Executive Summary

The Illinois Department of Human Services-Division of Mental Health (DMH) is responsible for managing and purchasing a comprehensive array of services that provide effective treatments to people most in need of publicly funded mental health care. The policies and practices of the DMH focus on fostering coordination and integration of services provided by DMH funded community agencies, private hospitals, and state hospitals across Illinois. The DMH has implemented a wide range of initiatives to increase coordination with other state agencies whose services are accessed by individuals receiving mental health services. The FY 2007 Mental Health Block Grant Plan reflects these coordination efforts as well as an emphasis on consumer and family driven and focused care. During the past year, the DMH has actively pursued a number of efforts which continue the transformation of the mental health service delivery system in Illinois to one that is recovery-oriented. These efforts include an expanded focus on planning and implementation of evidenced-based practices, planning and establishing the infrastructure for the transition to a fee-for-service system from a primarily grant-based funding system, and increasing consumer and family involvement in planning and implementation activities. A wide array of stakeholders representing consumers, family members of individuals with mental illnesses, advocates, and public service agencies which purchase or provide treatment to individuals with mental illnesses have participated in these efforts. The anticipated outcome of these efforts are improvements to the public mental health service system which support recovery and center on the needs of consumers and their families.

There continue to be significant fiscal challenges to the mental health service system in FY 2007. Illinois, like many other states, experienced a serious economic downturn that began in 2001, and although there has not been an increase in funding, the Division has worked diligently to increase revenue from Medicaid and to seek grant funding to support programmatic efforts.

During FY 2007, DMH efforts have remained focused on: (1) sustaining the significant accomplishments of recent years, (2) continuing the development of the public mental health service system through joint planning, coordination and implementation efforts, (3) emphasizing consumer education, recovery-orientation and enhanced consumer and family involvement in planning and evaluation activities, 4) continuing development and initiation of strategies to expand access to evidence-based practices, and (5) developing the capacity and readiness for moving the mental health system toward a transformed mental health system in a strategic and targeted manner. The format of the FY 2007 plan reflects this theme, synchronizing it with the overall planning process of the DMH.
The following are highlights of this year’s application and plan:

• The continued use of block grant funds to promote consumer-to-consumer outreach and mentoring,
• Continuing development of residential services, including a new supported housing initiative
• The continuing investment of block grant dollars to increase and improve psychiatric leadership and services,
• The use of block grant funds to support crisis services,
• Enhancing mental health services for children,
• Continuing to develop strategies to increase access to evidence-based practices,
• Maintaining established linkages with jails, juvenile detention facilities, and the Courts,
• Providing training and consultation to community-based staff serving children and adolescents,
• Working collaboratively in consultation with schools to expand early intervention and prevention in mental health, and
• Promoting the integration of mental health services and providing necessary consultation to meet the needs of elderly persons, especially in rural areas.

Implementation Report Format

This report provides detailed information regarding the implementation of the Illinois DMH State Block Grant Plan for FY 2007. Section I of the implementation report provides a narrative of the accomplishments of the Illinois Mental Health System. It contains an overview of the mental health system, discusses areas identified in the FY 2007 plan as needing improvement, and provides a description of significant events that have impacted the mental health system in the past year. Section II focuses on FY 2007 objectives and provides a narrative description regarding how these objectives were attained. The objectives in this section were excerpted from, and form a crucial part of the DMH Strategic Plan. Section III provides an update on the status of Illinois specific performance indicators and SAMHSA CMHS Core Performance Indicators. These indicators provide a basis for tracking progress of the Illinois Mental Health System in meeting its goals and objectives. Information regarding specific allocation of block grant funds is included as an attachment and general information is contained in Section II.

The uniform data on the Illinois public mental health system is presented in Part E of the report. The Basic and Developmental Tables are included, as well as the State Capacity Checklist for FY 2007 which provides the status of Illinois’ ability to report on all of the data tables. Table 10 of the Basic Tables provides detailed information regarding the specific allocation of Block Grant funds to DMH community providers.

A letter from the Illinois Mental Health Planning and Advisory Council documenting their review of the Implementation report is also included.
FY2007 IMPLEMENTATION REPORT

Part D OF THE FY2007 BLOCK GRANT COMMUNITY MENTAL HEALTH SERVICES APPLICATION
DESCRIPTION OF STATE SERVICE SYSTEM

Overview of the State’s Mental Health System

The Mental Health System at the State Level

The Illinois Department of Human Services Division of Mental Health (DMH) has a statutory mandate to plan, fund, and monitor community-based mental health services. Through collaborative and interdependent relationships with service system partners, the DMH is responsible for maintaining and improving an evidence-based, community-focused, and outcome-validated mental health service system which builds resilience and facilitates the recovery of individuals with mental illnesses. The DMH accomplishes this responsibility through the coordination of a comprehensive array of public/private mental health services for adults with serious mental illnesses and children/adolescents with serious emotional disturbances.

It is the vision of the Division of Mental Health that all persons with mental illnesses recover and are able to participate fully in life in the community. Within available fiscal resources, the priority for DMH is to provide access to clinically appropriate, effective and efficient mental health care and treatment for individuals who have serious mental illnesses and who have limited social and economic resources. Planning and budgeting decisions are guided by the basic principle that individuals will receive services in the least restrictive, most clinically appropriate environment, with the best quality of recovery-oriented and evidence-based treatment and care possible.

The administrative offices of the Division of Mental Health are based in Springfield and Chicago. Statewide efforts to maintain and improve the system of care are coordinated through the Central Office. Planning and program implementation are accomplished in conjunction with regional administrators. The Central Office is responsible for oversight of the system, policy formulation and review, the operation of nine state hospitals, planning, services evaluation, and allocation of funds. Interagency collaborative efforts and leadership in initiatives such as activities related to transformation, consumer participation/involvement, the promotion of evidence-based practices, the planning of clinical services, forensic services, and child and adolescent services are carried out by statewide administrative staff. There are 70.5 FTE positions in Central Office available to accomplish the manifold tasks required of it.

