state or nationwide system. This resource could serve as an option for dispatch, first-responders or law enforcement if clients are suitable for non-jail, less intensive crisis services since a provider with a smaller regional territory can better learn local referral resources and collaborate with providers.

Standardize Data Collection for Crisis Services

Boone County could expand on current data collection by determining what information should be collected at every crisis encounter. This could be done through use of a common form to be used by all Law Enforcement agencies. Law enforcement agencies could also work toward a county-wide procedure across all agencies for collecting and analyzing law enforcement data on mental health calls, encounters, and dispositions. This would enable more targeted communication with mental health providers, as well as a means for evaluating law enforcement strategies and outcomes when interacting with persons in crisis who have a mental illness.

Another potential solution to assist with standardizing data collection would be to look into county-wide implementation of an existing data collection tool. For example, ODMAP (Overdose Detection Mapping Application Program) is a tool that was developed by the Washington/Baltimore High Intensity Drug Trafficking Area (HIDTA) to track overdose data in real-time. The tool is offered to first responders and government agencies free-of-charge and allows users to track and monitor trends related to substance use in the community. Since ODMAP provides real-time overdose data, it allows communities to respond quickly to trends and can work in and across jurisdictions to support public safety and health responses to overdoses.

ODMAP is made up of Level I and Level II users. Level I users are typically law enforcement officers or fire/EMS providers. Level I users input the data via their mobile devices when they arrive on scene. Data points include whether the incident is fatal or non-fatal and the number of doses of Naloxone administered on scene (if any). In the event that the user can't enter the information at the scene (if they receive another call immediately after or if the scene is located in an area with limited internet accessibility), they can give the info to another user (like an administrator or dispatcher) and it can be entered into the system later. The Level I information is then submitted to a central database and mapped to an approximate location.

In terms of confidentiality, Level I users do not collect any personal identifying information on the victim. In addition, HIPAA does not pose an issue to ODMAP's use thanks to exceptions to the HIPAA Privacy Rule that support the policies and procedures of ODMAP. The tool is compatible with any mobile device or data terminal connected to an agency CAD system. The interface is very user-friendly and it takes only seconds to input data.

Figure 7: ODMAP Level I User Interface (Source: ODMAP)

Level II Users are usually public health and/or public safety officials, data analysts, or government staff.
This level of use requires the user to request and be granted a login credential that is then used to access the secure server so it is not accessible by the general public. Once granted credentials, Level II users have access to the central database and map which uses the approximate locations of the overdoses as reported by the Level I users.

ODMAP has many features that would help Boone County better understand patterns of substance abuse in the county. For example, the program has a feature that evaluates longitudinal data from counties (and/or surrounding jurisdictions) and determines the local baseline so that if there is a spike in overdoses, an alert is automatically sent to Level II Users (within 24 hours) describing the change. The implications of this are major: for the first time ever, Boone County would have the opportunity to use real-time data to respond to spikes in overdoses as they are happening and mobilize swift public health and safety responses. In short, they would have the information they need to intervene early, potentially reducing and preventing overdose deaths.

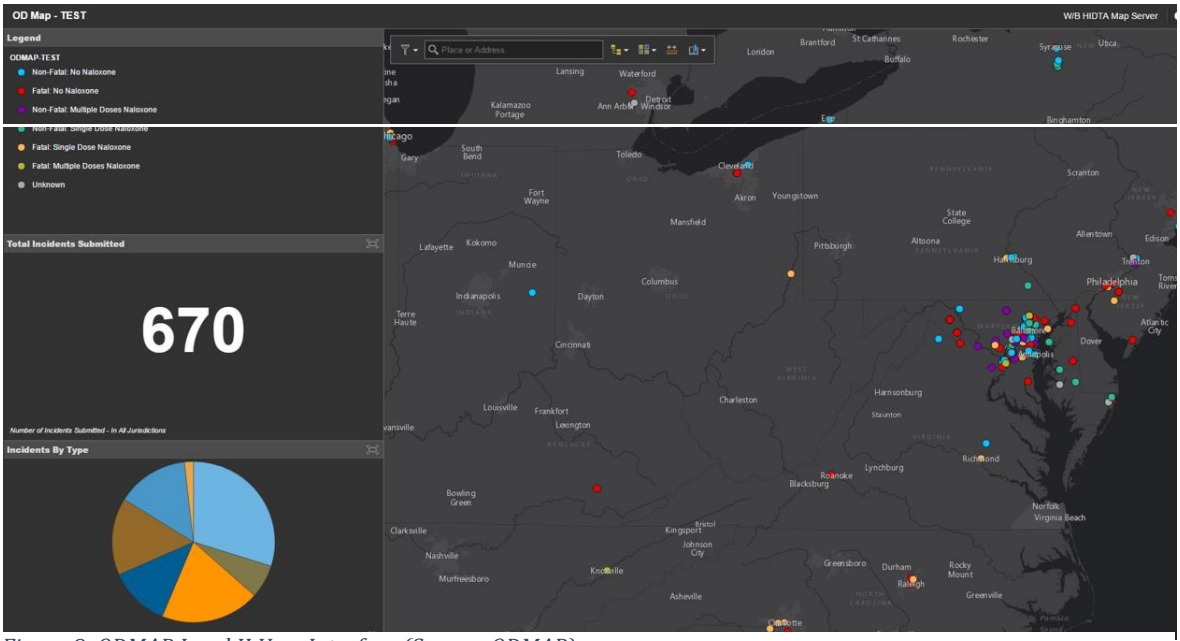


Figure 8: ODMAP Level II User Interface (Source: ODMAP)

ODMAP is just one example of a tool that could be used to improve data collection and analysis related to behavioral health in the community. By selecting and implementing a tool that can is multidisciplinary, Boone County would be able to overcome the question

currently plaguing communities across the country: how do we collect, aggregate and analyze data from disparate sources without violating confidentiality, compromising quality or limiting access to those who need it? While the current systems that collect and track overdoses are helpful, ODMAP would transform Boone County's data collection efforts from useful observation into a powerful weapon in the behavioral health arsenal.

Another major function of tools like this is that implementation would make Boone County part of a regional and national data collection effort, allowing stakeholders to compare local data to that of other communities in the database. This would not only allow local stakeholders to understand where Boone County stands in relation to other communities, it would be useful for competitive grant opportunities where communities are often asked to demonstrate that the community's problem is severe enough to warrant the award. ODMAP is one tool that has been identified that would assist with all of these things, but there are comparable tools that measure other indicators related to behavioral health that should be considered by the Task Force in the future. It is therefore recommended that Boone County not only implement the use of ODMAP, but that they explore implementation of other publicly available tools designed to standardize the collection and analysis of behavioral health data across systems and disciplines.

INTERCEPT II: (*FOLLOWING ARREST)* INITIAL DETENTION / INITIAL COURT HEARING

Initial Detention

The Boone County Adult Detention facility is a full service jail and is the county's only jail. Located in the City of Belvidere, the jail was expanded in early 2003 and increased from a capacity of 48 to 150. The jail has six holding cells and averages seven bookings per day, although activity fluctuates with court schedules and other factors. The jail uses Computer Information Systems as its data management software program.

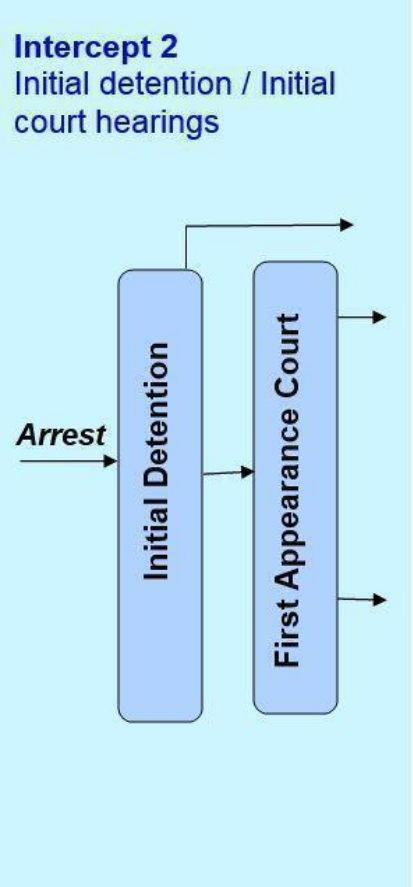


Figure 9: Intercept II

Deputies and corrections officers provide transport for inmates when needed and the facility serves male and female detainees. The jail utilizes a detainee management style referred to as Direct Supervision. Direct Supervision requires that staff closely supervise detainees in the day room of a housing unit that allows them direct unobstructed contact with the detainees. The officer in the housing unit coordinates all unit activities, reinforcing detainee behavior by acting as a role model. In Direct Supervision jails, positive behavior is rewarded by access to privileges such as classes, games, television, and day room time. Detainee's negative behavior is reinforced by the use of negative consequences for not following the rules. Consequences for detainees not abiding by the facility rules may range from short lock downs in their cells, limiting access to the unit activities or removal from the housing unit to a more restrictive unit.

The jail provides services to ensure the physical and mental well-being of detainees is maximized. At booking, a complete behavioral health screening is conducted by a corrections officer with a positive screen resulting in referral to Jail Medical. If warranted, they in turn refer to Rosecrance for a more thorough assessment. All other needs are referred to Jail Medical Services or through court-ordered referrals.

Arraignment

There is one criminal court in Belvidere with county-wide jurisdiction. Arraignment hearings for in-custody persons are held at 1:15 p.m. every day, typically via video. Within 48 hours, a judge must find probable cause that defendants have committed a crime. The Public Defender is present at the defendant's first court appearance, as required by law as of January 1, 2018. The Public Defender's office is staffed by the Public Defender, three Assistant Public Defenders and 3 additional staff members. An estimated 80% of individuals being seen in court are cases that involve individuals under the influence of substances or individuals with mental illness. Opiate addiction is noted to be a strong influence.

