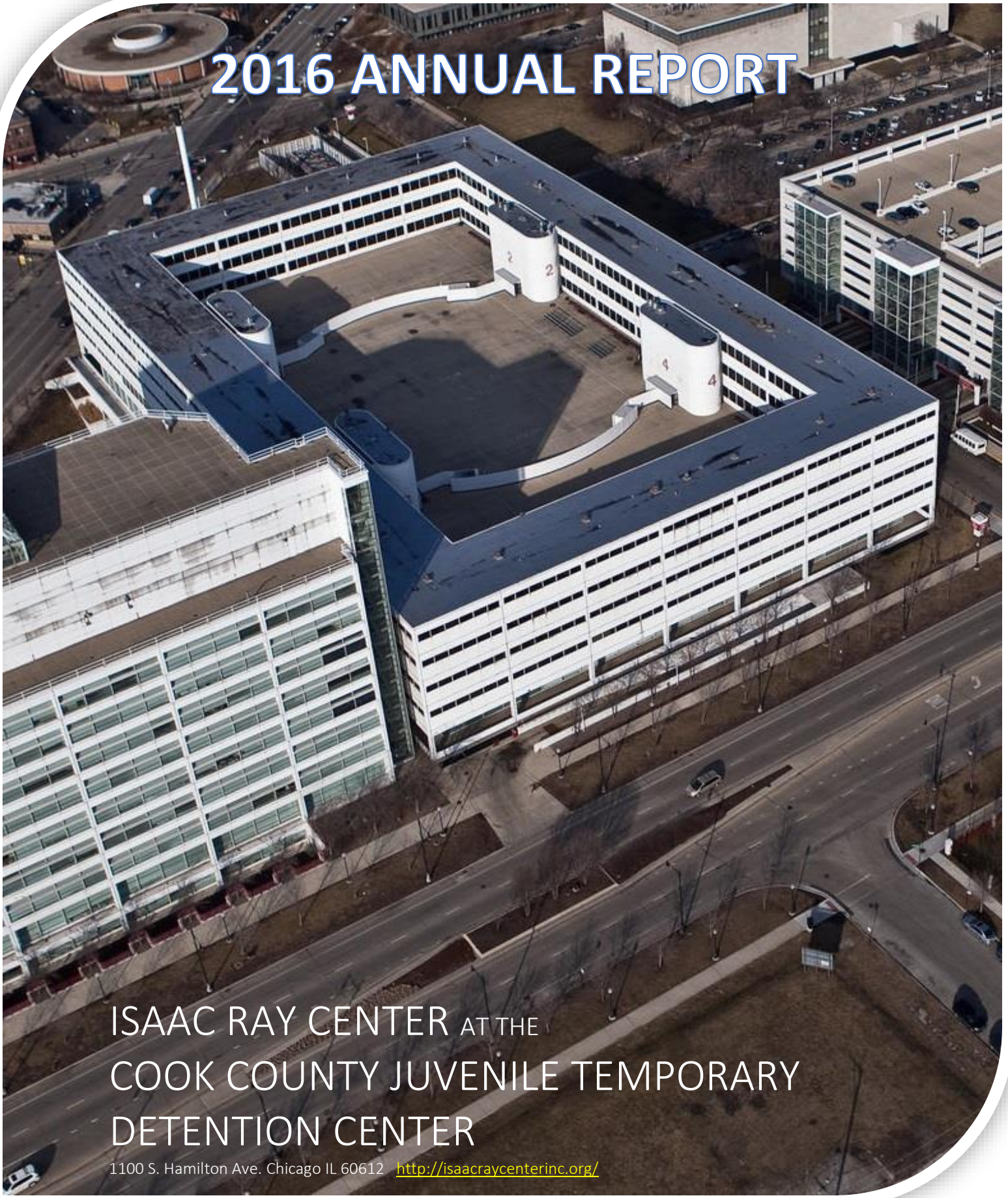
2016 ANNUAL REPORT



ISAAC RAY CENTER AT THE COOK COUNTY JUVENILE TEMPORARY DETENTION CENTER

1100 S. Hamilton Ave. Chicago IL 60612 http://isaacraycenterinc.org/

ISAAC RAY CENTER MISSION STATEMENT

The Isaac Ray Center at the Juvenile Temporary Detention Center will address the mental, emotional, developmental and social issues of the residents through clinical assessment and treatment with the goal of successful reintegration back to the family and community.

All residents will receive equal access to services regardless of age, religion, gender, ethnicity, socioeconomic status and/or sexual orientation.

We will work with the entire CC-JTDC team to assure the safety of these youths and to appropriately evaluate and manage their mental health needs while in JTDC.

We will develop a comprehensive system of mental health care for the residents providing psychiatric and psychosocial assessment, medication management, supportive therapies, and behavioral education in this temporary detention setting.

We will provide the necessary mental health support to enable the resident to proactively participate, with dignity and integrity, in their care, education and defense during the process of adjudication, transit through the detention center and reintegration into the community.

We will work with the residents and their families, the courts, probation, and the educational system to facilitate timely linkage to community.

We will seek feedback on our performance and make the necessary adjustments in our programs to increase productivity, encourage efficiency and continually provide accessible, innovative and effective mental health treatments.

We pledge to develop strategies to improve the quality of mental health care for the residents and to promote high standards of supportive, nonjudgmental care.

We will foster the personal and professional growth of our staff and model high ethical and professional standards.

INTRODUCTION / OVERVIEW

PROGRAM BACKGROUND / HISTORY

In 2007, The Isaac Ray Center, Inc. (IRC), a not-for-profit corporation specializing in forensic and correctional behavioral health sciences, was selected to provide professional clinical mental health services to the residents of the Cook County Juvenile Temporary Detention Center (JTDC) in addition to certain administrative and clinical supervisory services. Services are provided in a manner which is consistent with the Juvenile Standards of the National Commission on Correctional Health Care (NCCHC), the America Correctional Association (ACA) and the requirements set forth in the Memorandum of Agreement approved by the Federal District Court in the case of Doe v. Cook County. The JTDC became accredited by NCCHC in November of 2012 and was awarded re-accreditation in 2015. IRC began a new 4 year contract with Cook County on December 1, 2013.

IRC provides a range of services that include comprehensive mental health evaluations, comprehensive treatment planning, psychiatric treatment, individual counseling/therapy, family counseling, behavior management, psycho-educational groups, consultation to the court and probation, coordination of care with community service providers, referrals for hospitalization, and linkages to aftercare treatment.

This report covers the period of time between January 1, 2016 and December 31, 2016. Data from previous years (primarily 2014 and 2015) is presented for comparison and trend analysis. The report presents information regarding clinical contact data of IRC staff with individual residents in the provision of regular services. It is meant to be an overview of IRC activities and is not meant as an "all-inclusive" review of all contact types.

THE "CENTER" CONCEPT AND STAFFING PLAN

A "pod" is a living unit which can house up to 12 to 14 residents. A "Center" typically consists of 3 separate pods or living units. Each center has a dedicated: Team Leader, Assistant Team Leaders, Caseworkers, Youth Development Specialists, Recreational staff and Mental Health staff. The fundamental idea behind centers is to provide a greater concentration of trained support for both the residents and the working line-staff. The centers were initiated in June 2008 with a pilot project called the PHOENIX Center. That August, the successful PHOENIX model was expanded to provide services for female resident units, and the WINGS Center was implemented. In May of 2009, the Intake units were formed into the ALPHA Center. Since that time, more centers such as HOUSTON, LEGACY, OMEGA, RENAISSANCE, DESTINY, and JUSTICE have come into being, as the facility has moved to a newer and more comprehensive service delivery system. Today JTDC is entirely center-based.

IRC's approach is multi-disciplinary, team-driven, and customized to the needs of the individuals. Having smaller clusters of centers, with a core group of IRC professionals in each, gives greater stability to residents, improves communication, and makes their work more efficient. Each of the 9 JTDC centers has its own mental health team consisting of a Clinical Psychologist, Mental Health Specialist, Licensed Clinical Social Worker, and Psychiatrist or Advanced Practice Nurse (APN) (refer to Appendix B for IRC organizational chart and 2016 staffing plan).

ELECTRONIC MEDICAL RECORDS

In early 2016, IRC leadership partnered with Cermak Health Services of Cook County to begin the process of converting JTDC medical records into a paperless system. After months of development and testing, the electronic medical record (EMR) system was successfully launched in September. Today, the presence of an EMR has greatly enhanced communication, improved access to critical medical / mental health data, and has accelerated the ordering and delivery of vital services.

In addition to the basic EMR package, the Cook County Health and Hospital Systems purchased the Cerner Behavioral Health Module which gives IRC providers access to numerous assessments, tools and features that enhance mental health service delivery.

Part of the EMR deployment included a total re-design of the mental health intake and assessment process, which is now more comprehensive and includes several new assessment tools.

MENTAL HEALTH INTAKE & ASSESSMENT

The ALPHA and WINGS Centers receive all residents after they have completed the admission process. Residents are given comprehensive measures to assess for the need of specialized mental health services. All residents who enter the JTDC receive the Massachusetts Youth Screening Instrument- Second Version (MAYSI-2) and the Mental Health Intake Screening and Initial Treatment Plan. Starting in 2016, IRC clinical staff now search every new JTDC resident in the JEMS probation database for any history of involvement in the Clinical Interventions Division.

- The MAYSI-2 is a 52 item screening tool designed to assist juvenile justice facilities in identifying youths who may have imminent mental health needs. Domains measured include alcohol / drug use, anger, depression, somatic complaints, suicidal ideation, thought disturbance, and traumatic experiences.

- The Mental Health Intake Screening and Initial Treatment Plan is a structured interview that constitutes the foundation of IRC's mental health screening process. It was developed to be in compliance with The National Commission on Correctional Health Care's (NCCHC) juvenile health standards and the Prison Rape Elimination Act (PREA) federal standards. The Mental Health Intake Screening includes the following components:

- Demographic Information
- Family History
- Educational History and Intellectual Functioning
- Cerebral Trauma or Seizures
- Resident Strengths / Protective Factors
- Mental Health Symptom and Treatment History
- Suicide / Self-Injury Risk Assessment
- Abuse / Victimization / Trauma History
- Violence / Perpetration History
- LGBTQI
- PREA Inquiry
- Substance Use History
- Mental Status / Adjustment To Incarceration

Due to the launching of the EMR in September of 2016, some elements of the screening process have changed:

<u>January to September 2016:</u>
Until September 2016, IRC used the Brief Symptom Inventory (BSI), and the Drug Abuse Screening Test (DAST-10) as additional assessments during the screening process.

- The Brief Symptom Inventory provides client-reported data to help support clinical decision-making at intake and during the course of treatment. The BSI is a 53 item inventory that assesses the following problem areas: somatization, obsessive compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism.

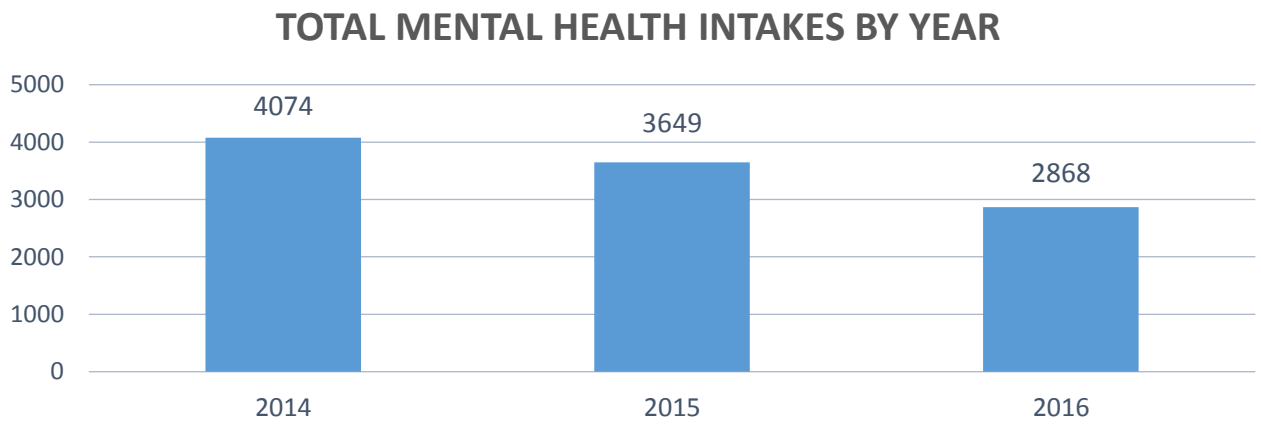
- The DAST-10 is a brief, self-report instrument for population screening, clinical case finding and treatment evaluation research. The DAST-10 yields a quantitative index of the degree of consequences related to drug abuse.