DMH Organization at the Local Level: The Community-Based Mental Health Service System

Community services are considered the cornerstone of the mental health delivery system. Services provided and purchased by the DMH are geographically based. The DMH is organized into five Comprehensive Community Service Regions (CCSRs). Through these Regions, the DMH operates state hospitals and contracts with 151 community mental health providers across the state. The DMH continually seeks input from consumers, family members, advocates, and representatives of public and private organizations through the framework of the Illinois Mental Health Planning and Advisory Council (IMHPAC) to aid in planning efforts.

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Comprehensive Community Service Regions are charged with the responsibility for managing care, developing the capacity and expertise of providers, monitoring service provision and increasing the quality and the quantity of participation from persons who receive mental health services. Two Regions are located in the Chicago Metropolitan area and surrounding suburbs, and three Regions cover the central, southern and metro-east southern areas of the State. Administratively, each Region has an Executive Director, a lead Clinical Director, a lead Recovery Services Development Specialist, and a Coordinator of Forensic Services. Child and Adolescent Service expertise is provided to Regional staff by statewide C&A Services staff who are centrally located.

The DMH uses emerging developments at the local, state and national levels as a basis for strategically setting statewide parameters and goals, with the CCSRs carrying the responsibility for the development of congruent local systems of care. CCSR Strategic Plans reflect the overall goal of the development of a recovery-oriented service system which is informed and driven by the vision of the President’s New Freedom Commission. Ongoing strategic thinking and planning efforts with Regional stakeholders are designed to uniquely meet local area needs within each Region. The DMH is able to improve linkage and insure that treatment occurs in the least restrictive and most cost-effective settings by integrating hospital-based services into a network of community outpatient services and supports that are coordinated across service providers and consumers. By building on the strengths of communities in which consumers live, the CCSRs are able to manage DMH funds, and coordinate the most effective use of the local tax dollars and private resources budgeted for public mental health services.

**Leadership & Coordination Of Mental Health Services-The Broader System:**

DMH exerts ongoing leadership through system integration initiatives, competence development, consumer development and continuous quality improvement. Emphasis is on developing systems integration at the statewide level that parallels the relationships that community mental health centers develop at the local level. The DMH provides leadership by coordinating mental health services with the broader system through the integration of services with other IDHS divisions and working closely with the code departments and organizations at the state level.

**Relationship of the DMH to the Illinois Department of Human Services (IDHS).**

The Illinois Department of Human Services (IDHS) is the cabinet level state agency which manages human service systems in the State, including management of the public mental health system through the Division of Mental Health. The mission of the IDHS is to assist Illinois residents in achieving self-sufficiency, independence and health to the maximum extent possible by providing integrated family-oriented services, promoting prevention, and establishing measurable outcomes in partnership with communities. The IDHS is able to connect eligible clients to a wide range of human services at one location because it administers community health and prevention programs, oversees programs for persons with developmental disabilities, mental health and substance abuse problems, provides rehabilitation services, and helps low-income persons with financial support, employment, training, child care, and other necessary family services. Local office staff use a family-centered approach to identify client needs; determine eligibility for benefits; link clients to appropriate programs, and refer them to services in their community.
Increasing systems integration among the divisions and offices of IDHS improves the accessibility of support services for the mental health service system and enhances service delivery for individuals coping with mental illness.

**IDHS Service Areas**

**Division of Human Capital Development (DHCD).** The DHCD oversees programs that help clients to achieve self-sufficiency including employment and training services, child care and family services, and financial support services. This Division serves over one million DHS customers each month through income supports such as: cash assistance, food stamps, medical programs, employment and training programs, help with child care, emergency assistance, refugee and immigration services, homeless services, and specialized social services. DHCD has six regional and 115 local Family Community Resource Centers which serve as the first point of contact for many IDHS clients. These offices offer direct transitional services and a link to employers and key community organizations.

**DMH and the State Welfare Program**

In an ongoing effort to address issues that may provide barriers to work readiness, the DMH and the DHCD work together in establishing and managing liaison relationships between local community mental health centers and local IDHS offices. The aim is to identify customers of IDHS who may be in need of mental health services (screening, assessment, and treatment). Statewide, DMH funds eleven community mental health provider agencies with General Revenue Funds (GRF) to provide for a full or half time Qualified Mental Health Professional (QMHP) staff position onsite at eleven designated IDHS Family Community Resource Centers. Of these, six DHCD offices located in the Metro Chicago area have a full-time QMHP, one has a part-time QMHP, and four offices in downstate Illinois have the presence of a part-time QMHP. Paralleling this co-location is a statewide collaborative effort involving 97 DMH-funded mental health centers that have liaison relationships with the remaining local DHCD offices. These liaisons have a presence in IDHS offices for a minimum of four hours a month, or may be present for more hours if mutually agreed by the DCHD Local Office Administrator and the mental health center’s administrative designee. Currently, each DHCD office has a liaison assigned to interface with the mental health center administration.

**Community Health and Prevention.** The Division of Community Health and Prevention (DCHP) encompasses community health services, family and youth development, violence prevention and intervention and addiction prevention. The DCHP includes: Maternal and Child Health Services, Comprehensive Services for Youth, Substance Abuse Prevention, the Teen REACH Program and Violence Prevention and Education Services.

**DMH Work with Community Health and Prevention**

Collaboration, cross training, and consultation between DMH and Division of Community Health and Prevention (DCHP) has continued in several key areas:

- A statewide perinatal mental health consultation service has been established for providers to use when a screening indicates that a pregnant or postpartum woman may be suffering from depression. This service is accessed by a toll free number and provides consultation with psychiatrists, information about medications that
may be used in the management of perinatal depression during and/or after pregnancy, and referral and linkage to available mental health resources.