The Boone County Probation Department does provide some ancillary services, such as bond reports, a risk assessment, and pretrial monitoring if the charges involve a felony or a domestic violence order of protection. If such a report is conducted, it does detail any known information pertaining to mental health/substance abuse if the defendant is found to be fit to cooperate with the investigation. If an individual repeats contact, history will be provided to the court. At the felony level, prosecutors make bail recommendations based on charges, probable cause affidavit, victim questioning, bond reports, and criminal history.

Intercept II – Identified Gaps

- People with bond previously set may not receive a full assessment- this can result in missed opportunities to identify behavioral health issues
- Need a treatment alternative to jail
- Jail release is unpredictable; difficult to link/access for needs
- Intake forms in jail collect limited information
- All agencies involved in booking have different data collection systems that are not compatible
- Lack of advocacy or peer support services

Intercept II – Identified Opportunities

- Create a jail diversion services program
- Share booking information i.e., client rosters from jail to Mental Health, Developmental Disabilities or other systems (there is currently no formal communication)
- Develop bonding options (personal recognizance, etc.) to address inability of persons with mental illness to bond out due to lack of money and/or waiting for mental health evaluation/assessment, while protecting public safety
- Expand intake process to better identify mental illness and implement interventions
- Create better data collection systems that interface across agencies

Recommendations

In order to diversion programs, Boone County would need a physical location for programming, The Task Force is exploring the idea of using the clinic that was attached to the now-abandoned St. Joseph's Hospital in Belvidere. Although the building would need considerable renovation, it is believed to be structurally sound, so if it were renovated, the clinic could be used for this purpose. In addition, the professional building next to St. Joseph's could also be used. This location and facility could be ideal for a jail diversion program or any one of many service programs. The Task Force is currently exploring colocation of this type of programming with other human service programming needs, such as a potential domestic violence shelter. In order for a venture such as this to be successful, it would need to be a partnership involving (at minimum) the City of Belvidere and Growth Dimensions, Boone County and the Belvidere Police Department.

Boone County should consider selecting a validated risk assessment tool to utilize e.g., Virginia Risk Assessment, and using results of the risk assessments to inform pre-trial decision-making in place of charge-based decision making. It is further recommended to use mental health and substance use screening or assessment results to link individuals with needed services and treatment. Individuals on pre-trial release could then be ordered by the court to participate in indicated treatment as a condition of release. In conjunction, it could be helpful to employ a liaison with the mental health system to coordinate response by the court and the mental health agencies for defendants with mental health needs.

Another recommendation would involve developing basic educational materials and procedures for informing mentally ill individuals of what to expect during their interaction with the criminal justice system. Peers, mentors, advocates, or navigators could be trained to fulfill this function, in conjunction with written materials.

A final recommendation would be to study best practices to start getting releases of information earlier in the process and identify a mechanism for cross-referencing detainees with mental health system enrollment and/or Medicaid enrollment as part of the booking processing to establish earlier access to resources and services. This would also reduce the number of detainees that are released before they are screened and subsequently linked to treatment. This data sharing could also provide a reasonably accurate count of individuals with mental illness in the jail and the opportunity to determine a baseline as well as subsequent departures from that baseline over time.

INTERCEPT III: JAILS / COURTS

Jail

Since the Boone County Jail is the county's only lock-up option, it is discussed in both Intercepts II and III. The facility's rated capacity of 150 persons does not account for the work release program, which adds an additional 23 beds for a total of 173. According to the Task Force, the average daily census is typically not at capacity. In addition to the six holding cells, there are also three solitary confinement cells, which are often used for inmates that are in withdrawal or in need of mental illness-related segregation.

The jail's inmate case management software, Computer Information Systems, contains offender details such as basic identifying information, charges, court dates, and limited medical information. The jail provides medical care and medications for people in custody through a third-party contractor, Guardian Correctional Care. Inmates are screened by a nurse who is on site 5 days per week. All detainees see the

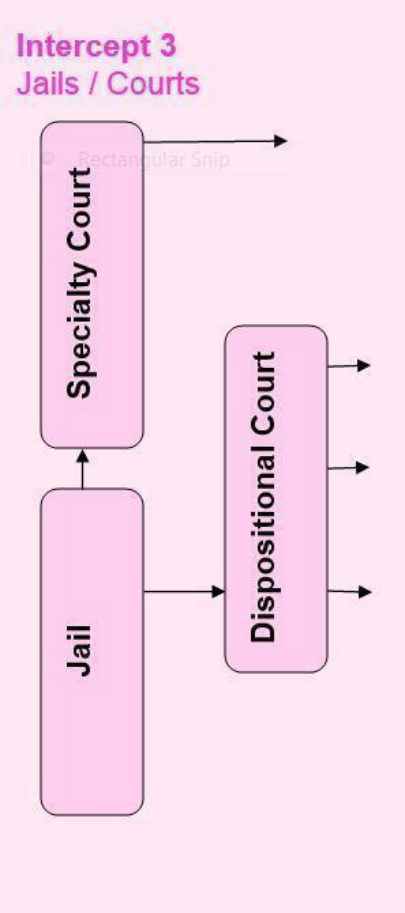


Figure 10: Intercept III

nurse within 14 days of intake, in compliance with Illinois Department of Corrections (IDOC) guidelines. Inmate medications are often billed to the inmates insurance and given to the inmate upon release. If preferred, inmates can also provide their own medications (if they are on their person when they arrive) or have family or friends bring them. If medications are not provided directly to the jail by the pharmacy, they must be approved prior to dispensing. If the medications come from the jail's in-house pharmacy, a 14-day transitional supply of psychiatric medications is provided upon release. The County reports that the average cost incurred to provide these medications is approximately $300 per inmate per month. They estimate the number of inmates provided with these medications to be 10 per month, for a monthly average of $3,000 and a yearly average of $36,000.

Rosecrance is the current recipient of the SAMHSA-funded State Targeted Response to the Opioid Crisis (Opioid-STR) grant through the Illinois Department of Human Services (IDHS)/Department of Alcoholism and Substance Abuse (DASA). The purpose of the program is to fund a comprehensive range of services in response to the opioid crisis in Illinois. Specifically, Illinois Opioid-STR funding supports contracts for the provision of case-finding, Vivitrol injections, and post-release linkage services for persons with Opioid Use Disorders (OUDs) who are incarcerated in specified Illinois County Jails in areas of high need. Boone County Jail has been designated as one of these jails. Under the Opioid-STR grant, Rosecrance provides Boone and Winnebago County jails detainees with pre-release screening and assessment for OUDs. Upon identification of individuals appropriate for treatment, those willing to engage in treatment can receive an initial injection (within 48 hours of release when possible) of Vivitrol and be enrolled in follow-up case management services including a "warm hand-off" to community-based Medication-Assisted Treatment (MAT) providers and ongoing post-release case coordination. In addition, up to two more post-release Vivitrol injections can be provided for individuals in the process of enrolling in Medicaid for whom there is a need to bridge the gap until coverage is established to pay for this service. Post-release continuing care can include cognitive behavioral therapy, substance use disorder treatment, wrap-around strength-based case management, co-occurring disorder counseling, and employment readiness services.

Court and Specialty Courts

The State of Illinois has a three-tiered judiciary consisting of Circuit Courts, Appellate Courts, and a Supreme Court. The highest court in the State is the Illinois Supreme Court. The Illinois Appellate Court is the second tier of the judiciary. The Appellate Court is divided into five Judicial Districts. The Seventeenth Judicial Circuit and five other circuits comprise the Second Judicial District of the Appellate Court.
The first tier of the judiciary is the Circuit Court, which is the trial court level. The State of Illinois is divided into 23 Judicial Circuits, including the Seventeenth Judicial Circuit, which is comprised of Winnebago County and Boone County.

The Circuit Court has two types of Judges: Circuit Judges and Associate Judges. The 17th Judicial Circuit has 11 Circuit Judges and 15 Associate Judges. Circuit Judges are elected by popular vote for an initial 6-year term and must run for retention every 6 years. The Circuit Judges elect a Chief Judge to provide administrative guidance to the entire circuit. The Circuit Judges also recommend Associate Judges to the Illinois Supreme Court, where they serve 4-year terms. Associate Judges may hear all types of cases. Boone County has one Judge for civil matters (an Associate Judge) and two Judges (1 Associate and 1 Circuit) for criminal matters assigned to the Boone County Courthouse in Belvidere. In Boone County, the court's bailiffs are Boone County Sheriff's staff and are under the supervision of the Sheriff.[8]
The Drug Court in Boone County was established in 2013. Referrals to Drug Court are made based on information obtained from Pretrial investigations. In order to be enrolled in Drug Court, defendants are required to meet the following eligibility requirements: individuals must reside in Boone County, be willing to participate in the program, be considered a high or medium risk and high or medium need for re-offending and be approved by the prosecutor and drug court team. They cannot be charged with possessing an amount of drugs that is determined to be more than for personal use or committing a violent crime. Individuals accepted into the program must attend drug court appearances, attend all recommended treatment, report to probation, live in an approved residence in Boone County and agree to frequent drug tests. The current maximum caseload for Drug Court is 25. The Task Force reported having a caseload of 15 in Drug Court at the time of this report.

Periodic Imprisonment (commonly referred to as Work Release) is another sentencing option. These individuals are housed in a separate area from other prisoners. Individuals in Work Release are allowed to go to work and must then return within a certain timeframe. They are allowed to work up to 60 hours per week while in the program. To be eligible they must: provide proof of employment; submit a work schedule, and; be employed within the geographic boundaries of the 17th Judicial Circuit. The cost to participate in the Work Release program is $20/inmate/day; there is an alternative fee scale based on income for those that qualify. Work Release residents sentenced to court-ordered counseling and classes are subject to approval of the Work Release Director. The person does not receive day for day credit against their sentence.