<u>September 2016 to Present:</u>
The re-designed mental health intake process now includes the Life Events Checklist, the CRAFFT Screening Tool, and a Traumatic Brain Injury (TBI) Screening Tool.

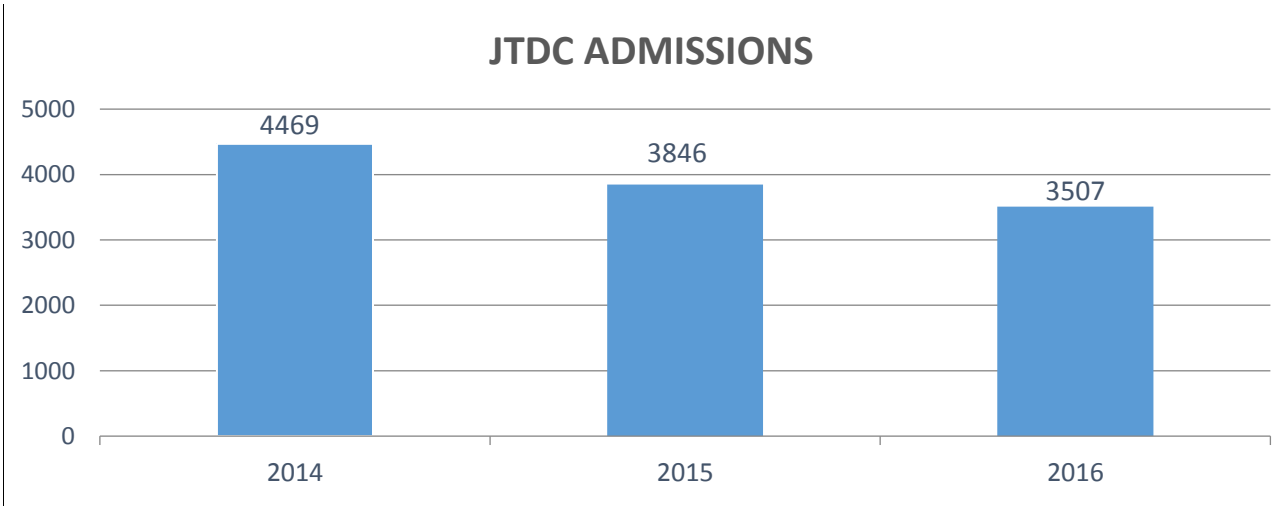
- The Life Events Checklist for DSM-5 (LEC-5) is a self-report measure designed to screen for potentially traumatic events in a respondent's lifetime. The LEC-5 assesses exposure to 16 events known to potentially result in PTSD or distress and includes one additional item assessing any other extraordinarily stressful event not captured in the first 16 items.

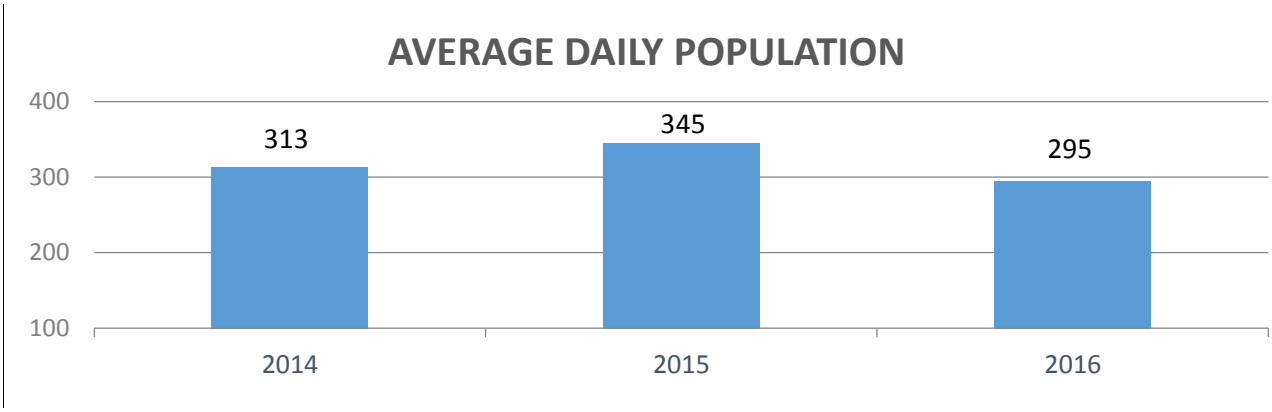
- The CRAFFT is a behavioral health screening tool for use with children under the age of 21 and is recommended by the American Academy of Pediatrics' Committee on Substance Abuse for use with adolescents. It consists of a series of questions developed to screen adolescents for high risk alcohol and other drug use disorders simultaneously.

IRC clinical staff conduct Mental Health Screenings and make appropriate referrals for all residents within 72-hours of their admission to the JTDC.



JTDC admissions and average daily population both dropped in 2016. This is thought to be due in large part to “raise the age” laws which have resulted in a significant decrease in youth being charged as adults. These decreases are also due to changes made to the Risk Assessment Instrument (RAI) used during the detention screening process. The RAI scoring system was revised in October of 2015 with the ultimate goal of screening fewer youth into detention. Lastly, weekend juvenile court calls were implemented in 2016, which has resulted in youth being released from detention sooner.





SCOPE OF SERVICE AND ACCESS TO CARE

All residents at JTDC receive mental health services, and good access to mental health care is a foundation that the program is built upon. All residents at the facility are given comprehensive mental health screening and assessment services. Additionally, all residents are offered individual mental health counseling services on an as needed basis. Residents are given frequent opportunity to request services via an easy to use referral system and via mental health outreach / milieu activity. All residents are also provided group counseling services and group psychoeducation. Any resident may also request a specialized list of community resources from an IRC social worker.

Starting in 2013, IRC introduced general population mental health orientation sessions. Every resident who is transferred from intake to a general population Center is seen by an IRC clinician within their first 48 hours on the pod. The purpose of this encounter is to evaluate the resident's adjustment to the pod, to re-assess mental status, and to provide the resident with an orientation to mental health services on that Center. During the orientation, residents are informed of how to contact mental health should the need arise. Centers provide newly arrived residents with entry packets describing specialized services. Centers also provide residents with information about the stages of processing through the legal system, in order to provide a realistic preview of what the resident will undergo in the upcoming weeks or months.

NEED FOR SERVICES **THE MENTAL HEALTH ROSTER**

Once a resident is determined to need mental health services s/he is placed on Mental Health Follow-Up Status (MHFU). Usually the need for mental health services is identified during the Intake process, but sometimes a resident may be added to MHFU later during his/her stay due to emerging mental health issues. The following are some of the criteria for being placed on MHFU:

- History of Mental Health or Substance Abuse Treatment
- Current Mental Health Symptomatology Including Trauma Related Symptoms
- Current or Recent Treatment with Psychotropic Medication
- Significant Substance Use Issues

- Significant Intellectual Functioning Issues or Developmental Delays
- Other Special Needs that May Require Mental Health Support

The Mental Health Roster is a list of all MHFU residents being actively followed by IRC mental health staff. The roster is updated on a daily basis and serves as a "working list" of all of the active mental health patients. Any resident on psychotropic medication is automatically added to the roster; however a resident need not be taking medication to be considered an active patient. The MH Roster moved to a secure share-drive location so that it could be continuously updated by IRC Psychologists and Psychiatrists. The tracking of MHFU residents is currently in a state of transition due to the arrival of EMR. In 2017, the EMR will automatically generate the roster along with a report of other performance metrics.

Comprehensive treatment plans are developed for all residents who are placed on Mental Health Follow-Up Status and are provided with mental health services as deemed appropriate by the treatment team. Such services may include individual therapy, family therapy, individualized skills training, psychiatric services, medication management, follow-up evaluations, comprehensive linkage planning and regular review of progress by the assigned treatment team. IRC utilizes a variety of evidence based or evidence supported emotional literacy program material including "Power Source", "Voices", and "Girls Moving On".

Prior to release, MHFU residents are also provided with re-entry plans which detail where the youth may continue treatment in the community. For those residents being treated with psychotropic medication, IRC social workers link those residents to providers in the community.

The Mental Health Roster averages approximately 95 residents across the past eight years. Over the last eight years, 43.3% of patients on the Roster were treated with psychotropic medication. In 2015, as part of an initiative to enhance substance abuse services at the JTDC, the decision was made to begin adding residents to MHFU for substance abuse only. This change, along with the new procedure of searching the JEMS probation database (see section on Information Sharing Agreement) has resulted in an increase in the average mental health roster. It's noteworthy that the average number of MHFU residents **increased** by 17.3% in 2016 despite a 14.5% **decrease** in the average daily population.

Size and composition of Mental Health Roster

	2014	2015	2016
Average Mental Health Roster	87.7	92	108
Number on Medication	31.5	30	38

TRAINING PROGRAMS

Student Training Program:

The Isaac Ray Center has a long history of providing graduate level training to some of the profession's brightest prospects. IRC considers itself a learning institution and has infused academics into all of its' programs. Students and trainees also bring new perspectives and an opportunity for our veteran staff to provide mentorship and clinical supervision.

Current training programs include:

- Post-doctoral Fellowship in Clinical Psychology (2)
- Doctoral level Psychotherapy Practicum in Clinical Psychology (5)
- Second Year Child and Adolescent Psychiatry Fellowship Rotation (fellows training at Rush University Medical Center and University of Illinois (8)
- Psychiatric-Mental Health Nurse Practitioner Doctoral level Practicum (2)

JTDC Staff Training Program:

Training, a crucial element of IRC's services at the JTDC, is part of the team approach that IRC is known for. The staff training program, geared to JTDC staff, is practical, relevant, and real-world. For example, IRC psychiatry and mental health staff discuss such topics as managing the mentally ill, trauma informed care, suicide prevention, crisis intervention, and communication.

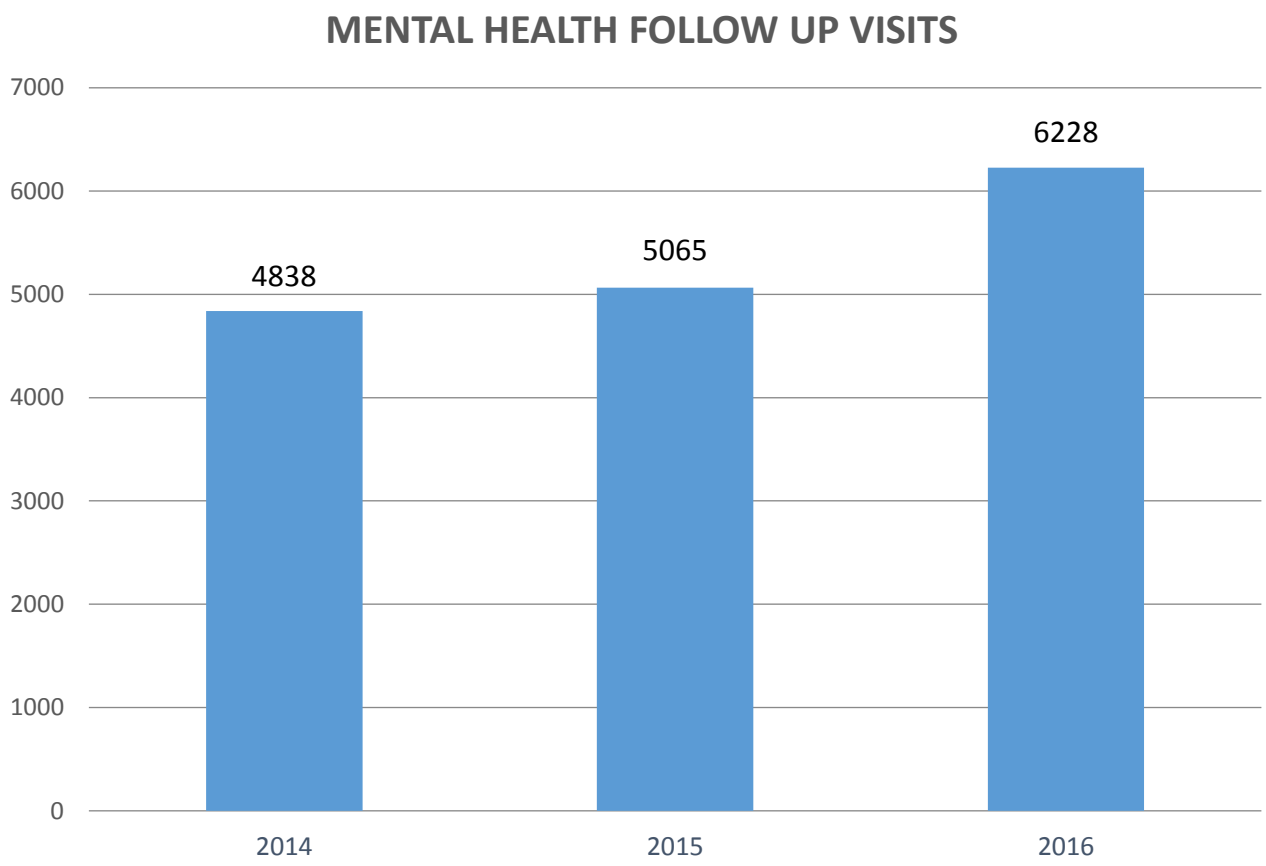
In addition, training new hires and veteran correctional staff at JTDC involves them pro-actively in our mental health efforts. That kind of hand-in-hand involvement improves the quality of care and enhances relationships among the detained youths, IRC, and JTDC and staff. In 2016 IRC staff provided **125 hours** of formal training to a total of **975** JTDC staff member participants.