- Early Intervention Services provided through DCHP for children under three years of age who are experiencing delays in one or more of the following areas: cognitive development; physical development; language and speech development; psycho-social development; and self-help skills. Evaluations and assessments are provided at no cost to families. Families with eligible children receive an Individualized Family Service Plan (IFSP) which lists the services and supports which must be made available to the family.

- The Domestic Violence and Mental Health Policy Initiative (DV/MHPI), funded by a contract with CMHS and supported by private foundations, is assisting DMH and CHP staff in research and training related to domestic violence. The DMH and the DCHP serve on a governance committee for DV/MHPI along with other child-serving agencies throughout the State. Both the DMH and the DCHP provide technical assistance to the DV/MHPI initiative. The DMH participates with the DCHP in other domestic violence treatment and prevention activities.

- DMH staff continues to participate in the DCHP Healthy Child Care Illinois (HCCI) initiative serving on its governance and planning committee. The DMH serves as the technical advisor on children’s mental health issues.

**Alcoholism and Substance Abuse.** The Division of Alcoholism and Substance Abuse (DASA) administers and monitors funding to a network of community-based substance abuse treatment programs. These programs provide a full continuum of treatment including outpatient and residential programs for persons addicted to alcohol and other drugs.

*The Challenge of Co-Occurring Disorder (MISA): Joint work by DMH and the Division of Alcoholism And Substance Abuse*

The Report of the Surgeon General on Mental Health, published in 1999, based on an extensive literature review of relevant and timely research, clearly stated that:

“As many as half of people with serious mental illnesses develop alcohol or other drug abuse problems at some point in their lives….Theories to explain co-morbidity (also known as dual diagnosis) range from genetic to psychosocial, but empirical support for any one theory is inconclusive. In short, the cause of such widespread co-morbidity is unknown. Co-morbidity worsens clinical course and outcomes for individuals with mental disorders. It is associated with symptom exacerbation, treatment noncompliance, likelihood of suicide, incarceration, family friction, and high service use and costs…..Furthermore, patients may be jeopardized by the consequences of substance abuse, namely, increased risk of violence, HIV infection, and alcohol-related disorders. Research amassed over the past 10 years supports a shift to treatment that combines interventions directed simultaneously to both conditions- that is, severe mental illness and substance abuse-by the same group of providers….but access to such treatment remains limited…”

DMH and the Division of Alcoholism and Substance Abuse (DASA) have collaborated to address services for individuals with co-occurring disorders for many years. Initiatives have included the establishment of consortia comprised of mental health and substance abuse providers to collaborate on treatment provision, cross-training of providers from both service systems focusing on integrated treatment, and the funding of an institute to provide training to service providers across the state. Additionally DMH and DASA have participated in the SAMHSA National Policy Academy on co-occurring disorders. Staff of both Divisions are actively working together to implement integrated treatment. Currently DASA funds more than 20 agencies statewide to provide both mental health and substance abuse services to persons with co-morbidity. The DMH and DASA jointly applied for and received, a SAMHSA grant for training providers and evaluation of the implementation of Integrated Dual Diagnosis Treatment (IDDT). The DMH and DASA also collaborated on the submission of an application for a Co-Occurring State Infrastructure Grant (COSIG) in June, 2006.

**Developmental Disabilities Services.** The Division of Developmental Disabilities (DDD) provides respite care, developmental training, and family support services to help individuals with developmental disabilities to become independent. Services are provided through residential facilities and programs that help disabled individuals live at home or in a community living center. Joint efforts are ongoing to resolve service issues for those consumers who have been dually diagnosed with a developmental disability and a mental disorder.

**Addressing Autistic Spectrum Disorders (ASD): Shared Leadership by DMH and the Division of Developmental Disabilities**

Both divisions share leadership tasks in addressing the needs of persons with Autistic Spectrum disorders (ASD). In FY 2004, a multi-agency Autism Task Force was established. The momentum and energy engendered by the Task Force dovetailed into complementary action by the Illinois legislature. Public Act 093-0773, An Act in Relation to Persons with Disabilities, directed the IDHS to convene a special task force to study and assess the service needs of persons with ASD. In FY 2005, the Division of Developmental Disabilities (DDD) and the DMH co-convened the Autism Task Force that continues to meet.

Illinois has undertaken two initiatives in the last eight years to address the impact of Autism Spectrum Disorder (ASD). The Illinois General Assembly commissioned The Autism Program (TAP), which addresses the needs of ASD-challenged children in the areas of screening, identification, diagnosis, programs and services, workforce development, and research. The second initiative is the Illinois State Board of Education’s (ISBE) sponsorship of the Illinois Autism Technical Assistance and Training program, which provides professional development and training to local school districts and special education cooperatives. ISBE has also sponsored Giant Steps, a school program with a professional best practices curriculum for ASD challenged children. Additionally, the IDHS has sponsored the Early Intervention Program noted above, which provides services to children birth to three years of age.
**Rehabilitation Services.** The Division of Rehabilitation Services (DRS) oversees programs serving persons with disabilities that include vocational training, home services, educational services, advocacy, information and referral. Also provided are a variety of services for persons who are blind, visually impaired, deaf or hard of hearing.

*Supportive Employment and Recovery Specialization: The Collaborative Efforts of DRS and DMH*

Since FY1999, DMH and DRS have collaborated on a Brand New Day Initiative to increase the access of persons with serious mental illnesses to vocational rehabilitation services and to improve the coordination of psychiatric and vocational services. Since FY 2004, the DMH and DRS have expanded their efforts in the development and provision of Certified Recovery Support Specialists training for consumers and the development of self-employment opportunities that are integrated with appropriate support services. Sixty (60) recovery support specialists were trained and certified in FY 2006. DMH, DRS, and DASA worked collaboratively with the Illinois Certification Board (ICB) during FY2007 to develop the Illinois Model for Certified Recovery Support Specialist (CRSS) which defines baseline criteria for CRSS professionals and provides a professional certification which is competency based. DMH and DRS continue to jointly assess their service systems to determine what gaps exist locally and emphasize technical assistance for needed program modifications.