Intercept III – Identified Gaps

- Currently no system for collecting community behavioral health history data
- Jail does not have 24 hours a day availability of mental health professionals
- People in jail are often cut off from Medicaid benefits, making it difficult for them to get access to services after they are released from custody
- Lack of specialized mental health training for correctional officers

Intercept III – Identified Opportunities

- Identify system for collecting community behavioral health history data

[8] http://www.illinois17th.com/images/2016%20annual%20report.pdf

- Explore possibility of bond review when client is improving within the jail
- Mental health providers could make recommendations in pre-trial phase based on experience with individuals
- Some interest in mental health court, but data not available at the time to determine if it is warranted
- When mental health issues are identified prior to screening, strive to complete full mental health evaluation and formation of appropriate recommendations to properly aid court at the time of sentencing
- Develop guidelines on compliance and violation policies regarding offenders with mental illness, including a range of sanctions to compel (and incentives to encourage) compliance with conditions of release, including the development of a review board
- Streamline the approval process in order to reduce the amount of time that inmates go without access to medications

INTERCEPT III – DISCUSSION

In order to implement these opportunities, funding for staff would need to be secured. Although Boone County currently provides some group counseling in the jail, through Rosecrance's STR grant program, there is only funding available for one counselor to come onsite once a week for up to 6 hours. The Task Force was able to identify that there is space in the jail that could be usable, if there were a reconfiguration of current spaces (the potential space is outside the women's cell block, in what is currently a recreation area). The jail also currently has 12 step meetings in the area between K and L block, and has indicated that they could do the same for female inmates, outside the J Block. This partnership would require at least the participation of a behavioral health provider and the Boone County Jail and Rosecrance has indicated a willingness to participate if funding were available.

INTERCEPT IV: PRISONS / REENTRY

Prisons

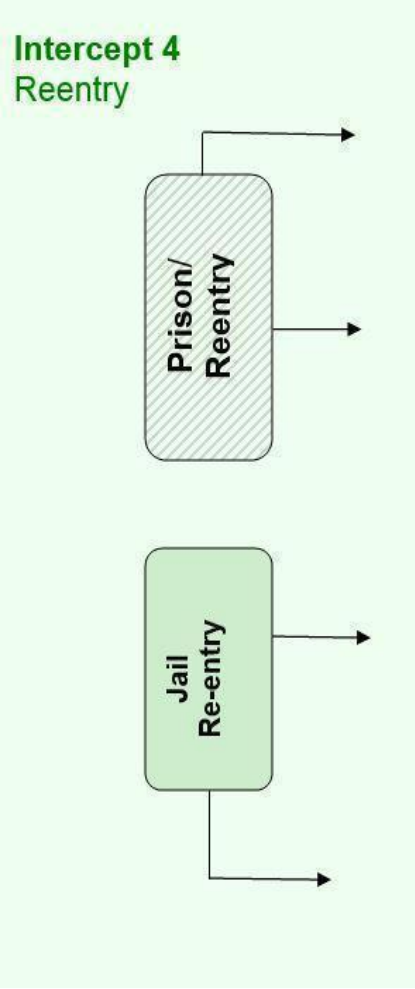


Figure 11: Intercept IV

Upon being sentenced to serve time in the Illinois Department of Corrections (IDOC), all male Boone County detainees are transported to the Northern Reception and Classification Center in Joliet for classification prior to IDOC assignment. Although they can be sent to any facility in the IDOC system, prisoners are usually sent from here to Stateville Correctional Center in Joliet. Prisoners assigned to minimum security remain onsite at the Northern Reception and Classification Center, which is home to the Stateville Minimum Security Unit. Others are transferred to Stateville Correctional Center in Crest Hill (also near Joliet). Boone County's female detainees are transported to Logan Correctional Center in Lincoln (near Decatur). Reception and classification of these prisoners takes place on-site.

Reentry

Upon parole or release, former defendants returning to Boone County enter the community from all Illinois Department of Corrections prisons as needed. Upon returning to the community from jail or prison, individuals may be referred to residential programs, such as halfway houses. There are no halfway house programs in-county at this time, so these individuals could be referred to programs including Rosecrance in Rockford, Serenity House in Dekalb, Sojourn House in Freeport, and the Rockford Rescue Mission, among others.

No housing assistance or transportation assistance funds are currently available for supporting reentry. In addition, housing options are very limited for Illinois' reentering citizens in general, but are more pronounced in Boone County.

INTERCEPT IV – IDENTIFIED GAPS

- Reentry support services are needed to assist individuals with assimilation into the community after release. There are currently no services available locally to assist with this transition.
- Rural transportation issues remain a major gap. This continues to be a significant issue since most services that people need are located outside Boone County.

- Lack of local psychiatrists makes linking people with appropriate behavioral health treatment upon release from jail or prison difficult.
- Lack of peer support network
- Lack of wraparound services (employment/vocational training, education services, family services, interventions to change thinking and environment, etc.)
- People lose benefits (such as Medicaid) when incarcerated with inadequate services existing in jail to assist in reinstatement upon reentry
- Lack of housing for people with felonies
- Limited release planning/coordination. Unexpected releases often limit coordination of services and follow-up
- Lack of services to ensure clients receive bridge medications and remain medication compliant upon release
- Limited data on released individuals for issues such as mental illness, substance abuse and homelessness

Intercept IV – Identified Opportunities

- Develop effective linkage case management (such as navigation model; see Chapter 3, Cross-System Recommendations)
- Linkage to Crusader Clinic for family planning, birth control, and other resources that are available but that could be used more effectively
- Examine the results of current reentry efforts by tracking individual cases. Determine who may have been missed or where efforts are not resulting in the desired outcomes for increased continuity of care and decreased return to the criminal justice system.
- Develop discharge planning program for people leaving the jail
- Explore ways to enhance "bridge medications" when a person reenters the community from the jail so there is not a lapse in treatment
- Consider the development of rapid reentry follow up appointments with select providers for people with serious mental illness or those who are on medication that need to be maintained to reduce recidivism and relapse
- Build on current work to systematically develop "in-reach" efforts into the jail to identify those with severe mental illness and often co-occurring disorders in order to facilitate continuity of care and alternatives to incarceration

Recommendations

These issues stem from the County's lack of access to psychiatric services in general, so the fact that individuals are having difficulty accessing services upon release comes as no surprise. The wait list to see a psychiatrist is often 3 or 4 months long, and although many people receive referrals to Crusader Clinic (the local Federally Qualified Health Center) for their medical needs, many doctors are uncomfortable prescribing psychotropics. In addition, many psychiatric meds call for close monitoring and psychiatric patients are notorious for an unwillingness or inability to comply with treatment. Case managers would help with this tremendously, so Boone County has a need for both case managers and psychiatrists. Ideally, Boone County would be able to build a mental health court model similar to the one currently in

place in Rockford.

There are a number of issues that could be addressed in order to bring a treatment model featuring coordinated navigation and comprehensive case management to Boone County. One of those involves the barriers that individuals face when signing up for insurance, which often causes people to be noncompliant with their medications. Another is finding a model suited to Boone County's smaller population. One model that would meet the needs of Boone County, Assertive Community Treatment teams (ACT) requires a minimum of 55 people to implement. Rosecrance currently operates such a program in Winnebago County and has agreed to look into the criteria and feasibility of implementing a team in Boone County.

There is likely much more that can be done to maximize opportunities and expand supports for those individuals returning to the community from the state prison system, beyond verification of an initial mental health service appointment. In addition, peer support services are a critical element to develop and are currently sorely lacking.

INTERCEPT V: COMMUNITY CORRECTIONS / COMMUNITY SUPPORT

Probation

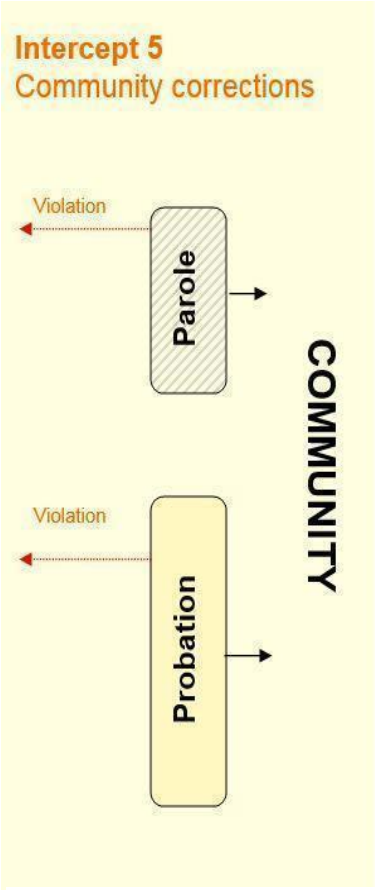


Figure 12: Intercept V

Boone County currently has six Probation Officers, 1 Drug Court Officer, and a Deputy Director. All of these positions are full-time. Two officers are primarily focused on juvenile offenders, but have other duties which service adults. At the time of this report, there were 334 individuals monitored on Probation, 120 individuals receiving pretrial services and 420 individuals monitored as administrative casework. These numbers do not reflect the monitoring of public service work or writing Pre-sentence Investigation reports. Specialized programs offered through Probation include Drug Court, Youth Recovery Court, Moral Reconation Therapy Group (adult and juvenile), and the Partner Abuse Intervention Program (PAIP).

Parole

Adult Parole does not have a physical location in Boone County. The office that is tasked with monitoring parolees returning to Boone County is located in Winnebago County in the City of Rockford. There is one main parole officer assigned to work with Boone County's parolees. Other officers assist with specialized supervision, such as that required for sex offenders.

Community Supports

Community supports include integrated service linkages such as those for housing, employment, behavioral health and other human services. Although the full list of these services is too long to describe fully here, the major providers for behavioral health services provide linkage to community supports. The major local providers of these services are Rosecrance (described earlier) and Remedies Renewing Lives.

Remedies Renewing Lives has a facility in Belvidere offering outpatient substance abuse and mental health services. There is no defined capacity on the number of clients allowed in these programs since client's frequently move through the continuum of care to aftercare. The program has two addiction clinicians on staff and each of their intensive outpatient groups accommodates 15 – 17 clients. They also offer a gambling addiction program at the Belvidere location which is facilitated by a certified gambling clinician.