2016 CLINICAL SERVICES DATA

MENTAL HEALTH THERAPY & FOLLOW-UP

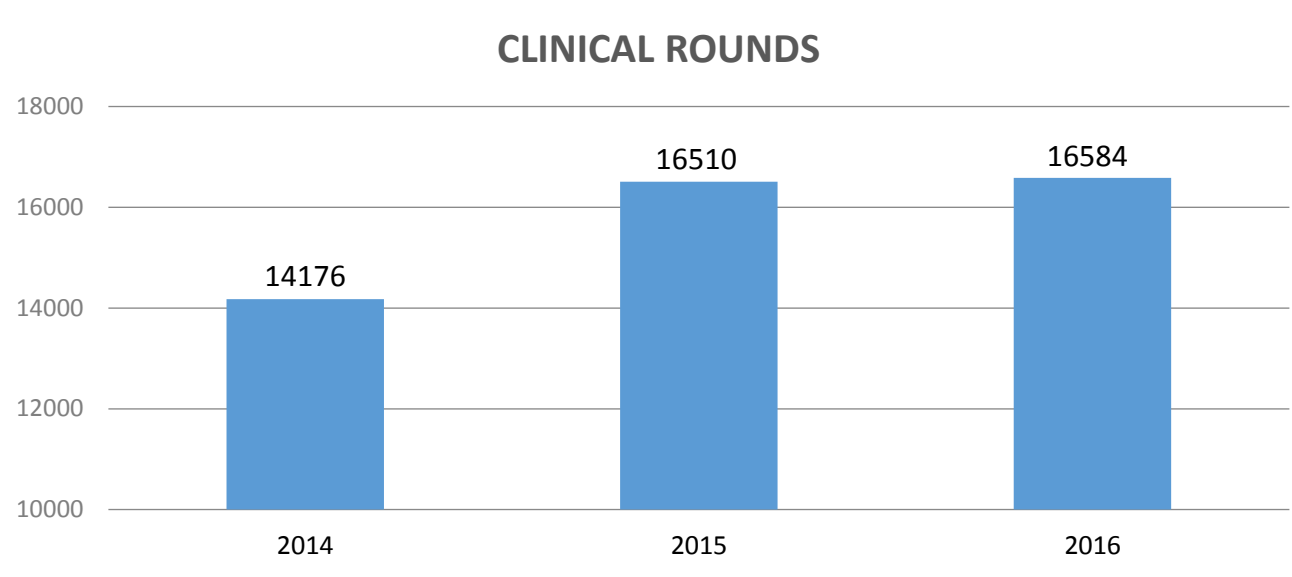
While some residents at JTDC are being treated with psychotropic medication, the first line of care is always counseling or psychotherapy. Whatever the resident's specific issue, "Follow-up" status residents are provided with weekly individual counseling sessions, often more depending on acuity, until the identified problems are resolved or the resident leaves the detention center. It should be noted that these therapeutic contacts only represent one segment of the total number of counseling sessions that mental health staff perform on an annual basis. Other counseling sessions occur during referral contacts, confinement contacts, milieu encounters, etc. Follow-up counseling sessions significantly increased in 2016, due in part to the fact that the average number of residents being placed on MHFU status also significantly increased.

IRC selects therapists who have education and training in evidenced based therapeutic approaches. Additionally, IRC provides all of its' mental health staff with monthly training and continuing education stipends.



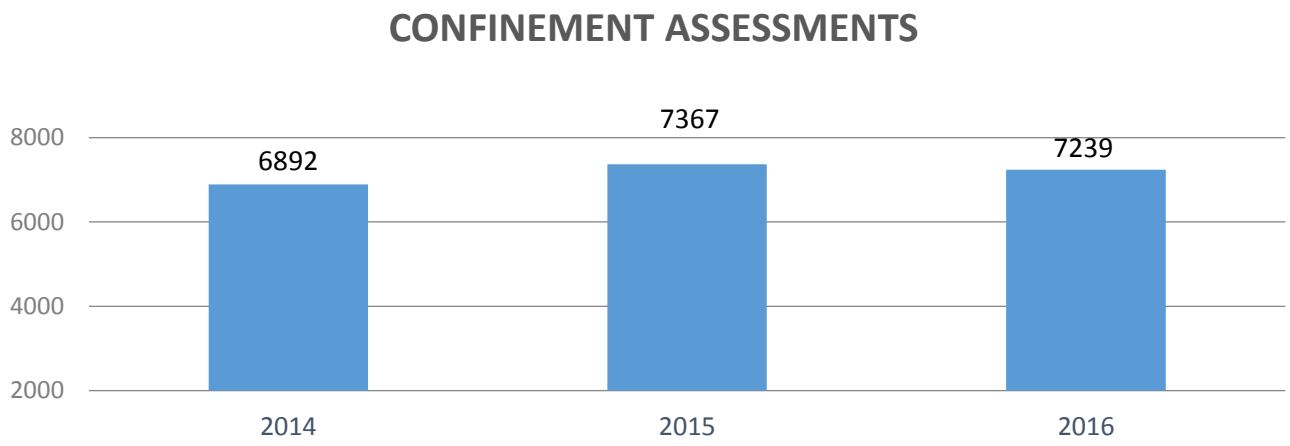
CLINICAL ROUNDS

A “Clinical Round” is defined as when Mental Health clinicians conduct daily rounds on their Center. The main objective of these rounds is to identify problem issues that residents may be experiencing and design interventions to address issues that may exist, before they worsen. During rounds, the clinician will speak with direct care staff, case workers, and center management staff about any mental health concerns and/or mental health referrals. The clinician may also review the pod’s log book, incident reports and any major rule violations. During mental health rounds, the clinician speaks directly with any youth who requests services, youth who are confined, and youth who are serving extended cool-offs. Increasing the volume of clinical rounds over the past 6 years may have resulted in decreases in number of mental health related crises and psychiatric hospitalizations.



CONFINEMENT ASSESSMENTS

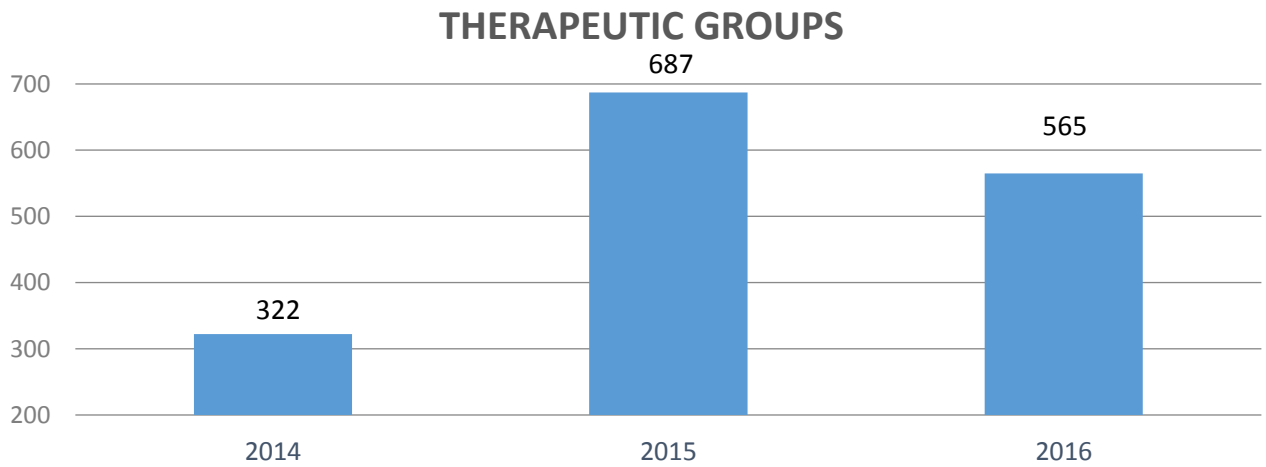
Mental Health clinicians conduct daily assessments of youth who are in room confinement. The purpose of this assessment is to evaluate the youth’s mental status and to ensure that the conditions of confinement are not contraindicated. In rare instances that a youth cannot be safely maintained in confinement, the mental health clinician will immediately provide an alternative plan, and the confinement will be discontinued. Mental Health clinicians also use confinement assessments as an opportunity to provide counseling and risk reduction interventions. Over the last two years, an increased emphasis was placed upon making confinement assessments more frequently as a means for ensuring procedural compliance and for increasing intervention opportunities. The observed increase in confinement assessment volume is related to mental health staff exceeding procedural compliance and is not related to an increase in confinement events at the JTDC.



THERAPEUTIC GROUPS

Isaac Ray clinicians conduct regular therapeutic groups on the center pods. The majority of Centers receive core psycho-educational groups that are skill-based and intended to teach and help residents make better adjustments within the environment, promote pro-social behaviors, and to encourage better decision making. Such groups include: Distress Tolerance, Anger Management, Substance Abuse, Problem Solving, Relaxation and Mindfulness.

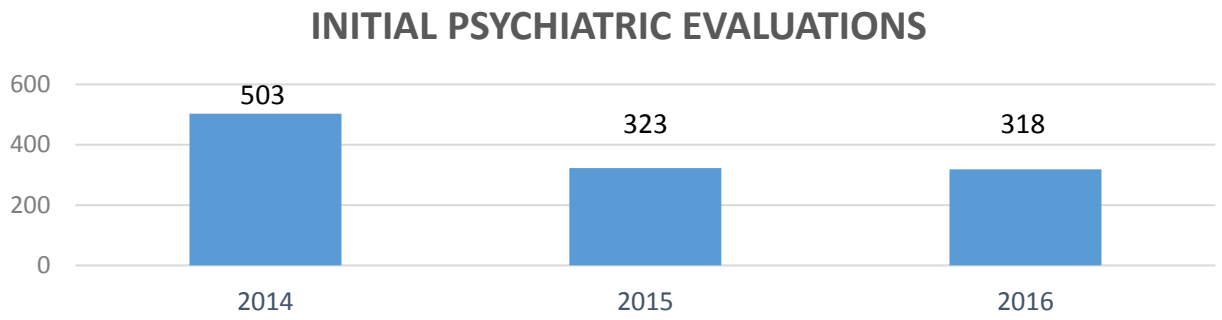
A goal for 2015 was to enhance collaboration between IRC and JTDC staff in terms of the co-facilitation of therapeutic groups. Mental Health Clinicians were challenged to increase the volume of therapeutic groups and to work with JTDC personnel to develop innovative group programming. As a result, group volume more than doubled. There was a decrease in group volume in 2016 (comparted to 2015), and efforts are being made to match or improve upon 2015 group productivity. One such effort is a collaboration between IRC and JTDC management to create a universal daily programming schedule. This schedule will provide IRC clinicians and JTDC staff with consistent, protected time to implement group programming.