*Relationship of the DMH to the Illinois Departments and Organizations.*

**Illinois Housing Development Authority**

*Activities Related to Housing*

The availability of adequate, safe, affordable housing is a necessary component of a comprehensive community support system. The DMH, through its Comprehensive Community Service Regions, is committed to pro-active involvement in expanding the pool of affordable, supported housing for persons with psychiatric disabilities. Permanent housing which emphasizes consumer choice, the rights and responsibilities of tenancy, and flexible support services should be available in communities across the state. DMH staff meets regularly with the Illinois Housing Development Authority (IHDA), a group with a legislative mandate to oversee and advise on Housing in Illinois, which includes the broader spectrum of state government in its membership (Department of Commerce, Department of Insurance, the State Treasurer, etc). The DMH Regions participate actively with HUD Community Builders to pave the way for local projects in housing development. Each Region continues to explore capital development for new construction and rehabilitation, as well as the availability of existing resources such as public housing. DMH staff also work closely with the Department of Human Rights and the Attorney General to support the needs and rights of mental health consumers when there is community resistance to housing for persons with a history of mental illness.

**Housing**

The DMH has retained national experts from the Technical Assistance Collaborative, Inc. (TAC), to assist in the development of creative strategies in planning for Permanent Supportive Housing (PSH) for persons with serious mental illnesses. With TACs’ assistance in FY2007, the DMH had the opportunity to establish a contractual
relationship with the Corporation for Supportive Housing (CSH), a nationally recognized organization in developing and funding PSH housing models. CSH, with an office base in Chicago, has worked with DMH in forging dialogue and partnerships with housing authorities, housing developers and other finance entities. Several meetings were convened with a broad network of stakeholders with discussions regarding the development of PSH housing arrangements with support service resources.

A housing consultant from the State of Tennessee Department of Mental Health, met with staff from the Illinois DMH and other key stakeholders in December 2006, to discuss the infrastructure of PSH, implementation strategies, and lessons learned in planning for the development of PSH. The Illinois Housing Development Authority (IHDA) and representatives of other key funding sources are participating actively in the planning process.

For FY2008, DMH is hopeful that $7 million will be identified from a Hospital Tax Initiative to provide PSH to an estimated 575 consumers of mental health services. Under this model PSH will be tenant based, with consumers holding the rights outlined in a lease agreement. Support services will be flexible and by choice, and are not a requirement to retain occupancy. Safe, decent, and affordable housing arrangements are being emphasized. If the Hospital Tax Dollars become a reality, an additional $750,000 has been earmarked for the development of a housing stock database and a consumer database that will be used in real time to identify available housing and concurrently match consumers with the available housing stock.

Extensive training will be provided to selected DMH staff who will serve as Housing Coordinators (one for each Region). These Coordinators will have the task of working with developers and provider agencies to set up the needed financing. Local offices of HUD, Federal Home Loan, the Illinois Department of Commerce and Economic Opportunity (DCEO), and other sources will be incorporated in actualizing the direction to achieve this reality. Additionally, Bridge Rental Assistant dollars will be identified to subsidize rents for consumers. Consumers will be required to commit up to 30% of their income for rent, in accordance with HUD standards.

Illinois Department on Aging

The DMH works closely with the Illinois Department on Aging (DOA) to increase training opportunities in the geriatric field, to improve the quality and accessibility of services for elderly persons with mental illness, and to enhance networking, collaboration and coordination of programs and services in provider networks. The DMH continues to jointly coordinate an Advisory Committee on Geriatric Services with the DOA. The Advisory Committee focuses its efforts on the assessment of the mental health needs of the elderly, and the identification of model programs, best practices and needed staff competencies to serve this population. The committee has increased awareness of geriatric mental health concerns and has provided training, consultation and technical assistance in the area of mental health and aging. In FY 2007, the DMH, in coordination with the DOA, successfully convened its annual Mental Health and Aging Conference. The DMH also continues to fund a Geropsychiatric Specialist Initiative that provides
support for the development of local mental health and aging coalitions, education and training on older adult mental health issues, and consultation to DMH case managers and aging personnel.

Illinois Department of Public Health and
Illinois Department of Healthcare and Family Services

**Mental Health Issues in Long Term Care**

There are a substantial number of individuals with serious mental illnesses who require long-term care services. Some require this level of care because of functional limitations associated with their mental illness, and others require it for functional limitations associated with both mental illness and medical needs. The Illinois Department of Public Health (DPH) is responsible for monitoring the licensing requirements of nursing facilities, and the Department of Healthcare and Family Services (DHFS) oversees Medicaid funding. The DMH has made a concerted effort to assist community providers and these two state agencies to understand the service needs of persons with serious and disabling mental illnesses and the long term care service options that are available.

**The “Money Follows The Person” Initiative**

Illinois will receive an estimated $55.7 million in new federal funding over five years to help people living in nursing facilities return to their homes or a community residence. The “Money Follows the Person (MFP)” grant will facilitate the transition of approximately 3500 persons into their communities over the course of five years. In addition to the federal award, the state has also committed $23.8 million to this expansion of home and community-based services. The Department of Healthcare and Family Services, the lead agency for the initiative, is working closely with IDHS, Department on Aging, and the Illinois Housing Development Authority on the project. The Secretary of IDHS announced that this new funding will greatly expand and enhance the department’s services and programs to help more people with severe mental illness, developmental disabilities and/or physical disabilities residing in long term care return to their home and community. She emphasized IDHS commitment to maximizing this funding in support of the goals of consumer self-direction, independence and community reintegration. Programs under the MFP grant are designed to: (1) Eliminate barriers or mechanisms that prevent Medicaid–eligible individuals from receiving support for appropriate and necessary long-term services in the setting of their choice; (2) Increase the ability of the state Medicaid program to assure continued provision of home and community based long term care services to eligible individuals who choose to move from an institutional to a community setting; and (3) Ensure that procedures are in place to provide quality assurance for individuals receiving Medicaid home and community–based long-term care services and provide for continuous quality improvement in these services.