Remedies also offers domestic violence services. They currently have one full-time domestic violence advocate and one full-time children's advocate at the 1908 Pierce Court location in Belvidere. Although Remedies is a provider of Medication-Assisted Treatment (MAT) at their main site in Winnebago County, they do not provide MAT in Boone County. However, they can perform the initial assessment for services at the Belvidere location. If deemed in need and appropriate, clients are then referred to a MAT provider in Winnebago County for services as needed. This often presents a problem due to the transportation issues defined earlier. Especially in the case of Methadone treatment, in which clients are required to be seen onsite daily so that their dose of medication for the day can be provided.

INTERCEPT V – IDENTIFIED GAPS

- Not enough treatment providers in county
- Need more Dual Diagnosis Anonymous groups
- Few resources for offenders with severe mental illness and a history of sex offenses
- Not enough assessment of trauma for those involved in the criminal justice system
- Not enough employment options for offenders
- Not enough housing options for offenders, especially for sex offenders, who currently have no housing resources in Boone County.
- Inadequate transportation for offenders for non-Medicaid eligible services

INTERCEPT V – IDENTIFIED OPPORTUNITIES

- Expand supportive employment options
- Explore expansion of housing options for people with mental illness involved with the criminal justice system
- Explore collaboration and coordination with the faith-based community, especially in the areas of reentry, housing, transportation, and community support
- Explore addition of post-release trauma assessment and services

- Develop transportation options for non-Medicaid eligible services
- Develop additional resources for sex offenders (ensuring inclusion of mentally ill sex offenders)
- Involve recovery community and/or NAMI to develop additional community-based supports for individuals and families

RECOMMENDATIONS

Boone County saw rapid growth in the decade prior to the Great Recession, particularly with Hispanic residents, yet still remains generally rural and spread-out nature. This presents significant challenges with connecting populations – particularly low-income and underserved populations – to the care needed to address the effects of mental illness and addiction. Medical and social service facilities are limited as are transportation options: Boone County only has one fixed-route bus line, connecting Belvidere with services in the next county, but leaving much of the geographic area of the county unserved. To complicate matters, the route's length and number of stops were recently reduced due to funding limitations. In a recent survey of Boone County human service organizations[9], 90% of respondents said there was an unmet need for transportation services for low-income people, the highest score for any one subgroup. Belvidere's Keen Age Center currently has access to bus tokens but availability is very limited. Helping Hands and St. James / St. Vincent also has transportation vouchers as well as a rent assistance program but this too is limited.

One potential opportunity identified by the task force to address this would be to work with local Taxi Companies and local human service providers to create a bulk purchasing program for ride vouchers. If this were the case, the county would need to collaborate to accept bids from providers and purchase a minimum amount of rides through which they could give out vouchers for certain trips, such as medical appointments. A call for proposals would be issued and qualified providers would be asked to provide a discounted price per ride to the funding organization in exchange for the guarantee of a certain amount of business. One provider would need to take the lead to manage such a fund. The Region 1 Planning Council was suggested as a potential lead agency. This would be a potential program for which to seek grant funding.

Finally, employment for reentering citizens is an opportunity area. One potential program to address this would involve creating and updating a list of employers and staffing agencies willing to hire people with criminal convictions. This could be done within the Task Force.

In addition, if the St. Joseph's facility were acquired and developed for housing, it could also be utilized for a reentry workforce training facility.

Additional Recommendations

- Utilize valid risk assessment tools to inform decisions related to community supervision, i.e., the need for supervision and the level/type of supervision indicated.

[9] Boone County Government 2016 Agency Transportation Survey

- As peer support services are developed in the county, peer mentors could be trained to supplement community supervision.
- Consider regular cross-system team meetings for case planning and evaluation, and to render recommendations for changes in status (could be accomplished through navigation model)
- Engage IDOC /parole in Task Force meetings to explore ways to better reintegrate returning citizens into the community.

CHAPTER 3: KEYS TO SUCCESS: CROSS-SYSTEM TASK FORCE, CONSUMER INVOLVEMENT, REPRESENTATION FROM KEY DECISION MAKERS, DATA COLLECTION

EXISTING CROSS-SYSTEMS PARTNERSHIPS

Boone County stakeholders and service providers have been involved in a number of collaborative relationships over time, often associated with grant applications, awards or new program initiatives. Examples include, but are not limited to:

- Boone County Mental Health Advisory Committee
- Boone County Mobilizing for Action through Planning and Partnership (MAPP) Steering Committee (IPLAN)
- Boone County Drug Prevention Coalition

CONSUMER INVOLVEMENT

The Boone County Behavioral Health Task Force included one self-identified consumer with personal experience dealing with behavioral health issues. This individual had direct experience with both the criminal justice and mental health systems. The Task Force also had participation from a representative from a local consumer advocacy group. There were no other designated family or advocacy representatives at the meetings.

RECOMMENDATIONS FOR CONSUMER INVOLVEMENT

It is recommended that the Task Force work to recruit additional Consumers to participate in the Task Force. Building more meaningful relationships with behavioral health treatment consumers would help create ongoing relationships and ensure the interests of family members and advocates who have shown interest in collaborating to improve the continuum of criminal justice and behavioral health services are represented.

Representation from Key Decision Makers

The group composition provided reasonable cross-sector representation with key decision makers present for the court system, jail, and mental health system.

Most of the key stakeholders were present at most of the meetings. The only identified stakeholders that were not actively engaged in the planning process were representatives from one of the local health systems. Although most of the local stakeholders were engaged in planning, levels of engagement varied. In addition, consumers, family members of consumers, and consumer advocates should be more fully engaged as the Task Force moves forward. This should ideally include representation from/for populations with severe mental illness, substance use disorders, and reentering citizens.

Data Collection

The Boone County Behavioral Health Task Force compiled the following items to be included in the participant manual for the Sequential Intercept Mapping meetings:

- A Completed Community Resource Survey
- A Completed Community Gaps and Opportunities Survey
- A Driver Diagram

Additional data collected by the Region 1 Planning Council included:

- Rosecrance Programmatic and Aggregate Utilization Data for Boone County, Mulberry Center, O-STR Grant Data, updated 2/12/18

Cross-System Recommendations Affecting Numerous Intercept Points

At all stages of the Intercept Model, seek opportunities to utilize and share data across systems that will aid in identifying and documenting the involvement of people with behavioral health disorders in the Boone County criminal justice system, e.g., jail booking information compared to mental health system client rosters to recognize individuals as they enter and reenter the justice system.

Improve Data Collection and Sharing

Boone County should work to be strategic in its data collection and identify clearly what data will help to inform the mental health and criminal justice systems of needs within the systems and needs of persons being served. This was briefly mentioned earlier in reference to utilization of the ODMAP data tool but other examples that affect all intercepts exist.

One such example of a practical application of data sharing can be seen in the advance directive model. Some states have created a centralized registry of advance directives. Individuals complete their plans and store them through a secure online portal. Individuals print a wallet card or store information on their phone that links their name and registry ID. In case of an emergency, a healthcare provider can access their documents with the individual's name and registry ID. The Task Force could explore the feasibility of implementing an option for individuals with a history of mental illness to choose in advance to decide to have information disclosed to law enforcement or other first responders in a crisis situation. The models reviewed did not necessarily mean that an individual's advance directive was integrated directly into the patient record. However, it could be adapted to allow a person to present at any healthcare provider and have that information be accessible. Conversely, law enforcement could also be given access to a registry containing information about individuals that had preauthorized the release of their information to first responders under certain circumstances. First steps in this process could include development of a standard form for voluntary disclosure to law enforcement to be used throughout the region.

Opioid Navigation Community Case Management Model

Boone County, like most communities, has a number of community services that are excellent resources for those with behavioral health needs, but for those unaware or unfamiliar with them, they can be difficult to access. Even when people know how to access them, the burden associated with fully utilizing them can be tremendous, especially for behavioral health patients who, by definition, often have a limited capacity for understanding the process due to mental illness. For those with substance use disorders, the resources required to get to and from appointments for things like medication-assisted treatment (MAT) are often out of reach.

To better support those with behavioral health issues, Boone County should consider developing a community case management program like those seen in the "navigation model". Patient navigation is a case management model that can be implemented for a variety of issues ranging from criminal recidivism to medical care and is intended as a way to reduce barriers and bridge gaps in service which serve as pitfalls for complex cases. Behavioral health patients and criminal justice-involved people are both populations that often experience fragmentation and gaps in service delivery, but when people have both of these issues, the need for assistance with system navigation to help people access resources becomes even greater. Navigators assist with fragmentation of the health and social service system through various methods including: communication with multiple agencies, facilitating access to care, navigating the system and services, or assisting individuals with health insurance. [10]

This model is based on the "Cascade of Care" framework introduced in the HIV/AIDS field and has been suggested as a way to address gaps in substance abuse care. Like HIV/AIDS, drug addiction is a chronic, relapsing, often fatal disorder that usually requires long-term medication treatment to be effective. Like HIV/AIDS, addiction treatment shares the goal of disease and symptom suppression and to be successful,

[10] "Navigation Delivery Models and Roles of Navigators in Primary Care: a Scoping Literature Review" https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5806255/

both require success along sequential stages, from screening and detection of substance use disorder/mental illnesses, to linkage to care, to medication initiation, and long-term treatment retention. The HIV Cascade of Care has been adapted to create the Opioid Treatment Cascade (including measures of success) and results have been promising. Boone County should consider adopting a navigation model, like the Opioid Treatment Cascade to help improve access to resources and outcomes in Boone County's mentally ill and substance abusers in order to ensure that the existing services are being fully utilized so that limited funds can be focused on the highest priority community gaps.[11]