PSYCHIATRIC EVALUATIONS

As mentioned above, residents who have been identified as having mental health needs receive a higher degree of support from Mental Health staff and higher degree of specialized services. Residents who have a history of psychotropic medication treatment and/or more acute psychopathology are referred for psychiatric evaluation.

Youth who are identified as in need of psychiatric evaluation receive enhanced services. They are evaluated by an IRC Psychiatrist or Advance Practice Nurse (APN) applying a Bio-Psycho-Social approach. This formulation serves as a foundation for understanding the youth, composing a treatment plan and making recommendations for reentry. The evaluation process includes a diagnostic interview with the youth (60 to 90 minutes). Collateral information is gathered from the parent, guardian, or primary caregiver and includes details of medical, developmental, social, cultural, familial, educational and treatment history. Of utmost importance in making an accurate diagnosis is understanding the chronology of symptoms over the years. If indicated, the evaluator will provide support and psycho-education for the parent/guardian, discussing the youth's diagnosis, prognosis and recommendations for services beyond the detention setting. If available, the evaluation may also include collateral contact with past or current mental health professionals. If psychotropic medication is indicated, consent to treat the youth while housed at the JTDC is obtained from the parent, guardian or guardian agency, i.e. DCFS, as applicable. Psychotropic medication is prescribed in accordance with guidelines set forth by the American Academy of Child and Adolescent Psychiatry, and in concert with recommendations for non-biologic treatments.



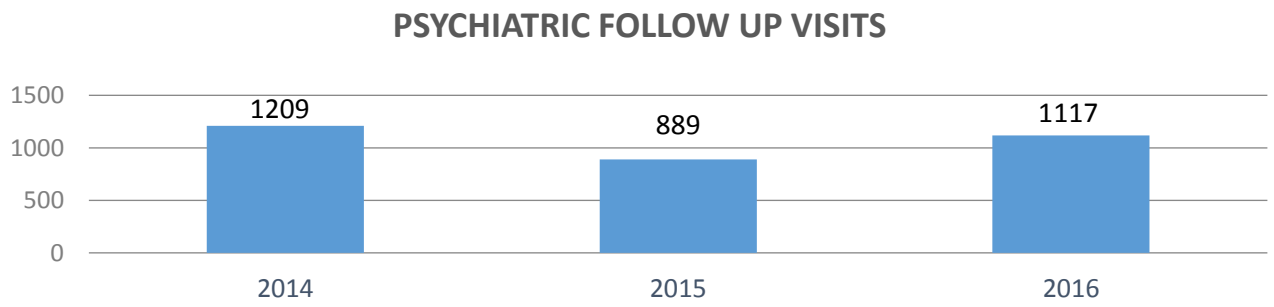
The number of psychiatric evaluations performed in 2015 and 2016 are significantly lower than years past. This reflects a thoughtful and evidence-based change in practice. Collateral information obtained from the guardian informs decision-making in terms of how to respond to each referral. It may be determined that a psychiatric evaluation is indicated. In other instances, based on symptom acuity and course of illness/treatment, it may be most appropriate to provide psycho-education, secure support for treatment to enhance future adherence, and set the stage for reentry planning. This approach is based on the belief that management of youth with mental disorders must involve interventions with the parent/guardian, community provider of mental health services, school, and other support systems to be successful. Increased systems support for treatment is projected to

increase treatment adherence beyond the detention setting, and in this way may have some impact on recidivism. The number of family contacts are illustrated in the section “Family Engagement and Collateral Volume”.

PSYCHIATRIC FOLLOW-UP

Youth who are prescribed psychotropic medication are monitored closely by way of follow-up clinic visits with the prescribing Psychiatrist/APN. In the clinic, youth are seen individually to monitor for symptoms, medication efficacy, treatment adherence and side effects. Laboratory work may be obtained and reviewed. Follow-up visits necessarily include a component of psycho-education to improve the patient’s understanding of his / her disorder, the reason for, and likely course of treatment. A significant and essential part of ongoing psychiatric assessment and follow-up includes regular discussion and consultation with the designated mental health team, nursing staff and often, primary custody staff from the JTDC living units. It is, at times, informative to conduct a direct observation of a youth in the school or other general population setting. It is common for youth (on or off of the Mental Health Roster) to have problematic behaviors, symptoms and distress in response to peer, family, and legal stressors. Youth who have received a psychiatric evaluation, but have not been prescribed psychotropic medication, *and* youth who *have never* received a psychiatric evaluation, may also receive monitoring and follow-up by the Psychiatry Team. Therefore, the number of patients prescribed psychotropic medication does not necessarily reflect the number being actively followed by psychiatry. Patients may be assessed off medication by a Psychiatrist/APN to determine whether medication is acutely indicated or whether a referral to a community-based provider would be most appropriate. Youth are often in crisis when entering the JTDC and time must be allowed to provide ongoing monitoring of symptoms during crisis stabilization before considering whether psychotropic medication is truly indicated. Additionally, some patients are evaluated and monitored by psychiatry at the request of court when there are questions about the need to initiate or continue psychotropic medication. Psychiatric follow up visits significantly increased in 2016, due in part to a slight increase in the number of patients prescribed psychotropic medications, but also due to an increase in the acuity of our patients and the need for closer monitoring.

Symptom monitoring may take the form of a psychiatric clinic visit, mental health team staffing and/or consultation to Multidisciplinary Team meetings and Custody Care Planning. The breadth of this Psychiatric consultative role is best captured under “Mental Health and Psychiatry Contacts” graphs (appendix A).



STAFFINGS, COLLATERAL CONTACTS AND INTERAGENCY COLLABORATION

Mental Health services ***do not*** operate in isolation from other systems whether inside or outside of JTDC. Mental health staff operate in a consultant role communicating with a wide variety of disciplines including: Youth Development Specialists, Team Leaders and Assistant Team Leaders, Caseworkers, Probation Officers, Medical Personnel (inside and outside of JTDC), Judges and family members.

"Staffings" encompass two broad types of clinical contacts: Team staffings and Hospital staffings. Team staffings are composed of the Mental Health treatment team designated to treat a particular individual. They are composed of a member of the Psychiatric Team (MD or APN), and several members of the Mental Health Team (Psychologist, Social Worker, and Mental Health Specialist). The purpose is to develop or refine a comprehensive approach to the mental health treatment of residents on the Mental Health Roster. When a resident is hospitalized outside of JTDC for psychiatric reasons, hospital staffings occur between hospital and JTDC mental health treatment teams.

	2014	2015	2016
Consultations	10429	8435	6477
Collateral Contacts	2222	1930	1791
Court Health Summaries	218	139	159
Probation Health Summaries	79	48	45

Consults are defined as meetings with in-house health providers (i.e. Nursing, Medical staff, other Mental Health, Youth Counselors, Team Leaders, etc.) to coordinate care and treatment for particular residents. Collateral contacts reflect contacts with outside providers such as parents/guardians, probation officers, court officials, medical personnel at John Stroger Jr. Hospital, personnel at other outside hospitals (typically psychiatric hospitals). Collateral contacts do not include formal Team Staffings or Hospital Staffings. Court Summaries and Probation Summaries are specific evaluations requested by those authorities about the resident's mental health condition, treatment regimen, etc.

Juvenile Justice Division Information Sharing Agreement

In February of 2016, an Information Sharing Agreement was entered into by the JTDC, the Juvenile Probation and Court Services Department, and the Juvenile Court Clinic. The ultimate goal of the agreement is to provide continuity of care which includes identification of mental health needs, initiation of appropriate interventions, improved treatment planning, and elimination of redundancies by member agencies. Information sharing protocols were subsequently developed and as a result, the "silos" of clinical data that once existed are beginning to open. For example, IRC clinicians can now search the JEMS probation database for pertinent clinical information. This new protocol has enabled IRC to more effectively identify youth with mental health treatment histories during the intake process.

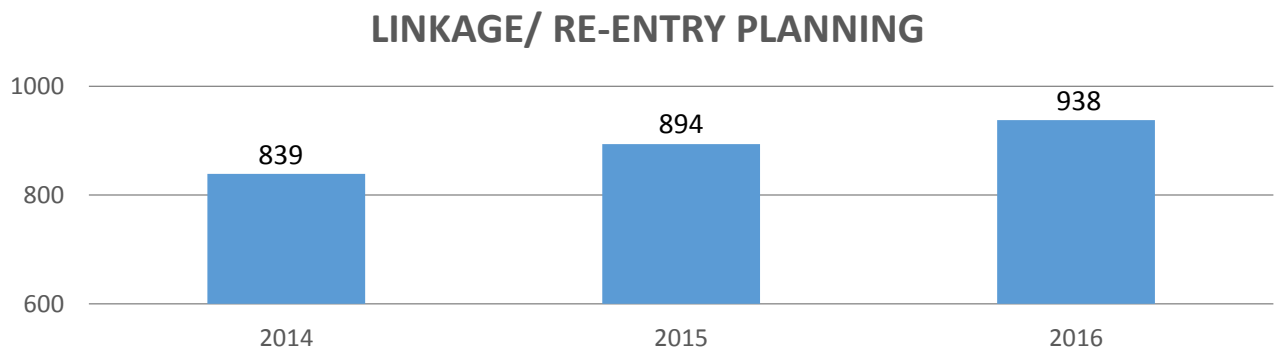
Legal Literacy Program

Beginning in 2012, staff of the Isaac Ray Center, in collaboration with staff and volunteer attorneys of the John Howard Association of Illinois (JHA), piloted an innovative legal literacy education project at the JTDC. Recognizing that lack of knowledge and access to basic information about legal terminology and the criminal justice system were a source of serious anxiety and stress for many youth and families, JTDC and JHA worked together over the past four years to establish a program that today provides monthly, one-hour legal literacy education clinics to all automatic transfer youth in custody at JTDC, as well as the parents and family members of all youth at JTDC. In 2016, the legal literacy team began offering the program to youth being tried in juvenile court, with the ultimate goal of servicing all JTDC youth in 2017.

LINKAGE SERVICES

Community re-entry planning, or Linkage, is designed for youth who are being released from the JTDC and returning home in an effort to enhance the youth's and family's awareness of and access to community resources. Additionally, the goals of community re-entry are to promote a healthy, prosocial life-style and reduce the risk of recidivism. While successful re-entry begins to be planned and coordinated with court services upon admission to JTDC, final phase re-entry is a process that typically begins with a referral from a primary mental health clinician indicating that the youth may be returning to the home and has identified mental health and/or psychiatric needs upon returning to the community. The re-entry planning process begins immediately upon admission and continues throughout the youth's stay in detention.

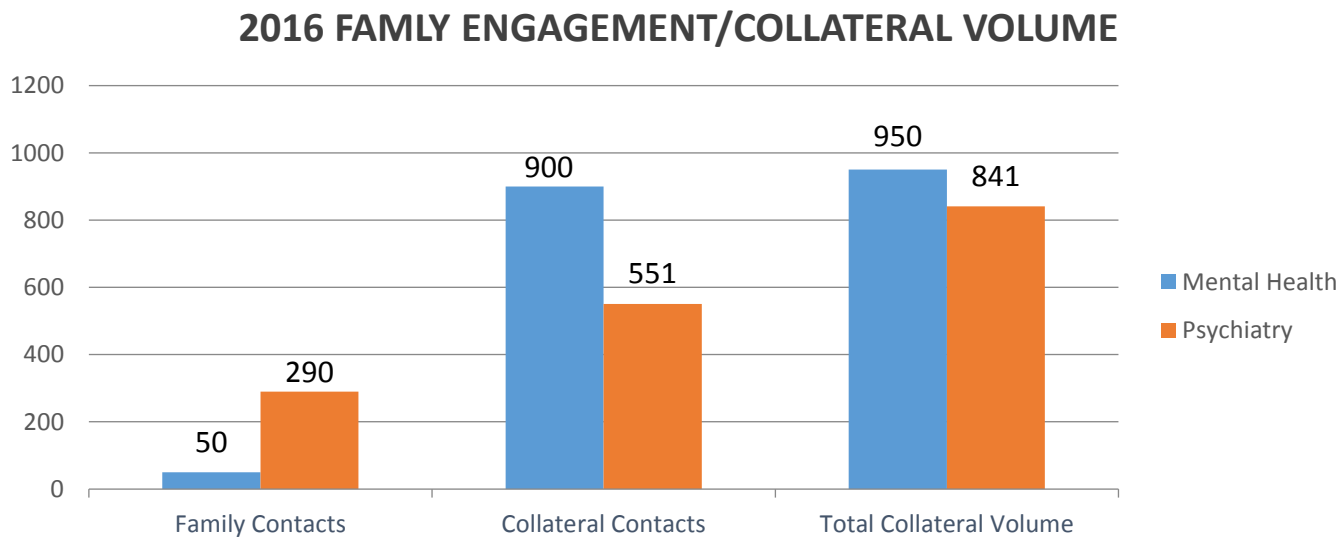
Re-entry services can address a wide range of programming needs including the following: educational programs (school reenrollment, after-school programs, tutoring programs), mental health services (psychiatry services, counseling services, group programs), employment services (job training, Job Corps) and programs to manage the resident's free time (mentoring programs, sports and/or arts programs). Additional support services may also be coordinated with the Mental Health Juvenile Justice (MHJJ) initiative. In 2016, the JTDC launched the "Effective Case Management" pilot project. JTDC caseworkers are now developing individual service plans for residents that stay longer than 30 days. In 2017, these plans will incorporate linkage / re-entry information from IRC social workers and represent a step towards greater integration of services and coordination of care.