**Mental Health and the Justice System**

In addition to oversight and management of inpatient hospital services for persons with mental illnesses who have been declared unfit to stand trial (UST) or not guilty by reason of insanity (NGRI), the DMH Forensic Services collaborates with a range of agencies in the Criminal Justice System including:

- Illinois Department of Corrections
- Illinois Department of Juvenile Justice (Established in FY2006)
The following four initiatives are highlighted as these clearly demonstrate leadership and an increasing clinical role in serving individuals with mental illnesses who have been adjudicated in the criminal courts:

**The Jail Data Link Project**
A pilot program between the Cook County Department of Corrections (CCDOC) and the mental health system begun in FY2000 has now expanded to other sites around the state. The initial program effort was implemented through Thresholds, a community mental health center, and was designed to serve adults diagnosed with serious mental illnesses who are detained at CCDOC (pre-trial). The project received a Gold Award from the American Psychiatric Association. A key aspect of this project was the development of a database for the daily exchange of information between Cook County Jail and the community mental health provider. The learning experienced from this project, which is referred to as the Jail Data Link Project, was used to expand the project to Will, Peoria and Jefferson counties.

**Rockford Crisis Services Collaborative**
In the Rockford area, a collaboration between DMH Forensic services staff, Janet Wattles Community Mental Health Center, Singer Mental Health Center, and Rockford Jail liaisons developed strategies for providing post release and emergency mental health services to detainees of the Rockford Jail. The emphasis of services is on detainees with misdemeanors who are known to local mental health providers. As a result, a mental health court was established that provides for diversion, discharge planning, and service linkage to Janet Wattles Community Mental Health Center. This program began initial operations during FY 2005.

**The Mental Health Juvenile Justice Initiative**
The DMH has a Juvenile Forensic Program that develops treatment programs for forensic youth who are court-ordered into mental health care (i.e. unfit to stand trial or not guilty by reason of insanity). The Juvenile Forensic Program oversees the DMH Mental Health Juvenile Justice Initiative (MHJJ), which links minors in juvenile detention centers who have a major mental illness and sometimes co-occurring substance abuse problems to comprehensive community-based care. MHJJ began as a pilot program in FY-2000 and expanded statewide by the end of FY-2002. Funding is provided to support local agencies in employing a Masters level clinician who serves as a liaison and works with the minor, the minor's family, the court, the detention center, and local community agencies to develop a community wraparound plan that is intensive, integrated and specialized. Participants in the MHJJ program have been found to exhibit significant clinical improvement within three months. These youth have also been found to have better
school attendance and a lower re-arrest rate. MHJJ is available at all the detention centers in Illinois.

**Law Enforcement and Crisis Intervention Training**

The DMH regularly collaborates with law enforcement agencies and emergency services at general hospitals to facilitate appropriate and effective psychiatric intervention to persons who are in crisis. Each DMH Region is committed to working on improving relationships through cross-training events for law enforcement officers and mental health staff of community agencies. DMH has worked collaboratively with a number of law enforcement agencies to provide training targeting police officers that interface with individuals with mental illnesses. Topics have included mental illness crisis and police response. DMH has also provided partial funding, and worked with the Illinois Law Enforcement Training and Standards Board (LETSB) to develop a one day training program targeted for experienced police officers on working with individuals who have mental illness and are in a behavioral crisis. On-going training in the curriculum has been implemented in 16 Mobile Training Units (MTU) covering the state. The DMH has also worked with the Illinois Sheriff’s Association to examine the issue of the persons with mental illness in county jails and to develop model protocols for mental health screening, suicide, and referral to mental health providers.

**Illinois State Board of Education**

**Chicago Public Schools**

**DMH and the Education System**

The DMH has pursued the Positive Behavioral Interventions and Supports (PBIS) model of collaboration between education and mental health primarily through work on the System of Care Grant and through collaborative efforts with the Children's’ Mental Health Partnership. Work is continuing to expand the education/mental health partnership and to utilize existing expertise to produce a replicable model for this collaboration. Discussions have been held with the Office of the Mayor of Chicago, the Chicago Public Schools, and child-serving state agencies to identify the needs of students and their families for a range of mental health services. A work group has been established which includes university researchers, mental health providers, educators and technical advisors who have designed universal, selected and targeted interventions to meet student and school needs.

**New Developments and Issues Affecting Mental Health Service Delivery**

**Mental Health Transformation**

In June, 2005, Illinois submitted a proposal to SAMHSA under the Mental Health Transformation initiative. Although Illinois was not awarded a grant, DMH and other state entities continue to work toward envisioning and organizing the Illinois transformation effort to meet New Freedom Commission goals. The DMH convened meetings in July and October, 2006 in which all agencies purchasing or providing mental health services participated. The meetings were well attended by a wide range of stakeholders, including consumers, family members, advocacy organizations such as NAMI, the Mental Health Association in Illinois, the Illinois Federation of Families, members of the Illinois Children's Mental Health Partnership, and others. Planning is
underway to convene several workgroups to address key components in transformation that were identified in the meetings.