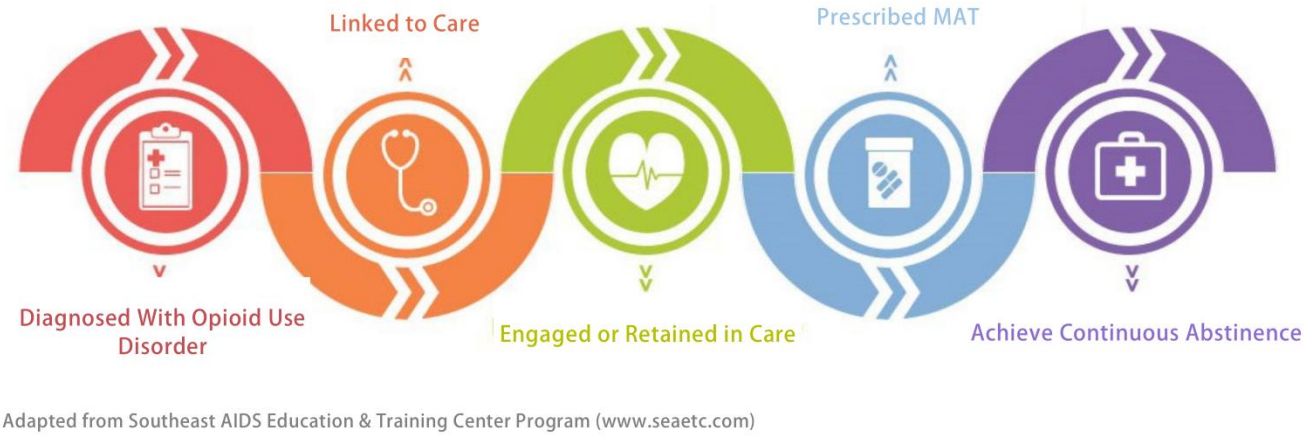


Figure 13: Proposed Opioid Cascade of Care Model

Common Transportation Fund

Another idea discussed in the strategic planning sessions is that of a shared pool of funding to address the transportation barriers prevalent across the intercept points. If there were one fund administrator to manage the funds and distribute payment to transportation providers, nearly all of the Task Force's members have indicated a willingness to participate and a general enthusiasm for such a solution. In addition, the administrative burden associated with implementation of such a program would be decreased if the resource were a shared one. Further, a program of this nature would be much more likely to be funded by a grant if it were done in such a way.

Common Fund Development Efforts

Finally, Boone County's stakeholders could pool resources so that when grant opportunities with the potential to positively affect the intercept points are identified, proposals can be developed and submitted on behalf of the group. Various members of the group have expressed interest in this model and all members have indicated a need for funding in order to implement the recommendations contained in this report.

[11] "To Battle The Opioid Overdose Epidemic, Deploy The 'Cascade of Care' Model" https://www.healthaffairs.org/do/10.1377/hblog20170313.059163/full/

Crisis Intervention Team (CIT) Training

The Boone County Sheriff and Belvidere Police Department could implement 40 hours of pre-service CIT training for all officers through the Law Enforcement Academy. In service officers would get 4-8 hours of refresher training every 3 years. Because of the high cost of taking in service officers off patrol for 40 hours, pre-service training is the best approach to attain 100% CIT training for law enforcement. In addition, courses could be made available for Fire/EMS responders. Additional training on trauma-informed care, including sexual assault, could be incorporated.

New officers may be more receptive to training, but each agency will need veteran officers or leadership who are trained and invested in the CIT model. Changes in policy may be needed to realize best outcomes, including clarifying who is the lead officer at a scene involving a mental health crisis.

Mental Health/Law Enforcement Co-responder Models

Boone County could pilot models for embedded mental health providers within law enforcement. While national models are available, some questions will need to be answered as we map those ideas to the local service spectrum. One major concern will be the availability of a qualified workforce. Nationally, models for co-responders have emphasized having a master's level provider as the embedded person. They have a more significant clinical background, are better equipped to accurately assess risk, and have a licensing board to whom they are also accountable. This may help provide a counter balance to any pressure they experience to deliver services in a manner that is expedient to law enforcement.[12]

One of the key needs that a collaborative or co-responder model can meet is in informing police about the decision making process for assessment and intervention. Law enforcement officers frequently reference the experience of bringing an individual to the hospital, only to encounter them again in a short time period. Without a solid assessment of what, if anything, a hospital might reasonably provide to an individual, the officer's decisions tend to err on the side of caution, resulting in that person being transported to the ER. This gap in expectations results in lost time, inferior outcomes, and significant costs. Boone County should work with regional partners to make a careful assessment of how to best provide for collaboration and communication that addresses that gap. The required workforce is in short supply across the state, particularly in places like Boone County, which is designated as a Mental Health Professional Shortage Areas (MHPSA). While the time that the embedded mental health professional spends in ride-alongs and other non-clinical work can help bridge healthcare and law enforcement cultures, Boone County, like most communities, already struggles to hire and retain the workforce needed for clinical services.

The other major need addressed by different co-responder models is proactive outreach to individuals who come in frequent contact with crisis providers and law enforcement. Models in Texas and California

[12] Smith-Kea, N., Yarbrough, M., & Myers, S. (2016, September 28). Police-Mental Health Collaboration Programs: A Different Way of Policing. Retrieved October 04, 2017, from https://csgjusticecenter.org/law-enforcement/webinars/police-mental-health-collaboration-programs-a-different-way-of-policing/

emphasize this function. In most cases the mental health provider is leading the conversation, and the officer is there to build trust in the event that law enforcement has to respond to that person in the future. Health providers, such as navigators, can obtain a release of information that covers the mental health team on the law enforcement agency to proactively prepare for future encounters. The Task Force should carefully consider how closely this role should be tied to law enforcement, as it is not always clear whether client-provider relationships benefit from long-term police involvement.

Some co-responder models are a standalone unit within a police department. The mental health provider is directly hired and is accountable to that agency. Others are a collaboration between mental health crisis services and law enforcement. These providers already have expertise in crisis assessment, intervention and stabilization. They cover distinct geographic regions, and have 24/7 access to a mental health professional, even if the assigned "embedded" clinician is not on duty. With any of these models, racial disparities are a possible collateral consequence. Communities that have significant levels of mistrust towards police may be less likely to call for crisis services if they believe that they are connected to law enforcement. This effect could be especially pronounced in Boone County given the large number of Hispanic and undocumented immigrants, so tactics to mitigate these effects would be needed.

A significant factor in long-term outcomes is the strength of the community services to which individuals are being redirected. Despite differences in various co-responder models, a common point is that a mental health provider assists law enforcement in making choices about disposition related to mental health. If the choices available are insufficient, the co-responder model will struggle.[13] Strengthening relationships with facilities such as Rosecrance's Triage Center, would help to ensure this does not happen.

Trauma Informed Care

The Boone County IPLAN discusses the concept that poor health and poor life conditions, such as homelessness and substance abuse, are a symptom of decades of ignoring the social determinants through lack of policy and practice. It suggests that public health provides a lens for looking at all aspects of our lives in such a way that we see the long-term effects of living in poverty, of living with violence and prejudice, of being exposed to substance use and abuse, i.e. the social determinants. One lens through which we must view behavioral health is that of trauma informed care. Viewing individuals through a trauma-informed lens means recognizing there are potentially traumatic experiences in a person's history that are contributing to an individual's behavior and health choices. Furthermore, a trauma-informed system or individual is one which recognizes the widespread nature of trauma and actively resists inadvertently traumatizing individuals. Moreover, the system the individual seeks care through can become a vehicle of intervention to help address unresolved trauma. Adverse Childhood Experiences, or ACEs, can affect our health and wellbeing throughout our lifetime as they disrupt our neurological and behavioral development, often impeding our social development and may lead to risk-taking behaviors that often include interpersonal violence, self-destructive behavior such as eating disorders, substance abuse or other high-risk behaviors that can lead to early death.

[13] Helfgott, J.B., et al., A descriptive evaluation of the Seattle Police Department's crisis response team officer/mental health professional partnership pilot program, International Journal of Law and Psychiatry (2015), http://dx.doi.org/10.1016/j.ijlp.2015.08.038

Becoming a trauma-informed system is a relatively new addition to the health improvement continuum. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2015) has defined a Trauma-Informed Approach as having widespread impact on individuals, families, groups, organizations, and communities. The ability to recognize the signs and symptoms of trauma in others in the system and the integration of trauma knowledge and awareness into policies, programs, and practices is the first, best step to creating a service delivery climate of empathy and respect for all individuals. Boone County should support the goals and objectives of the Boone County IPLAN which seek to "increase community resilience with a focus on individuals diagnosed and/or living with behavioral health conditions by becoming a trauma informed community by 2021."[14]