FAMILY ENGAGEMENT

It is widely acknowledged that consideration of a youth's ecological context, particularly the family, is essential when contemplating the challenge of reducing recidivism. However, oftentimes families are left feeling disempowered and frustrated due to the lack of resources, support, awareness, and understanding of the legal system. As a result, the much-needed engagement of families is often compromised. Acknowledging this issue, IRC began an initiative to increase and enhance family engagement efforts.

(2016)	Family Contacts	Collateral Contacts	Total Collateral Volume
Mental Health	50	900	950
Psychiatry	290	551	841
Total	340	1451	1791



Family Night Program

IRC began the family engagement initiative in 2011 when, in partnership with the JTDC, it established the Family Night program, with the hopes of increasing parent knowledge and involvement, reducing family stress, disempowerment, youth recidivism, and community fragmentation.

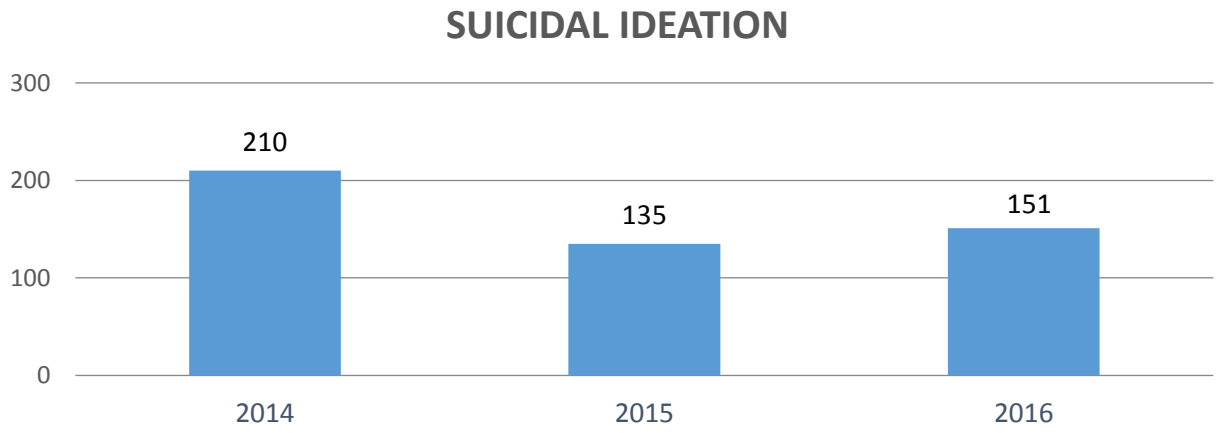
The Family Night program is held on a weekly basis (Saturdays) from 3:00pm-4:30pm at the JTDC and is broken down into (4) sessions. Each session covers a different topic such as Parents Orientation to JTDC, Medical/Mental Health services, Legal Literacy, and Community Resources.

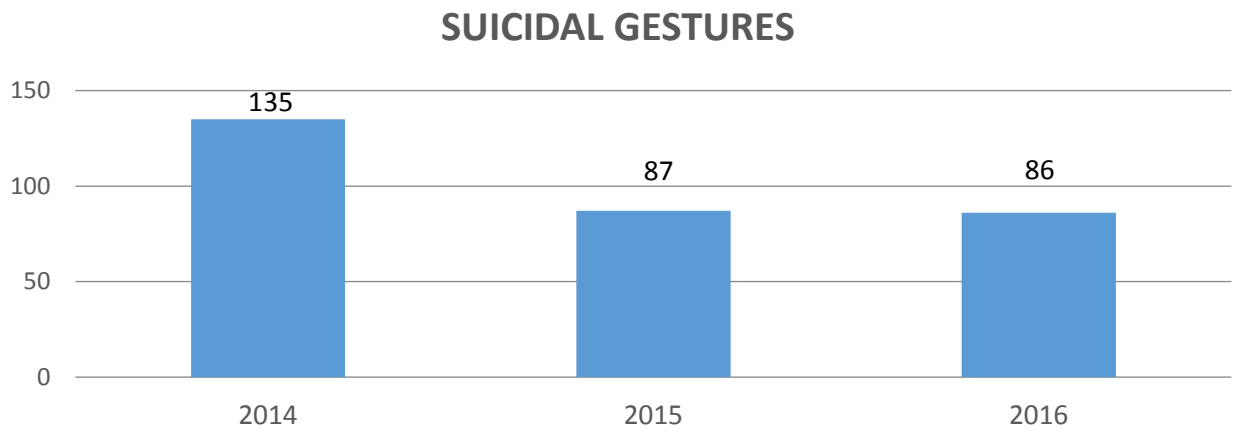
Since its inception, the Family Night program has supported over 2,000 family members. There has been overwhelming feedback from the families, that as a result of the program, they feel more empowered to become advocates for their detained loved one. The Family Night program is committed to educating, strengthening, and empowering families to thrive despite their circumstances. In 2016, the family night program added several new community partners and continues to be a great way to connect families with providers.

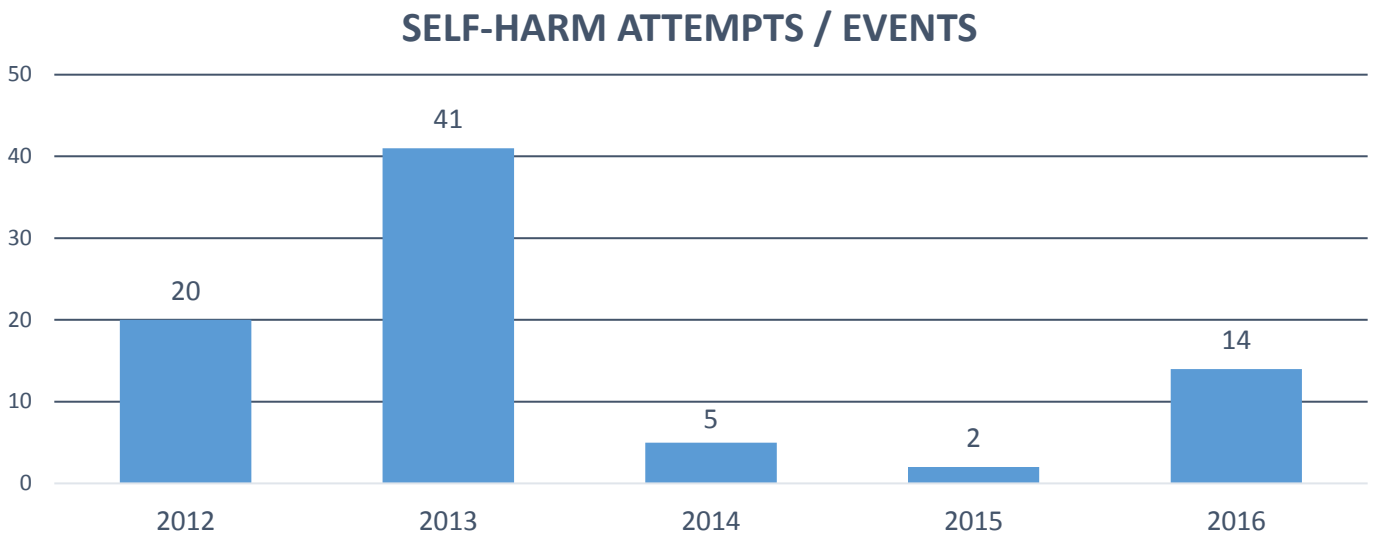
2016 OUTCOME AND CRISIS DATA

CRISIS DEFINED

IRC mental health clinicians respond to various resident crises. A “crisis” is defined as anytime a resident exhibits extreme behavior which requires an immediate mental health evaluation. Sometimes crises are a resident expressing suicidal ideation (i.e. “I want to die.”, “I’m going to kill myself”, etc.). Sometimes the resident is actively engaging in self-harm (scratching self, banging head on wall, etc.). Sometimes a resident is acting out in a violent behavioral fashion towards staff or peers and requires immediate assessment. Mental health staff respond to various crisis calls on a regular basis. In addition to on-site crisis coverage, IRC provides 24 hour mental health and psychiatric on-call crisis coverage. Crisis volume has decreased since 2009 which may be due in part to significantly increased volume of clinical outreach (clinical rounds and confinement assessments) and early intervention.







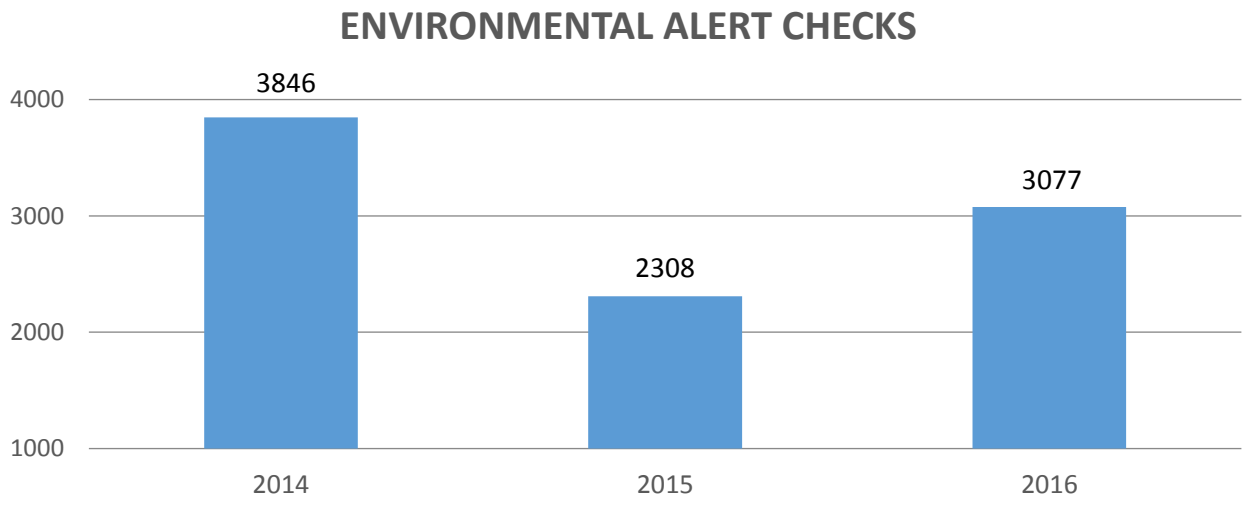
	2014	2015	2016
Self-harm/Suicide Ideation	210	148	151
Self-harm/Suicide Gestures	135	87	86
Self-harm Attempts/Events	5	2	14
Suicide Attempts	0	0	0
Total	350	237	251

Suicide and self-injury related crises remained low in 2016, suggesting that the combined efforts of IRC mental health and JTDC staff have been effective. As noted previously, better mental health staff retention / fewer position vacancies may have also contributed to these findings.

In one category, self-harm attempts / events, it was noted that there was an increase from the previous two years. Compared to data from 2012 and 2013, the 2016 total remains relatively low. Self-harm attempts are defined as behaviors that typically do not require significant medical attention. More serious acts of self-injury are classified as suicide attempts. The increase in self-harm attempts in 2016 can be attributed to one resident who had several instances of exhibiting self-injury behavior that, while not serious, were logged as self-injury events.