**The Fiscal Integrity of the Public Mental Health Service System**
Illinois, like many other states, continues to experience an economic downturn that is reflected in increasing deficits in the state budget and minimal new funding for mental health services. The operating principle being applied during these difficult times is to act in a way that results in the least damage to the current service structure and supports the needs of mental health consumers. Although there has been growth in Medicaid funding, the budget for mental health services has remained essentially level for the last few years with a few exceptions. New program initiatives continue to be limited.

**System Restructuring Initiative (SRI)**
As noted above, Illinois is continuing work to transition to a fee-for-service system (see Section III, Criterion 5). Stakeholders at every level are involved in the System Restructuring Initiative task force including DMH staff, members of the IMHPAC, consumers of mental health services and their families, and service providers. The SRI has focused on integrating the goal of increasing fee for service revenue with the goal of transition to a recovery-resilience oriented system.

**Administrative Services Organization**
In FY2008, DMH is planning to reconstitute administrative services through an Administrative Services Organization (ASO). The primary goals are to ensure the quality and appropriateness of DHS/DMH-funded services and to support and improve the transition to fee-for-service financing. The Governor’s budget request allocated approximately $6 million to initiate this reorganization. A Request for Proposal (RFP) was issued in March, 2007. Five proposals were accepted for review and the selection process is continuing as of this writing. It is anticipated that the ASO will be procured and contracted by the end of October, 2007. The role and function of the ASO in the management of the public mental health system in Illinois is far-reaching and encompasses a broad spectrum of administrative activity as evidenced by the objectives stated in the RFP which are listed below. Through a statewide system of administrative services, the successful bidder is expected to accomplish the following:

- Promote recovery, resiliency, and self-determination for consumers through services based on principles of consumer choice, high quality biopsychosocial assessment and individualized treatment planning. and by implementation of consumer communication, maintenance of a consumer handbook, and a measurable commitment to meaningful consumer leadership within daily operations.
- Improve provider clinical and administrative practices in documentation, appropriateness of service provision (including coordination across providers) and valid claims submission.
Promote best practices through an utilization management program, system-wide quality management processes, implementation of consumer perception of care surveys and complaint/grievance procedures, and ongoing evaluation of all aspects of the work performed.

Facilitate the development of the provider system, including but not limited to the following: provider relations functions, provider training and technical assistance, publishing and maintaining a provider manual and provider directory, provider contract monitoring, and provider satisfaction surveys.

Through contract monitoring, service authorizations, and other appropriate mechanisms, ensure that service resources are distributed statewide and within each service region in appropriate proportion to the distribution of the DHS/DMH priority populations and their clinical needs.

Coordinate and administer all aspects and mechanisms which are necessary to implement and optimize fee-for-service financing while minimizing clinical risk to consumers and promoting financial viability and service capacity of providers. Implement fee-for-service mechanisms in accordance with the DHS/DMH coordination of benefits policy.

Coordinate and administer all non-fee-for-service financing mechanisms and service reporting and incorporate mechanisms to accommodate any provider pooled loan payments.

Design and implement consumer enrollment processes and procedures which ensure that DHS/DMH funding is used only for rehabilitative or medically necessary services for DHS/DMH priority populations.

Design and implement efficient and effective mechanisms for provider claims submission, validation, processing, adjudication, and payment.

Implement a state-of-the-art management information system (MIS) which supports the preceding objectives through: reliable, valid, and expeditious data transmission among all appropriate federal, state, and local entities; efficient and accessible data storage/warehousing/access; and HIPAA compliant procedures and processes throughout the system.

Provide consultation and technical assistance to DHS/DMH administration on all aspects of systems development including recommendations for new and/or modified service definitions.

Anti-Stigma Campaign
In FY2008, DMH is continuing its anti-stigma campaign. Initially, $200,000 was allocated for an adult public awareness anti-stigma campaign. A children's’ mental health public awareness campaign, a collaboration between the Illinois Children's’
Mental Health Partnership and the DMH Child and Adolescent Program, is also continuing at an annual cost of $300,000. During FY2007, a contractor to implement the campaigns was successfully selected through an RFP process and is planning the details of implementation in FY2008 with a committee appointed to carry out the campaigns.

**Initiatives of the Illinois Department of Healthcare and Family Services (DHFS)**
During the last year, the DHFS which is the Illinois Medicaid Agency, has implemented two new initiatives that impact mental health service delivery. One initiative is the All Kids insurance program which significantly expands medical and mental health services to children across the state. A second initiative is Disease Management which seeks to manage and coordinate services across service systems for individuals with targeted diagnoses.

**Legislative Initiatives And Changes**
During FY 2007, several key legislative initiatives were passed that will have some impact on the landscape of mental health service delivery in Illinois.

The Governor signed legislation in July, 2007 that gives Illinoisans living in rural communities increased access to psychiatric care. Public Act 95-16 allows rural Medicaid patients to receive treatment through telepsychiatry- the use of technology, primarily videoconferencing- to provide psychiatric care despite the distance. This addresses the shortage of psychiatrists working in rural communities, a problem that affects not only Illinois, but the nation. Many persons with mental illness live long distances from a mental health facility and have limited access to transportation, making it difficult to obtain adequate mental healthcare. The new law requires the Illinois Department of Healthcare and Family Services to reimburse psychiatrists and federally-qualified health centers (FQHCs) for mental health services provided via tele-psychiatry. Illinois joins more than ten other states which have similar regulations in place. Upon signing the bill, the Governor said. "Everyone who needs psychiatric care should be able to get it, regardless of where they live. The use of tele-psychiatry is an exciting step in expanding access to healthcare for all."

A bill clarifying the definition of “children with disabilities” was signed into law by the Governor in July. The Law establishes uniformity in the School Code making students statewide eligible to receive special education services up until the day of their 22nd birthday. It helps assure that students with disabilities are able to continue to receive the educational services they need to become productive adults. It provides Illinois schools with clear guidance on their responsibilities in this area and provides these students with a stronger foundation for life after graduation.