CHAPTER 4: DRIVER DIAGRAM, GOALS, & OBJECTIVES

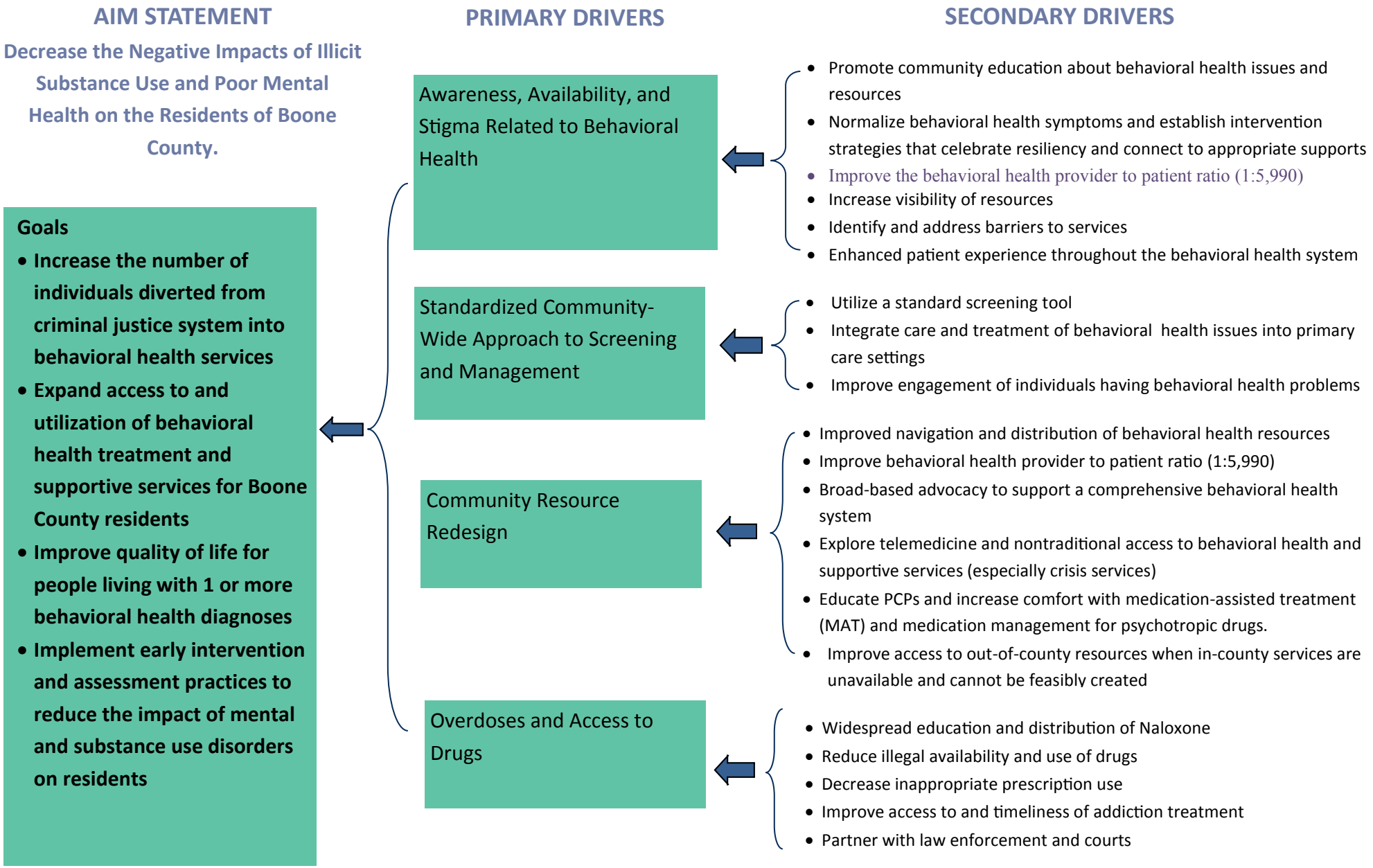
DRIVER DIAGRAM

Finally, a Driver Diagram has been included as a visual display of the Task Force's strategy. In general, driver diagrams illustrate a team's theory of what "drives," or contributes to, the achievement of a project's purpose. This clear picture of the Task Force's shared view is a powerful tool for communicating the inner workings of a strategy to a range of stakeholders.

A driver diagram shows the relationship between the overall aim of the project, the primary drivers (sometimes called "key drivers") that contribute directly to achieving the aim, the secondary drivers that comprise the primary drivers, and specific change ideas to test for each secondary driver.

[14] Boone County IPLAN 2018-2023

Population Health Driver Diagram for Improving Boone County Behavioral Health



GOALS, OBJECTIVES, & STRATEGIES

Upon completion of the *Sequential Intercept Mapping*, the assembled stakeholders reviewed identified gaps and opportunities across the intercepts and then proposed priorities for collaboration in the future. After discussion, they participated in an online survey to rank what they viewed as the most significant gaps and opportunities in order to help determine the group's priorities. Listed below are the goals, objectives and specific strategies that were developed based on the selection, along with specific data points and sources of such data that could be used to measure success relative to these items.

In addition to these items, the reader will find references throughout this tactical plan to the Boone County IPLAN 2018-2023. Boone County has been at the forefront of communities taking the proactive step of incorporating behavioral health priorities into their comprehensive plans at all levels. Behavioral Health was selected as one of three health priorities for the the IPLAN, Boone County's premier public health planning strategy. In addition, Behavioral Health was identified as a priority in the County's Comprehensive Plan. Given that Boone County has the 3rd highest drug arrest rate in the State of Illinois, it is clear that Boone County's rural nature has not exempted it from what have historically been viewed as problems exclusive to bigger cities. The strategy contained herein will help Boone County to provide a higher quality of life for its residents and once again prove to the community that when its residents speak, local leaders listen.

Objective or Impact	Strategies	Responsible Party	Timeframe	Relevant Data
Vision: Achieving Optimal Health and Wellness for individuals diagnosed and/or living with behavioral health conditions in Boone County.				
Measurable Outcome1: Health Equity: To establish a coordinated system for people living with one or more behavioral health diagnoses no matter race/ethnicity, language, gender, or socioeconomic status.[15]				
1A. Promote Awareness & Availability of Resources to Reduce Stigma Related to Behavioral Health[16]	-Promote community education about behavioral health issues and resources -Mental health/drug courts	BCHD, NAMI, Group Hope, La Voz Latina, District 100 Potential Partners include: District 100- Trauma-informed and cultural competency trainings Pregnancy Care Center- Outreach partner YMCA- Outreach partner (especially at Summer events for kids and families)	12/31/2021	Utilization numbers for behavioral health, website traffic, substance abuse calls for service, brief surveys Culturally significant outreach- need to start doing outreach to schools for what's available in mental health, need to also have outreach to non-English speakers.
1B. Reduce incarceration for people living with one or more behavioral health diagnosis, prioritizing at risk populations in Boone County			12/31/2021	5% decrease in mentally ill and/or substance abusers arrested, jailed
1C. Employ one standardized community-wide approach to screening for behavioral health issues and condition/disease management to identify high-risk individuals for additional services, support, and navigation, implementation of this system			12/31/2021	Whether or not standardized screening has been selected and implemented
1D. The behavioral health and criminal justice workforce in Boone County will complete at least one training in cultural competence			12/31/2019	Whether or not training has been completed
	1.D.i. Normalize behavioral health symptoms and establish intervention strategies that celebrate resiliency and connect	NAMI, Group Hope, local 12 step groups, BCHD, City, County	12/31/2021	Utilization numbers for behavioral health, website traffic, substance abuse calls for service, brief surveys

[15] Linked to Boone County IPLAN Measurable Outcome: BH1, BH2
[16] Linked to Boone County IPLAN Measurable Impact: BH1

	to appropriate supports 1.D.ii. Include behavioral health awareness in local wellness fair 1.D.iii. Look into restarting mental health screening	Rosecrance (mental health screenings)		
Measurable Outcome 2: Access: Expand access and utilization of behavioral health treatment and services for Boone County residents by employing a community resource redesign by 2021.[17]				
2A. Improve the behavioral health provider to patient ratio (current- 1:5,990; target- 1:630)	2.A.i. Partner with colleges and universities to incentivize professionals to practice in Boone County 2.A.ii. Utilize Task Force as platform to distribute and apply for new grant funding	Crusader Clinic and SwedishAmerican NIU, OSF, UIC (provider pipeline) Potential Partners: BCHD and Rosecrance	12/31/2021	County Health Rankings
2B. Increase visibility and access to behavioral health resources in Boone County by integrating behavioral health into at least one primary care provider office		Task Force	12/31/2021	Website traffic, Social Media followers Review and update at every meeting
2C. Identify and address at least 2 barriers to establishing a comprehensive behavioral health system in Boone County	Preliminary priorities to address- transportation, language, cultural	Task Force	12/31/2021	Deferred- To be determined when priorities are chosen
2D. Advocate for at least one policy promoting better access to behavioral health care and coverage	Preliminary priorities to address- transportation, language, cultural	Task Force	12/31/2021	Deferred- To be determined when priorities are chosen
2E. Enhanced patient experience throughout the behavioral health system		Rosecrance, Remedies	12/31/2021	See Health Equity outcome above

[17] Linked to Boone County IPLAN Measurable Outcome: BH2

2F. Explore telemedicine and nontraditional access to behavioral health and supportive services (especially crisis services)	2.F.i. Explore police and/or first responder models like Mobile Integrated Health (MIH) program- mobile access to mental health practitioners for calls involving behavioral health crises 2.F.ii. Assess potential for Navigator model for Behavioral Health	Rosecrance (Triage Center) Remedies (resource sharing for Domestic Violence calls Rockford Fire Dept (to model MIH program)	Deferred	Deferred until specific programming is determined
2G. Explore Task Force partnerships with other Boone County coalitions, Winnebago County and/or Rockford for Police/Behavioral Health	2.G.i. Partner with Boone County Drug Prevention Coalition	Task Force	12/31/2019	Deferred until specific programming is determined
2H. Educate PCPs and increase comfort with medication-assisted treatment (MAT) and medication management for psychotropic drugs.		Crusader Clinic, Rosecrance, SwedishAmerican, OSF, Mercy	Deferred	Number of providers prescribing psych meds and/or MAT
Measurable Outcome 3: Overdoses and Access to Drugs				
3A. Partner with Naloxone distributors to spur widespread education and distribution		BCHD, Sinnissippi	12/31/2019	Number of kits distributed
3B. Reduce illegal availability and use of drugs (Related to Outcome 2)		Local Law enforcement	12/31/2021	Defer to Outcome 2
3C. Decrease inappropriate prescription use	3.C.i. Provider training and education	Health Systems, Crusader	12/31/2021	If available, number of opioid prescriptions dispensed
3D. Improve access to and timeliness of addiction treatment	3.D.i. Implement Navigator Model	Deferred	Deferred	Implementation of Navigator completed

	3.D.ii. Develop Recovery Corps comprised of individuals in recovery 3.D.iii. Create list of 12 step groups with information regarding appropriateness for special populations (individuals on psych meds, dual diagnoses, etc)			
3E. Partner with law enforcement and courts	3.E.i. Explore strategies to bring behavioral health in jail, including telehealth options	Law enforcement, courts, schools	Deferred	Deferred
3F. Decrease youth drinking and drug use	3.F.i. Social media campaign demystifying alcohol and drug use 3.F.ii. Support creation of sober activity venue 3.F.iii. Provide resource list to partents at end of school year with opportunities for sober recreation	Deferred	Deferred	Deferred

CHAPTER 5: TOP-RATED GAPS AND OPPORTUNITIES SELECTED BY TASK FORCE

INTERCEPT 1

Gap: Lack of in-county crisis services (crisis beds, detox, etc)

Opportunity: Develop additional services for clients that are difficult to engage and don't meet criteria for involuntary hospitalization other than jail.