SUICIDE PRECAUTIONS

When a resident is in crisis (or returning from an outside hospital following a suicidal crisis), the resident may be placed on an observational status called: Environmental Alert (EA). Residents on EA status are evaluated by mental health staff at least twice per day (at least once on the day shift and at least once on the evening shift). The purpose of these risk assessments is to evaluate the youth's current mental status and current level of risk.

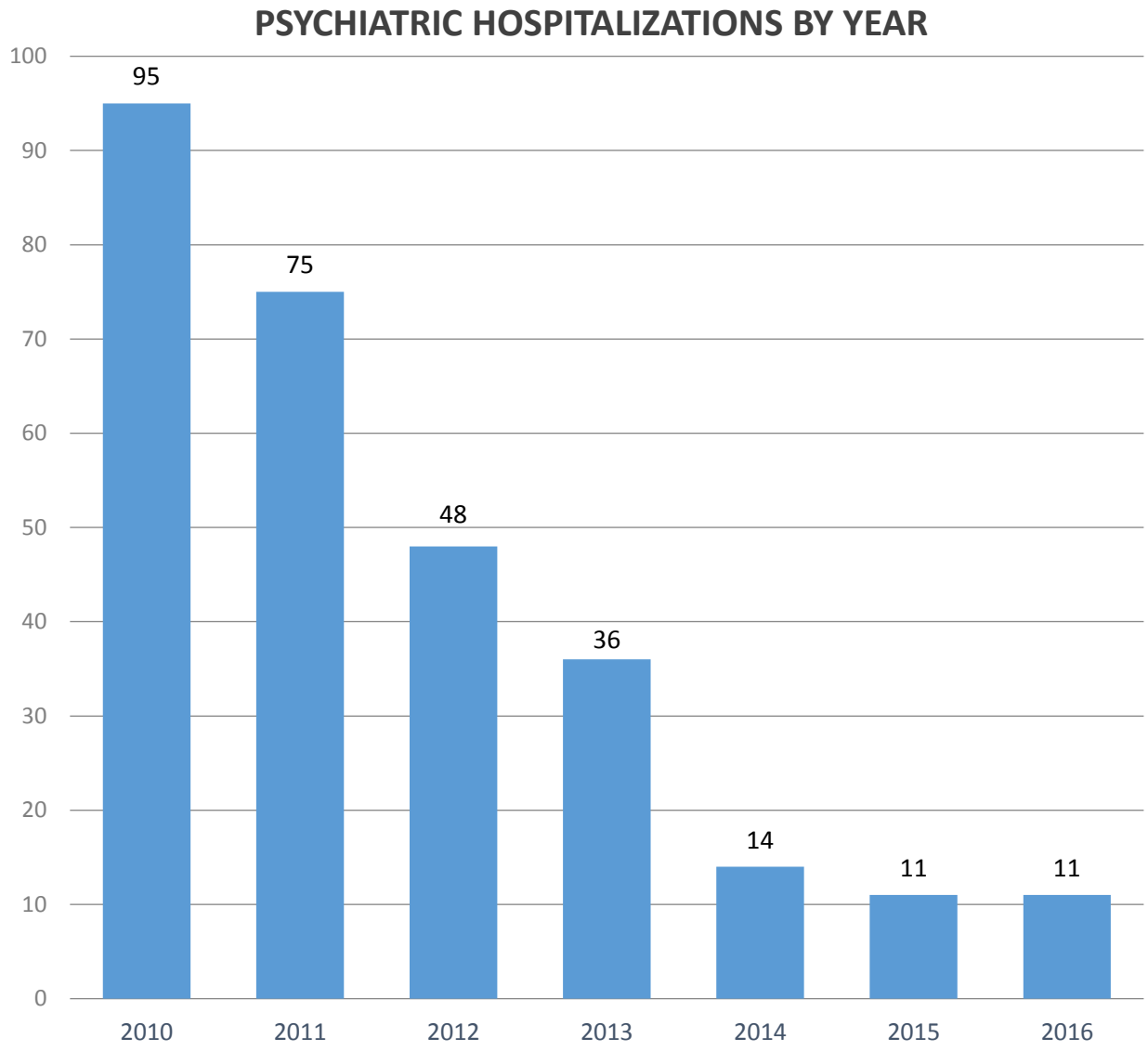


In late 2013, Lindsay Hayes, Project Director of the National Center on Institutions and Alternatives, conducted an evaluation of the suicide prevention practices within the JTDC. He concluded that the JTDC is making "efforts to continue improving an already very good suicide prevention program."

Feedback from Mr. Hayes' report has been incorporated into the latest draft of the JTDC suicide prevention policy. IRC staff teach the JTDC staff suicide prevention training program which was revised in 2015. In 2016, IRC trained several clinicians in "Shields of Care", which is currently the gold standard in terms of suicide prevention curricula. In 2017, IRC clinicians will re-train the entire JTDC staff using Shields of Care.

PSYCHIATRIC HOSPITALIZATIONS

Sometimes residents experience symptoms which cannot be adequately managed in a correctional setting and require placement in an outside hospital for stabilization and treatment. In 2016, a total of 11 residents were hospitalized. The leading causes of psychiatric hospitalization across all years were "Self-harming/Suicidal gestures".



The annual number of psychiatric hospitalizations has steadily decreased over the last 7 years, suggesting that the mental health program at JTDC is providing efficacious services. This **88%** reduction in hospitalizations is a significant outcome as transfer of residents to outside psychiatric facilities disrupts the adjudication process and is very costly (the average cost to hospitalize a youth for one week in Illinois ranges between $12,000 and $16,000).

Another factor that may have contributed to the falling rate of hospitalizations is the emergence of the Multi-Disciplinary Team (MDT) meeting. MDTs are a special collaboration between various departments at JTDC including administration, security, medical, mental health, and education. MDTs develop individualized plans for youth who have special needs. Over the last four years, MDTs have successfully implemented plans that have allowed for youth to be safely maintained at JTDC when they may have needed hospitalization in the past.

HOSPITALIZATIONS	2010	2011	2012	2013	2014	2015	2016	Average
Suicidal Ideation	25	10	12	3	5	4	1	8.6
Suicidal Gesture	35	45	12	9	2	1	2	15.1
Psychosis	11	9	3	9	3	4	5	6.3
Aggression	16	2	14	0	4	1	1	5.4
Self-Harm Attempt / Event	4	6	6	12	0	0	1	4.1
Other	4	3	1	3	0	1	1	1.9
Total	95	75	48	36	14	11	11	46.5

PROGRAM EVALUATION

CONTINUOUS QUALITY IMPROVEMENT

Continuous Quality Improvement (CQI) studies are one of the foundational elements of IRC's annual evaluation of the Mental Health Program. IRC collaborates with Cermak Health Services of Cook County to hold quarterly Medical / Mental Health CQI meetings. CQI meetings provide the medical and mental health departments with the opportunity to present CQI studies, annual performance statistics, and to receive feedback from other JTDC departments. The first quarterly CQI meeting of every year is dedicated to joint program evaluation, including a full review of the previous year's statistics and presentation of program initiatives for the new year.

2016 PSYCHIATRY / MENTAL HEALTH CQI STUDIES

Post- Release Adherence to Psychotropic Medication Study (July 2016)
Purpose: To better understand the scope of and reasons for psychotropic medication non-adherence after release from the Cook County Juvenile Temporary Detention Center (JTDC). The goal of this analysis is to improve psychotropic medication adherence after release by addressing its contributing factors.
Method: The records of residents who were released on prescription psychotropic medication during the first quarter of 2016 and returned within the first six months of 2016 were reviewed. Adherence to treatment was noted, as well as reasons for and barriers to non-adherence.
Results: There were 52 residents who left the JTDC on prescribed psychotropic medications during the first quarter of 2016. Among these 52, almost half (27) returned to custody within the designated time frame. There were 10 for whom adherence was confirmed. Nearly half (44.4%) were found to have been non-compliant with medication post-release. The most frequently reported barrier to adherence was elopement from the home.

Group Psychoeducation / Treatment Analysis (September 2016)
Purpose: To examine trends in group psychoeducation delivery of IRC mental health staff. To verify that group psychoeducation topics are consistent with guidelines set forth by IRC administration.
Method: Aggregate group treatment data from 2015 IRC Encounter Forms were collected and sorted by topic for this analysis. Comparison of resident problems areas, principal diagnosis and group psychoeducation treatment was assessed for consistency.
Results: 688 group treatment sessions were conducted in 2015. 48 unique treatment titles were logged by IRC Clinicians; the most common group treatment sessions being Substance Abuse, Legal Concerns, Social Skills and Anger Management. These findings indicate that group treatment is largely provided to residents consistent with resident problem areas and principal diagnoses as documented via the MH Multidisciplinary Treatment Plan.

Treatment Plan Problem List and Diagnosis Analysis (September 2016)
Purpose: To examine several factors within the treatment planning practices of IRC staff. Those factors include diagnostic trends, and problem area identification. Another purpose of this study is to examine the prevalence of certain mental disorders within the JTDC population.
Method: Aggregate resident problem and principal diagnosis data from 2015 MH Multidisciplinary Treatment plan form were collected and sorted by resident number for this analysis. Only the most current treatment plan for each resident was used in order to prevent duplication of information. In turn, 436 treatment plans were retained.
Results: 84 unique resident problem categories were logged by IRC Clinicians; the most common problem being substance abuse, anger/irritability and mood dysregulation. 16 unique principal diagnoses were logged by IRC Clinicians; the most common diagnoses being substance abuse, mood disorders, ADHD and conduct disorder. The consistency between problem areas and diagnoses suggests that IRC Clinicians are selecting treatment goals appropriately.

Psychiatry/Mental Health Chronic Disease Services Study (April 2016)
Purpose: To determine whether Psychiatrists and other QMHPs are following chronic disease protocols as evidenced by documentation in the medical record (Compliance Indicator #2).
Method: Forty medical records of youth diagnosed with a chronic psychiatric disorder were reviewed for evidence of the following:

a. The frequency of follow up for medical evaluation is based on disease control.
b. The patient's condition and status are monitored and appropriate action is taken to improve patient outcome.
c. The type and frequency of diagnostic testing and therapeutic regimens are indicated.
d. Appropriate instructions for diet, exercise, adaptation to the correctional environment and medication are written.
e. Any deviation from the protocol is clinically justified.

Results: Compliance with Indicator # 2 was 100%.

Mental Health Youth Services Survey Study (December 2016)
Purpose: To evaluate the quality of IRC clinical services as assessed by the youth at the JTDC and to identify opportunities for improvement.
Method: JTDC Quality Assurance Specialists presented the IRC Youth Mental Health Services Survey to residents on all centers. Summary statistics were conducted for frequency of affirmation (agreement/ disagreement) on 25 areas of focus.
Results: Findings suggest that the majority of residents positively affirm that IRC provides quality MH services in most areas of focus for MH staff, services and overall satisfaction (40% or more agreement). Most respondents agreed that they are approached with a positive attitude and treated with respect. There were six areas of focus where respondents disagreed/strongly disagreed with elevated frequency (17%- 37% disagreement). These findings suggests that the residents would like to be more involved with the staff when they choose the services they receive, their behavior goals and their treatment. Residents also indicated that they would like to receive services more privately.