**Moving from Institution to Community: Leadership in Olmstead Activities**
Since the Supreme Court ruling in the case of Olmstead vs. L.C. issued in June, 1999, which stated that the unjustified institutionalization of people with disabilities is a form of discrimination under the Americans with Disabilities Act (ADA), Illinois, as other states, has been working on a state Olmstead Plan. DHS was assigned the lead role in
developing the State’s Olmstead Plan and a grant-funded DMH Olmstead Coordinator has been active in interfacing with existing statewide planning coalitions, planning and implementing regional training to inform consumers about Olmstead and encouraging their participation, and keeping consumers updated on the progress of the Real Systems Change grant activities. The coordinator has also ensured that a mental health perspective is present on the IDHS Olmstead web-site and has helped to facilitate state level partnerships in order to create new opportunities for individuals to transition to community living. During FY2005, the IDHS strengthened its operation of Olmstead activities through the newly established Disabilities Services Advisory Committee (DSAC) which is comprised of a wide-range of stakeholders and established by statute. In FY 2006, DSAC developed a strategic plan, which was submitted to and approved by the Governor and the Legislature. The Plan and updates are available on the DHS Website at http://www.dhs.state.il.us/projectsInitiatives/dsac/.

**DMH and Disaster Response Activities**

The Governor has designated the DMH as the State agency to lead disaster resource coordination and recovery functions related to mental health. Working in the context of the overall State-wide Disaster plan and the Illinois Emergency Management Administration (IEMA), the DMH coordinates Illinois’ disaster preparedness for state operated and state funded psychiatric service providers. Working primarily through its Regions, the DMH is assisting in the development of local response capability for issues of Mental Health. The operational focus includes collaboration with other state agencies, monitoring, and facilitating ongoing concordance with National Policy. The DMH participates in relevant Grant applications and collaborates with qualified partners in providing training. The DMH is also developing plans to coordinate surge deployment of mental health services in response to disasters, be they natural or caused by terrorists.

A Statewide Mental Health Disaster Preparedness Plan has been developed which recognizes the concept of local response to disaster mental health needs of Illinois communities and which builds on the strengths of the communities. Each Region has a designated Disaster Resource Coordinator to identify lead providers for each Region (generally by county for most of the state).

In recognition of the potential for natural or terrorist caused disasters in the State, an emphasis of disaster planning has been on developing and/or maintaining a local response capacity. This includes educational offerings and the availability of trained mental health professional and paraprofessional volunteers to respond to the needs of their community in time of crisis. A central list of Illinois mental health professionals who were willing to be deployed on an urgent (surge) basis is continually updated as a resource in the event of future terrorist aggression or disaster requiring a mental health response. As necessary, the Red Cross may draw down the volunteers in groups. DMH continues to provide training on disaster response in conjunction with other state agencies and entities.

During FY 2006, like many states, Illinois offered assistance to Hurricane Katrina evacuees. As the state lead on mental health in disaster planning, DMH applied for, and received an Immediate Services Program (ISP) Crisis Counseling Grant to provide services to evacuees. DMH further applied for a Regular Services Program (RSP) grant to
continue the program beyond the initial period and was one of seven states awarded an RSP.

**Update on Areas Needing Attention in FY 2007 Plan - Significant Achievements**

This section provides a brief summary of areas identified as needing attention in FY 2007 and notes significant achievements in these areas.

**Consumer Participation and Involvement**

During FY-2007, the DMH continued work on several exciting initiatives aimed at enhancing recovery services. In-service training on the foundational principles of recovery and the implementation of a recovery-oriented system was provided to the following groups and educational settings: Illinois Community College Nursing Students, Cross-Divisional MISA Training, Community Hospital of Ottawa, NAMI-Macomb, Faces and Voices of Recovery, Region 5-South Advisory Council, Region 1-Central Provider’s Meeting, South Side Office of Concerned Board of Directors Annual Retreat, Mental Health Juvenile Justice Liaisons, IAODAPCA Annual Conference, and the GROW in Illinois and Region 1 Joint Advisory Council. The training was enriched by the feedback and recommendations garnered from Consumer Focus Groups conducted as part of the SRI process.

In collaboration with the Illinois Certification Board (ICB), the Divisions of Mental Health, Rehabilitation, and Alcoholism and Substance Abuse have developed the Illinois Model for Certified Recovery Support Specialist (CRSS). The Model has defined baseline competencies and skills for CRSS professionals. Access to this new credential became available through the ICB beginning in July of 2007. As a means of disseminating information regarding this new credential, training on the conceptual approach to certification was provided for interested stakeholders at conferences convened by the MISA Training Institute in FY 2007.

Since the inception of the Wellness Recovery Action Plan (WRAP) Initiative in Illinois in FY 2003, nearly 200 individuals (including consumers currently receiving services) have completed training to receive Certificates as WRAP Facilitators through completion of a 40-hour intensive course. Eighty (80) new individuals received this training in FY 2007. Refresher/Continuing Education courses are held bi-annually for Certified WRAP Facilitators. Additionally, training on WRAP for providers who work with teens through DMH-funded child-serving agencies and the Mental Health Juvenile Justice Initiative began in FY 2007.