INTERCEPT 2: INITIAL DETENTION AND INITIAL HEARINGS

Gap: Need a treatment alternative to jail

Opportunity: Create a jail diversion services program

INTERCEPT 3: JAILS / COURTS

Gap: Jail does not have 24 hours a day availability of mental health professionals

Opportunities[18]: Find space to provide group counseling in the jail.
When mental health issues are identified prior to screening, strive to complete full mental health evaluation and formation of appropriate recommendations to aid court in sentencing.

INTERCEPT 4: REENTRY

Gap: Lack of services to ensure clients receive bridge medications and remain medication compliant
Lack of wraparound services (employment/vocational training, education services, family services, etc)

Opportunities: Develop effective transition case management (such as navigation model)
Explore ways to enhance the "bridge medication" when a person reenters the community from the jail to avoid lapses in treatment

INTERCEPT 5: COMMUNITY CORRECTIONS AND COMMUNITY SUPPORT

Gap: Inadequate transportation for offenders with behavioral health issues, especially for non-Medicaid eligible services.

[18] Some intercepts have more than one gap or opportunity listed. This is because these items received equal votes from the group.

Opportunities: Explore expansion of housing options for people with mental illness involved with the criminal justice system
Explore collaboration and coordination with the faith-based community, especially in the areas of reentry, housing, transportation, and community support

OTHER PRIORITIES – ITEMS RANKED AS 2ND, 3RD OR 4TH MOST IMPORTANT OPPORTUNITIES[19]

- Implement video/Skype crisis services to connect clinical staff to first responders during crisis calls (Intercept 1)
- Develop crisis stabilization bed capacity within Boone County (Intercept 1)
- Streamline initial contact with law enforcement to decrease time police spend with individuals in crisis (Intercept 1)
- Expand intake process to better identify mental illness and implement interventions (Intercept 2)
- Develop bonding options (personal recognizance, etc.) to address inability of persons with mental illness to bond out due to lack of money and/or waiting for mental health evaluation/assessment, while protecting public safety (Intercept 2)
- Develop data needed to determine if implementation of mental health court is warranted (Intercept 3)
- Develop guidelines on compliance and violation policies regarding offenders with mental illness, including range of sanctions to compel (and incentives to encourage) compliance with conditions of release, including the development of a review board (Intercept 3)
- Examine the results of current reentry efforts by tracking individual cases. Determine who may have been missed or where efforts are not resulting in the desired outcomes for increased continuity of care and decreased return to the criminal justice system. (Intercept 4)
- Build on current work to systematically develop "in-reach" efforts into the jail to identify those with severe mental illness and often co-occurring disorders in order to facilitate continuity of care and alternatives to incarceration (Intercept 4)
- Develop discharge planning program for people leaving the jail (Intercept 4)
- Develop transportation options for non-Medicaid eligible services (Intercept 5)
- Develop additional resources for mentally ill sex offenders (Intercept 5)
- Involve recovery community and/or NAMI to develop additional community-based supports for individuals and families (Intercept 5)

[19] It was originally planned that the second and third highest rated responses would be included in the report. However in some instances, there were 2 or 3-way ties between responses. To provide the most accurate representation of the group's selections, it was decided that in the event of a tie, all of the responses would be included in the report.

APPENDIX A: RELATED HEALTHY PEOPLE 2020 GOALS AND OBJECTIVES

The Boone County IPLAN and the State Health Improvement Plan (SHIP) are the guiding documents addressing public health in Boone County. Since the goals and objectives of these plans are closely tied to those of the nation, any strategy to address behavioral health in Boone County must also be. The most comprehensive and widely cited federal public health plan is undoubtedly Healthy People 2020.

The Healthy People initiative is a federal framework managed by the Office of Disease Prevention and Health Promotion (ODPHP) at the U.S. Department of Health and Human Services (HHS) designed to provide science-based, national goals, objectives, and targets to guide national health promotion and disease prevention efforts. For three decades, Healthy People has established ten year targets and benchmarks and monitored progress over time with the aim of improving the health of all people in the United States.

The mission of the current iteration of this plan, Healthy People 2020, is to:

- Identify nationwide health improvement priorities.
- Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress.
- Provide measurable objectives and goals that are applicable at the national, State, and local levels.
- Engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge.
- Identify critical research, evaluation, and data collection needs.

Healthy People 2020, aims to reach four overarching goals:

- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death
- Achieve health equity, eliminate disparities, and improve the health of all groups
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development, and healthy behaviors across all life stages.

Healthy People 2020 contains about 600 objectives with 1,200 measures in 42 Topic Areas. Those used in the development of this plan are included below.

Goal: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services.

TREATMENT EXPANSION

MHMD-5: Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral

> National Baseline: 79.0 percent of primary care facilities provided mental health treatment onsite or by paid referral in 2006

Target Setting Method: 10 percent improvement

MHMD-8: Increase the proportion of persons with serious mental illness (SMI) who are employed

National Baseline: 56.0 percent of persons with serious mental illness (SMI) were employed in 2008

Target Setting Method: 10 percent improvement

MHMD-9: Increase the proportion of adults with mental health disorders who receive treatment

MHMD-9.1: Increase the proportion of adults aged 18 years and older with serious mental illness (SMI) who receive treatment

National Baseline: 65.7 percent of adults aged 18 years and over with serious mental illness (SMI) received treatment in 2008

Target Setting Method: 10 percent improvement

MHMD-9.2: Increase the proportion of adults aged 18 years and older with major depressive episodes (MDEs) who receive treatment

National Baseline: 69.0 percent of adults aged 18 years and over with major depressive episodes received treatment in 2008

Target Setting Method: 10 percent improvement

MHMD-10: Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders

National Baseline: 3.3 percent of persons with co-occurring substance abuse and mental disorders received treatment for both disorders in 2008

Target Setting Method: 10 percent improvement

MHMD-11: Increase depression screening by primary care providers

MHMD-11.1: Increase the proportion of primary care physician office visits where adults 19 years and older are screened for depression

National Baseline: 2.2 percent of primary care physician office visits included screening for depression in adults aged 19 years and over in 2007

Target Setting Method: 10 percent improvement

MHMD-11.1: Increase the proportion of primary care physician office visits where youth aged 12 to 18 years are screened for depression

National Baseline: 2.1 percent of primary care physician office visits included screening for depression in youth aged 12 to 18 years

Target Setting Method: 10 percent improvement

Goal: Reduce substance abuse to protect the health, safety, and quality of life for all, especially children.

Substance Abuse Prevention

SA-2: Increase the proportion of adolescents never using substances

SA-2.3: Increase the proportion of adolescents never using substances- Alcoholic beverages

National Baseline: 27.7 percent of high school seniors reported never using alcoholic beverages in 2009

Target Setting Method: 10 percent improvement

SA-2.4: Increase the proportion of high school seniors reported never using substances- Illicit drugs

National Baseline: 53.3 percent of high school seniors reported never using illicit drugs in 2009

Target Setting Method: 10 percent improvement

SA-4: Increase the proportion of adolescents who perceive great risk associated with substance abuse

SA-4.1: Increase the proportion of adolescents aged 12 to 17 years perceiving great risk associated with substance abuse—Consuming five or more alcoholic drinks on a single occasion once or twice a week

National Baseline: 40.0 percent of adolescents aged 12 to 17 years reported that they perceived great risk associated with consuming five or more alcoholic drinks on a single occasion once or twice a week in 2008

Target Setting Method: 10 percent improvement

SA-4.2: Increase the proportion of adolescents aged 12 to 17 years perceiving great risk associated with substance abuse—Smoking marijuana once per month

National Baseline: 33.4 percent of adolescents aged 12 to 17 years reported that they perceived great risk associated with smoking marijuana once per month in 2008

Target Setting Method: 10 percent improvement

SA-4.3: Increase the proportion of adolescents aged 12 to 17 years perceiving great risk associated with substance abuse—Using cocaine once per month

National Baseline: 49.4 percent of adolescents aged 12 to 17 years reported that they perceived great risk associated with using cocaine once per month in 2008

Target Setting Method: 10 percent improvement

SA-5: (Developmental) Increase the number of drug, driving while impaired (DWI), and other specialty courts in the United States

Screening and Treatment

SA-7: Increase the number of admissions to substance abuse treatment for injection drug use

National Baseline: 255,374 admissions to Level I and Level II trauma centers to substance abuse treatment programs for injection drug use were reported in 2006

Target Setting Method: 10 percent improvement

SA-8: Increase the proportion of persons who need alcohol and/or illicit drug treatment and received specialty treatment for abuse or dependence in the past year

SA-8.2: Increase the proportion of persons who need alcohol and/or illicit drug treatment and received specialty treatment for abuse or dependence in the past year

National Baseline: 9.9 percent of persons aged 12 years and over who needed alcohol treatment and/or illicit drug treatment reported that they received specialty treatment for abuse or dependence in the past year in 2008

Target Setting Method: 10 percent improvement

SA-9: (Developmental) Increase the proportion of persons who are referred for followup care for alcohol problems, drug problems after diagnosis, or treatment for one of these conditions in a hospital emergency department (ED)

SA-10: Increase the number of Level I and Level II trauma centers and primary care settings that implement evidence-based alcohol Screening and Brief Intervention (SBI)

National Baseline: 325 Level I and Level II trauma centers met the criteria for implementing evidence-based alcohol Screening and Brief Intervention in 2009

Target Setting Method: 10 percent improvement

EPIDEMIOLOGY AND SURVEILLANCE

SA-12: Reduce drug-induced deaths

National Baseline: 12.6 drug-induced deaths per 100,000 population occurred in 2007 (age adjusted to the year 2000 standard population)

Target Setting Method: 10 percent improvement

SA-13: Reduce past-month use of illicit substances

SA-13.1: Reduce the proportion of adolescents reporting use of alcohol or any illicit drugs during the past 30 days