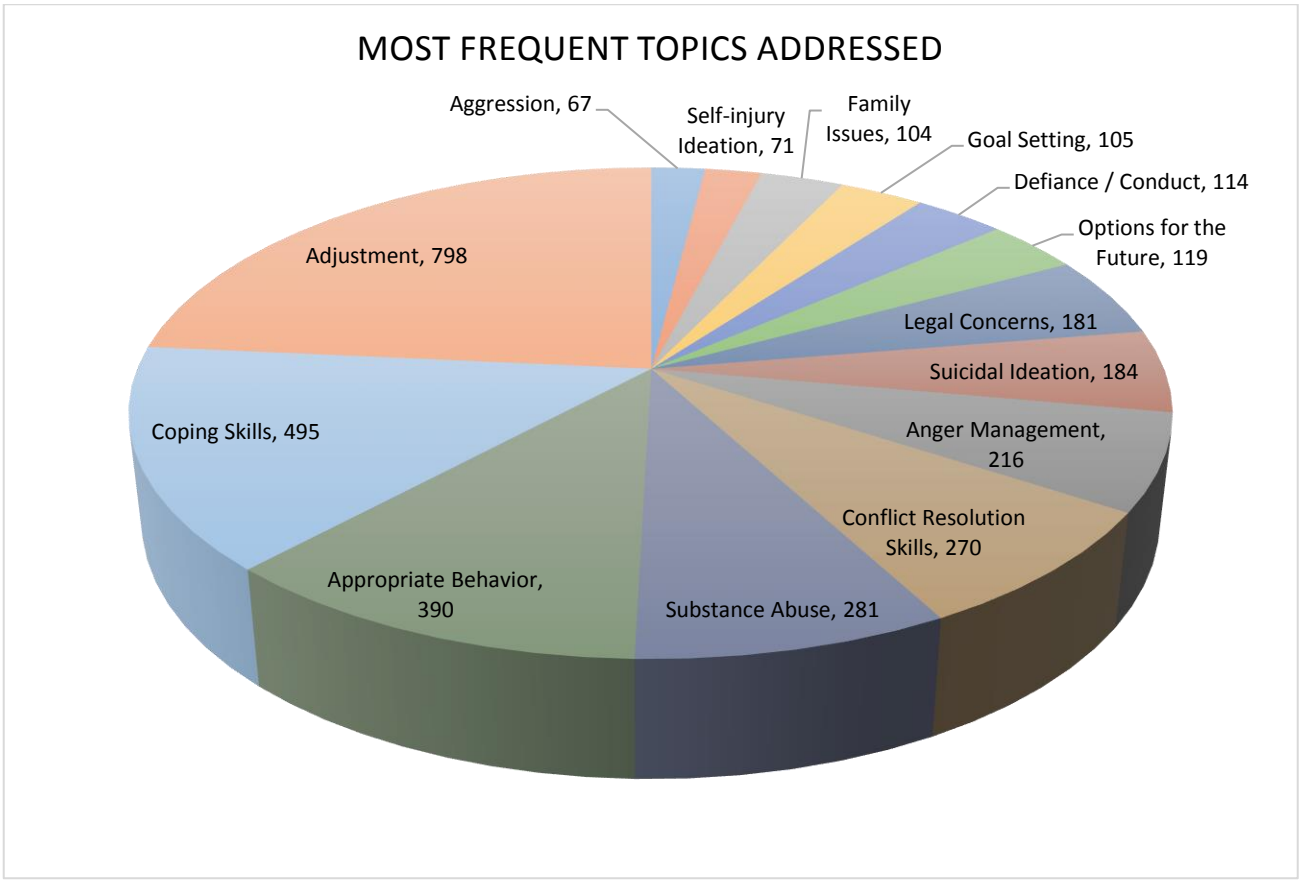
PRODUCTIVITY REPORTS

Productivity monitoring is another key component of IRC's program evaluation efforts. Monthly productivity reports identify the following:

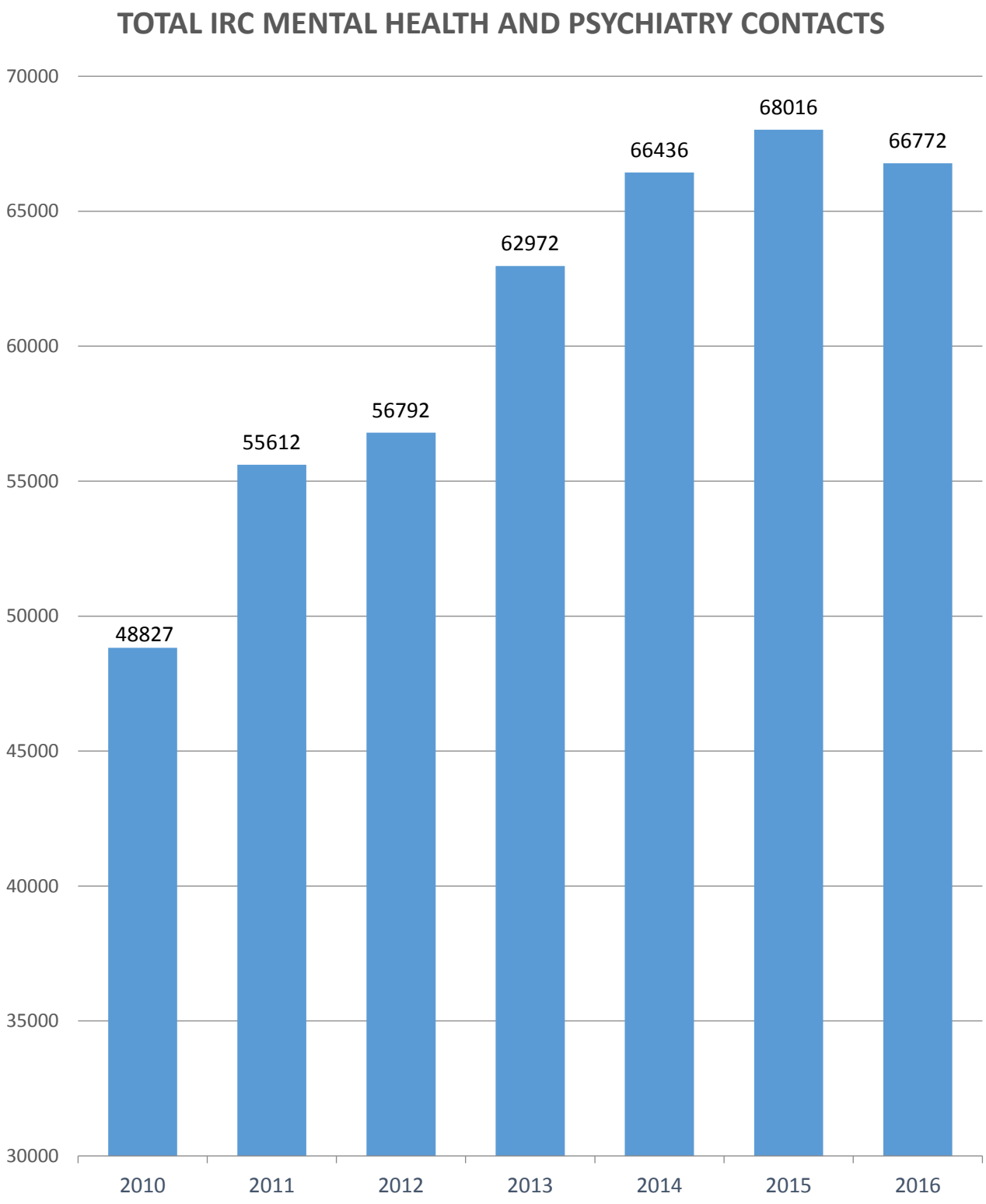
- which residents are being seen most frequently
- identified reasons for MH contact
- individual clinician contact volume
- monthly confinement statistics
- location of MH contacts
- topics being addressed in counseling
- group therapy statistics

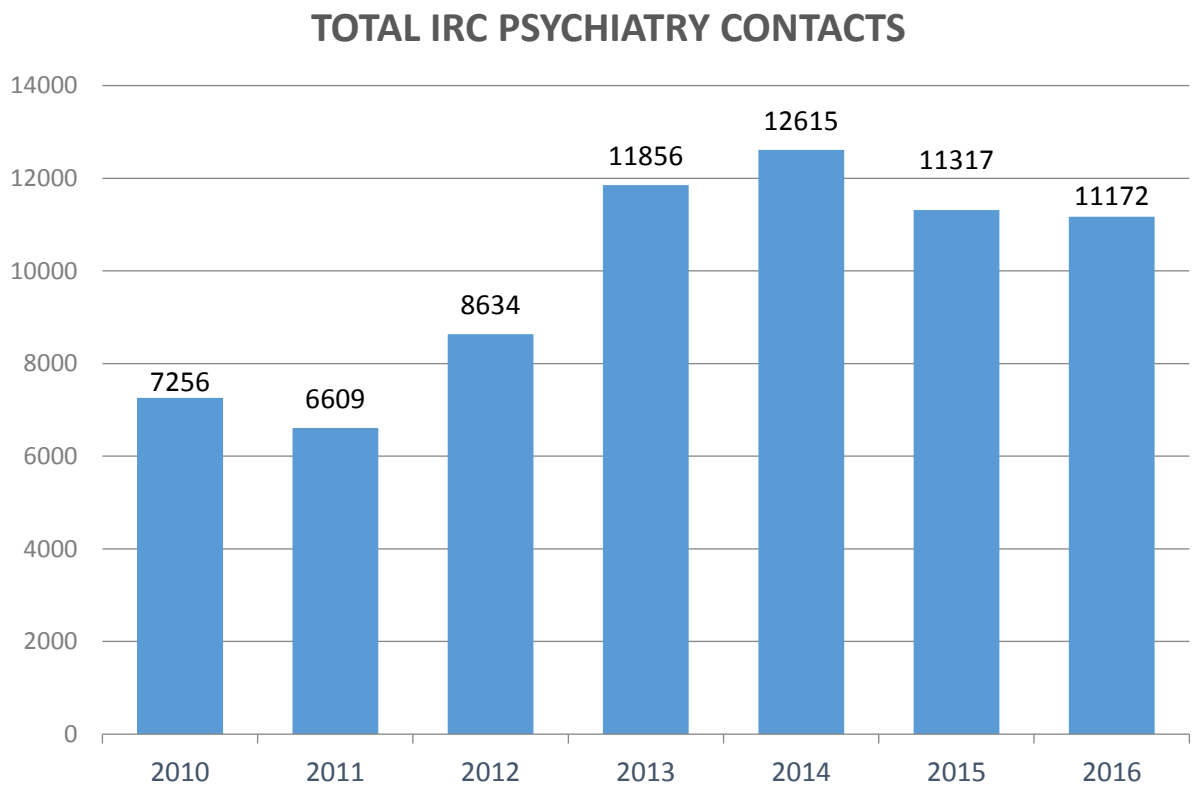
Productivity reports provide metrics that assist the management team in identifying areas where programmatic attention is needed. Examination of monthly reports also provides leadership with ideas for future CQI studies and other program evaluation components.

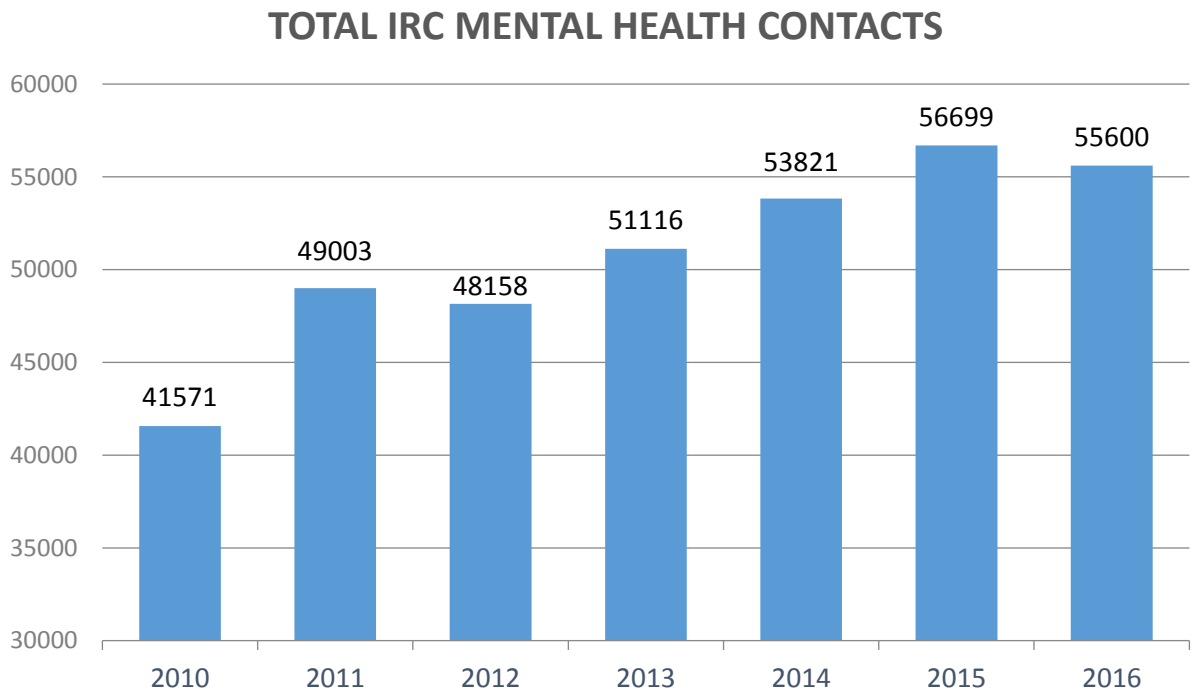
The following is a chart sample from the monthly report. This chart reports on freqency with which certain topics are addressed in individual counseling:



APPENDIX A:

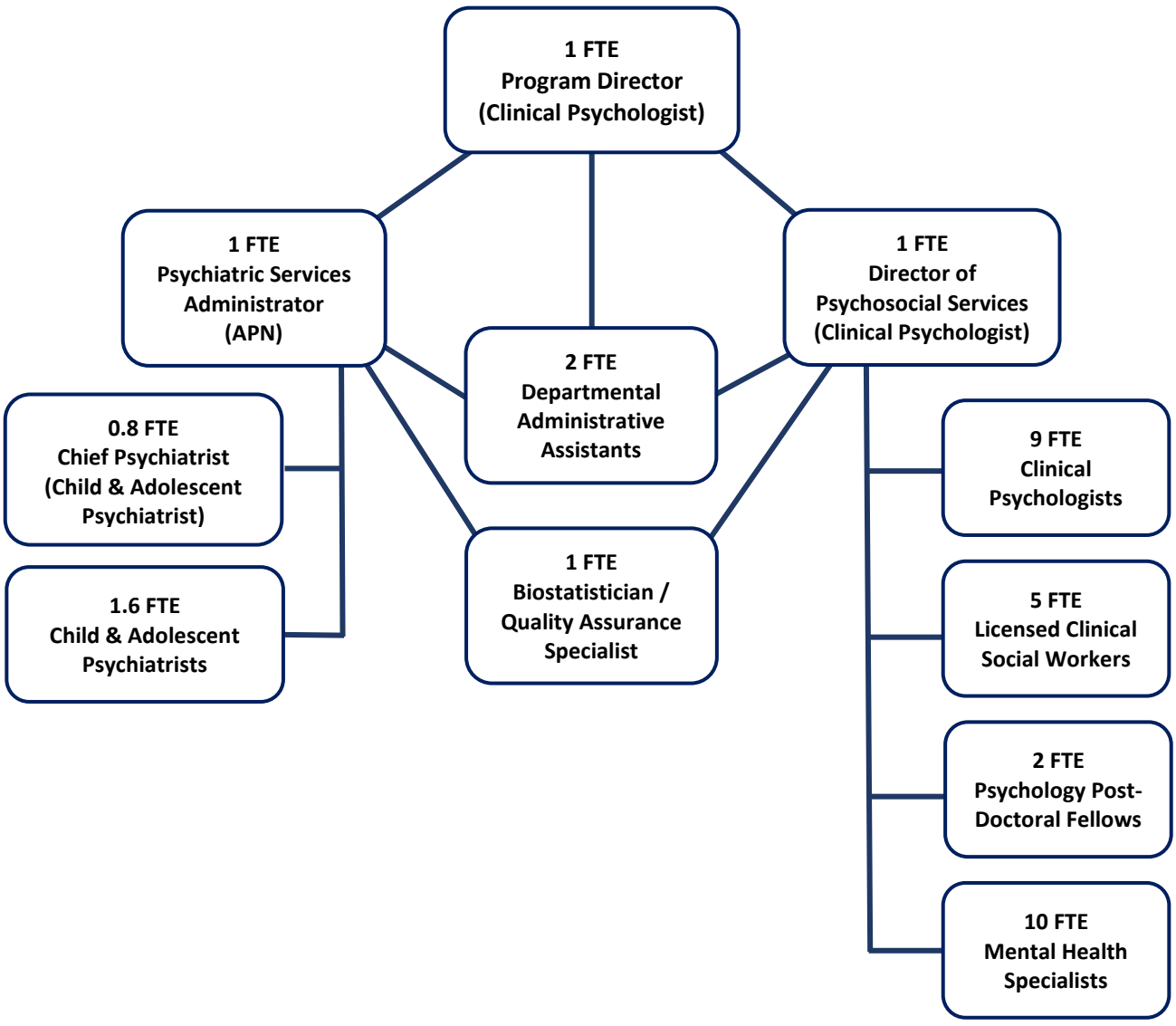

TOTAL IRC MENTAL HEALTH AND PSYCHIATRY CONTACTS
70000
65000
60000
55000
50000
45000
40000
35000
30000
48827
55612
56792
62972
66436
68016
66772
2010
2011
2012
2013
2014
2015
2016


TOTAL IRC PSYCHIATRY CONTACTS
14000
12000
10000
8000
6000
4000
2000
0
7256
6609
8634
11856
12615
11317
11172
2010
2011
2012
2013
2014
2015
2016

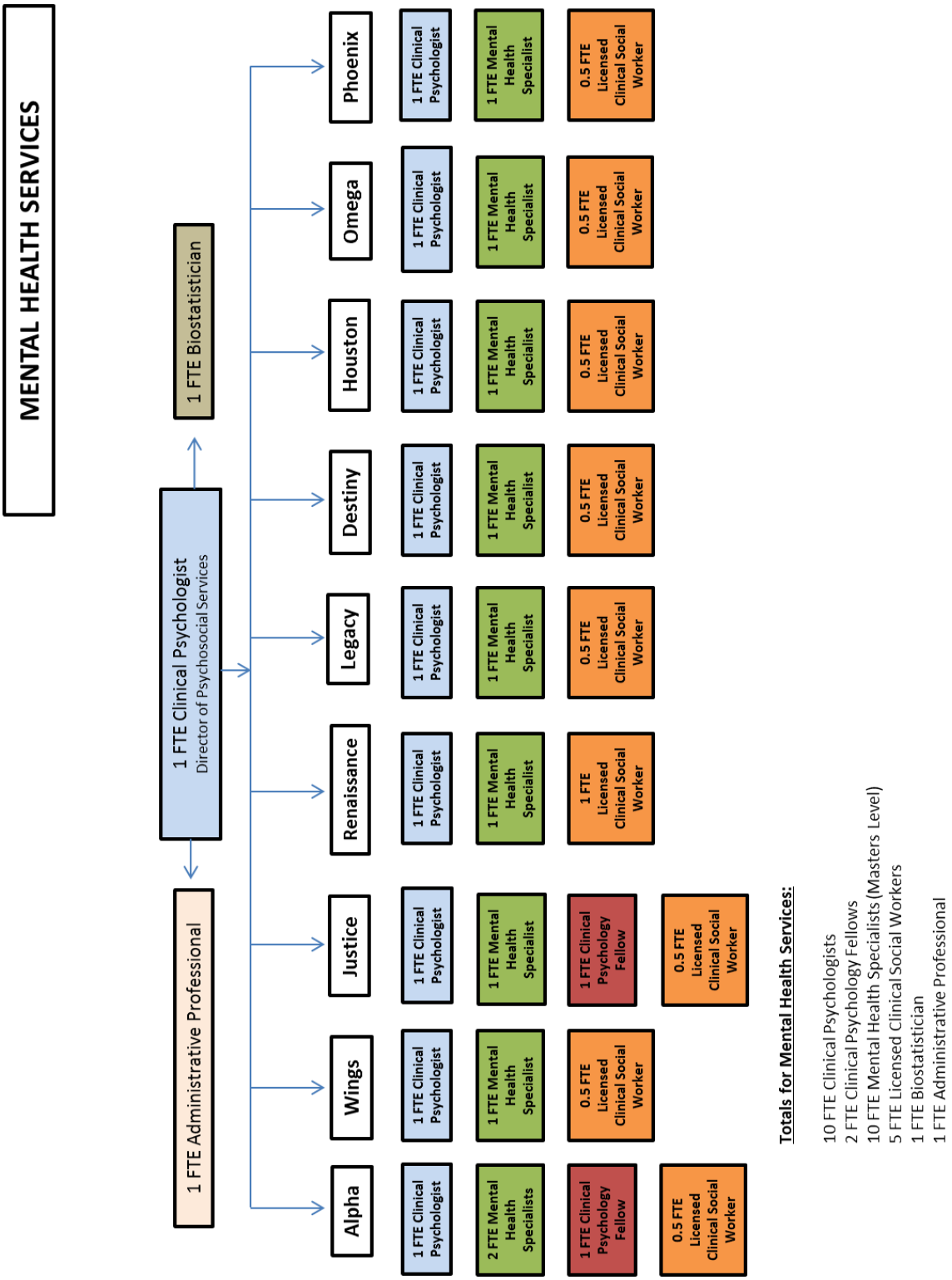

TOTAL IRC MENTAL HEALTH CONTACTS
60000
55000
50000
45000
40000
35000
30000
41571
49003
48158
51116
53821
56699
55600
2010
2011
2012
2013
2014
2015
2016

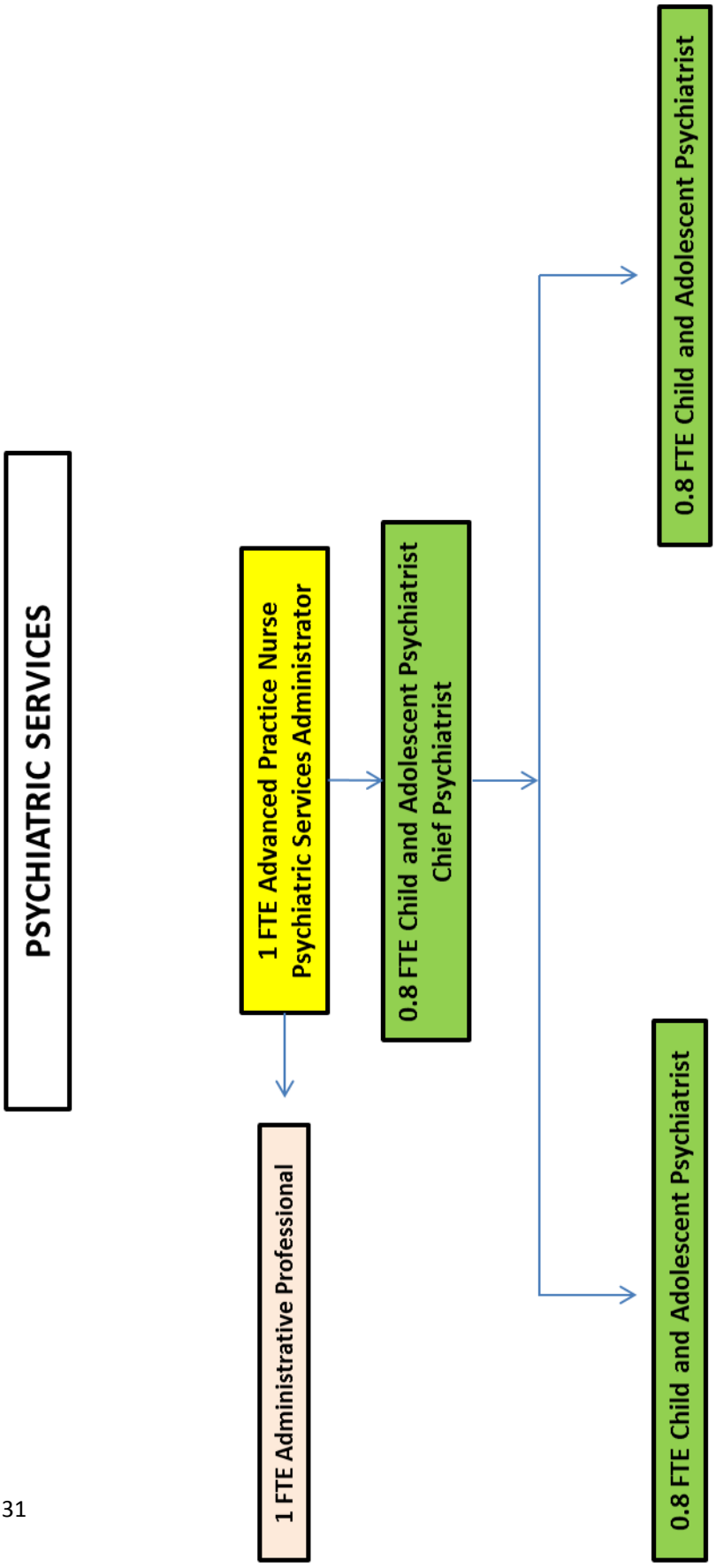
APPENDIX B:

IRC AT JTDC **ORGANIZATIONAL CHART**



IRC 2016 STAFFING PLAN





Totals for Psychiatric Services:

2.4 FTE Child and Adolescent Psychiatrists
1 FTE Advanced Practice Nurse
1 FTE Administrative Professional