National Baseline: 14.2 percent of adolescents aged 12 to 17 years reported use of alcohol or any illicit drugs during the past 30 days in 2015

Target Setting Method: 10 percent improvement

SA-13.3: Reduce the proportion of adults reporting use of any illicit drug during the past 30 days

National Baseline: 7.9 percent of adults aged 18 years and over reported use of any illicit drug during the past 30 days in 2008

Target Setting Method: 10 percent improvement

SA-14: Reduce the proportion of persons engaging in binge drinking of alcoholic beverages

SA-14.3: Reduce the proportion of persons engaging in binge drinking during the past 30 days—adults aged 18 years and older

National Baseline: 26.9 percent of adults aged 18 years and over reported that they engaged in binge drinking during the past 30 days in 2015

Target Setting Method: 10 percent improvement

SA-14.4: Reduce the proportion of persons engaging in binge drinking during the past month—adolescents aged 12 to 17 years

National Baseline: 9.5 percent of adolescents aged 12 to 17 years reported that they engaged in binge drinking during the past month in 2008

Target Setting Method: 10 percent improvement

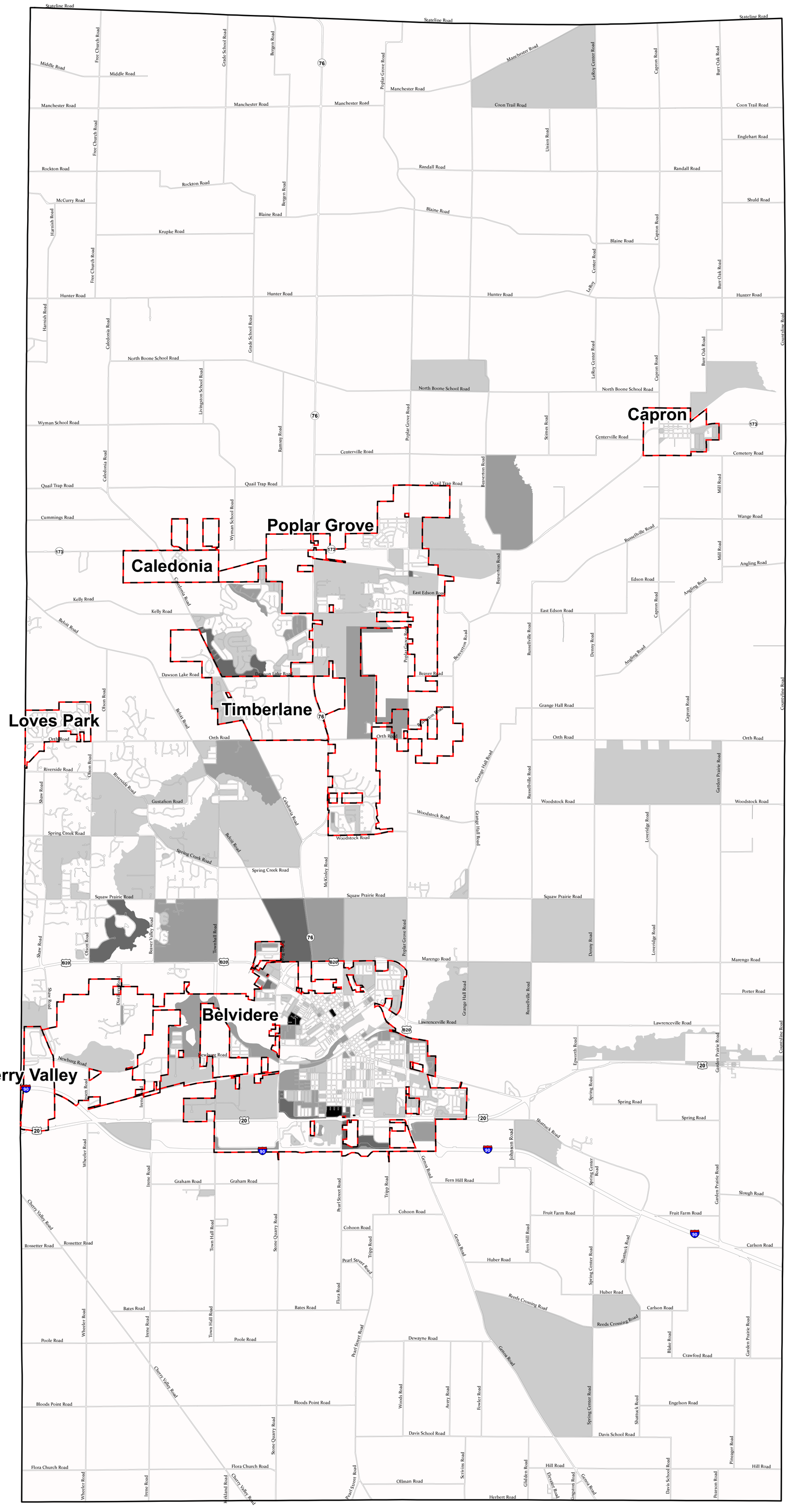
SA-19: Reduce the past-year nonmedical use of prescription drugs

SA-19.5: Reduce the past-year nonmedical use of any psychotherapeutic drug (including pain relievers, tranquilizers, stimulants, and sedatives)

National Baseline: 6.1 percent of persons aged 12 years and over reported nonmedical use of any psychotherapeutic drug in 2008

Target Setting Method: 10 percent improvement

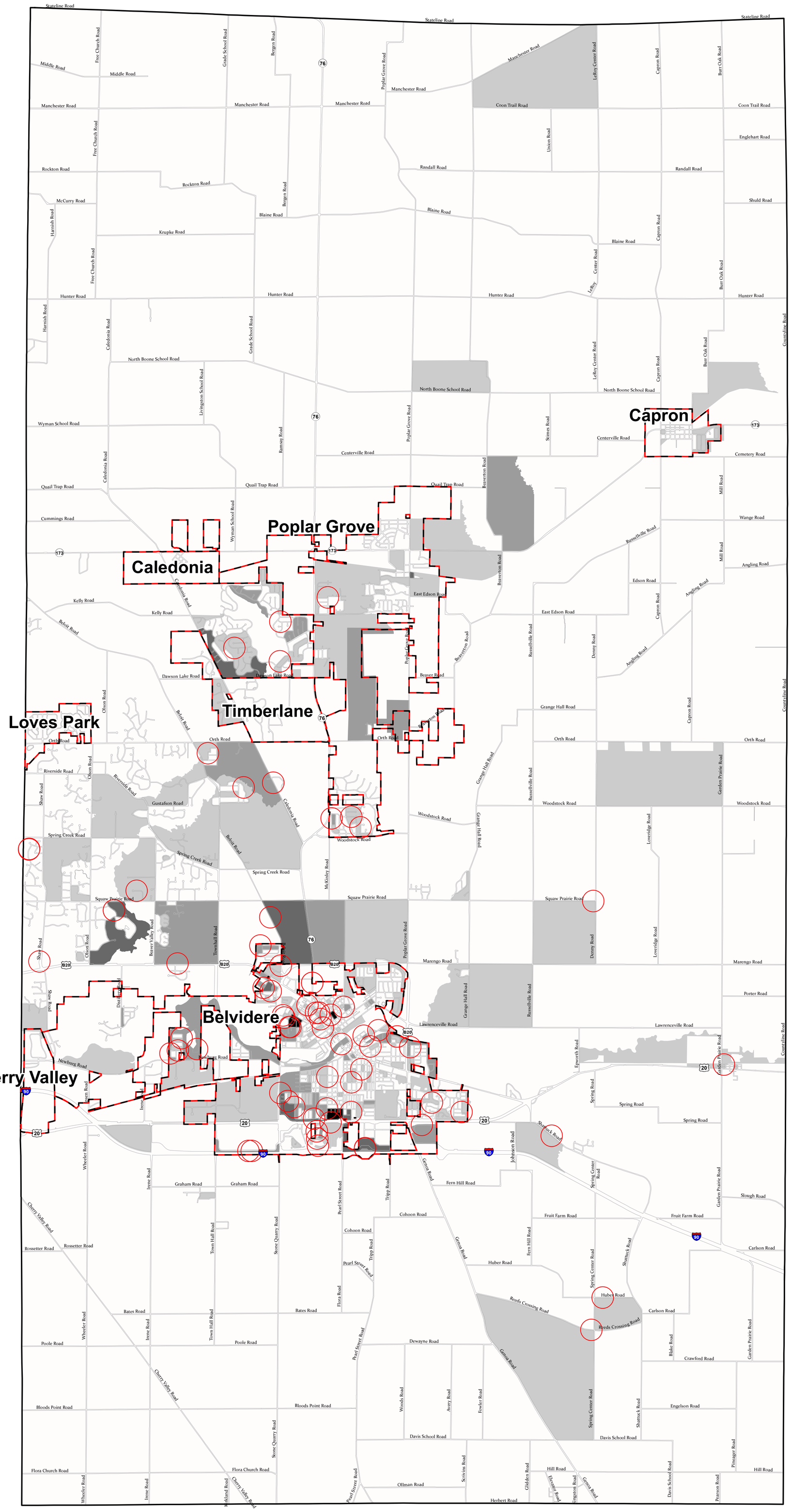
Boone County Overdose Distribution 2009-2018



This map represents the distribution of overdose calls recieved by Lifeline and Capron rescue from 2009-2018. The calls were then joined to the 2010 Census blocks and a total number of overdose calls within each block was calculated.
The purpose of the map is to identify areas in Boone County where overdoses may be more prevalent than others. This information will help the Boone County Health Department determine the best strategies for Boone County in terms future planning of Public Health.

***These records were categorized by first responder's first impressions as "Poisoning/Drug, Substance/Drug or Overdose." While these are all suspected drug overdoses it is unknown in many cases which specific drug is the cause of the overdose or in some instances if it is an overdose at all.

Boone County Overdose Distribution 2009-2018



N
W E
S
1 in = 1 miles

Overdose Call Count Per Census Block 0 | 1 | 2 - 3 | 4 - 5 | 6 - 7 | Municipal Borders (Outline) | Narcan Deployment

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