DMH Recovery Support Specialists work with stakeholders to design, plan and convene annual consumer conferences in each DMH region. These conferences typically have a well-known national speaker who delivers the keynote address and who sets the "tone of recovery" for the conference. Consumer education is provided through a variety of venues in the state. Eight (8) regional conferences were held across the state during FY 2007. Hundreds of consumers, family members, providers, DMH and other state agency staff attended these conferences.
C&A Services focused on family participation by increasing the availability of family resource developers (FRDs) and the advisory role of youth who utilize or have utilized services. Of the 54 agencies providing SASS services, only three of the agencies have never hired a FRD. There is generally a modest level of turnover in the FRD staff, and at the point that the FY 2007 FRD survey was conducted 41 of 49 reporting agencies (84%) had FRDs employed. Thirty-one (76%) were FTE positions. Monthly meetings are held for the FRDs in order to provide education, resource development and support for the positions. FRDs from the Federal Systems of Care demonstration grants also attend these meetings. The survey results could not specify the number of positions that were FY 2007 new hires. Some agencies have expanded the support role and are using FRDs to assist with Individual Care Grant application processes and service planning. Each System of Care site has emphasized the importance and hiring of FRDs.

The Teen Advisory Group Meetings were held each month in FY 2007 to provide feedback to the C & A network regarding quality of care. Members of the group are compensated for each meeting they attend. During FY2007, the group conducted a survey of mental health counselors in the system regarding their perceptions of the counseling services they provide the problems they encounter and their clinical roles. As part of the analysis and report to the C&A Advisory Council, they are comparing their own experiences with counseling to identify differing perceptions of issues involved in access and treatment.

Evidence-Based Practices

During the year, the DMH continued major initiatives to adopt and implement evidence-based practices in various areas across the state. Work continues to implement Supported Employment (SE), Family Psychoeducation, Integrated Dual Diagnosis Treatment (IDDT), Medication Algorithms and Wellness Recovery Action Planning. As an early adopter of Assertive Community Treatment (ACT), the DMH continues to work with agencies to ensure that the evidence-based ACT model is utilized within the State. Work also has continued on two SAMHSA System of Care grants. One involves all child-service systems and partnerships in the Metropolitan Chicago area. The second involves child service systems and partnership in McHenry County, Illinois. A major focus of these grants is the adoption of evidence-based and best practices.

The DMH has made significant strides in implementing and planning for the implementation of EBPs in the last few years. Efforts are underway to pilot each of the adult EBPs identified by SAMHSA. In July 2007, the DMH convened a statewide conference, entitled Evidence-Based Practices in Illinois: A State of Change. Experts on each of the EBPs made presentations on focusing on implementation, organizational and financing issues that should be taken into consideration when planning for implementation. Approximately 300 individuals (consumers, family members, advocate, providers and state agency staff) attended the two day conference. These efforts address SAMHSA’S National Outcome Measure of Implementing Evidence-Based Practices.

Systems Integration

The DMH continued collaborations with many system partners including, collaboration with the Education system on the Positive Behavior Interventions and Support Model. The DMH continued its partnership with the Illinois Department of Healthcare and
Family Services (the Illinois Medicaid agency) and the Illinois Department of Children and Family Services (the Illinois Child Welfare Agency) on the purchase of Screening, Assessment and Support Services (SASS) for children and adolescents and their families. DMH and the Division of Rehabilitation Services’ continue its collaboration the ‘Brand New Day Initiative' and the provision of Benefits Planning, Assistance and Outreach Project funded by the Social Security Administration. DMH also collaborates with the City of Chicago Mayor's Office for Persons with Disabilities on the latter initiative. Collaborative work with the Illinois Department on Aging on joint training and advocacy programs.

**Program Enhancement**

The DMH continued work on a SAMHSA funded statewide initiative to move toward a violence-and-coercion-free hospital environment, reducing the need for seclusion and restraint as alternative person-centered interventions are established.

**Service Administration**

During FY 2006, the DMH revised Medicaid Rule 132 to support the service system changes that will be necessary in the transition to a Fee-for-Service System. In FY2007, workgroups continued to meet and participate in planning for this initiative. The DMH also continued to work with consultants to identify technical assistance needs of providers and to provide technical assistance to support the move to the fee-for-service system.

**Information Technology**

DMH continues its efforts to refine and streamline data collection efforts to provide information that supports decision-making. An assessment of the MIS has been undertaken to determine how the system will need to be modified to support the DMH SRI initiative.

**Grants**

In FY-2007, the DMH received continuation grants for the following areas: Data Infrastructure for Quality Improvement; the Training and Evaluation grant from SAMHSA to continue work on Integrated Dual Diagnosis Treatment (IDDT), Work Incentive and Planning Assistance Services for SSI/SSDI Beneficiaries, Supported Employment; a SAMHSA Targeted Capacity Expansion - Jail Diversion grant called the Community Reintegration Collaborative to support the DMH Jail Data Linkage Program; and two grants in child and adolescent services: System of Care-Chicago, and a second System of Care grant focusing on McHenry County originally awarded by SAMHSA in 2005.

The System of Care-Chicago (SSOC) project was developed in response to the multiple needs of children and youth who are involved in several service systems. Planning for the service implementation began in the first year of this five-year, $9.5 million grant from SAMHSA. A curriculum on evidence-based practices was developed based upon information regarding the types of mental health challenges and diagnoses presented by the children involved in the initiative. Significant goals for training in evidence-based practices were established this year, with a major training effort also implemented. Increased focus on the implementation of EBPs for children and adolescents will occur in FY 2007.
REPORT ON THE FY2007 ADULT SERVICES PLAN

CRITERION I:

Objective 1.1  Consumer Education - Continue to enhance the statewide system to educate consumers of mental health services in leadership, personal responsibility and self-advocacy through participation in Network Consumer Conferences, and the use of Wellness Recovery Action Plans (WRAP).

Indicators:

- Number of Regional consumer conferences held
- Number of Certified WRAP facilitators trained
- Number of WRAP and Recovery Education Groups established in FY 2007
- Total number of established WRAP and Recovery Groups in DMH funded community agencies and state hospitals

This objective has been completed with excellent results. Education for consumers of mental health services in the above areas has continued to be emphasized in FY2007. Consumer education is provided through a variety of venues.

- Eight (8) regional conferences were held across the state during FY 2007. Hundreds of consumers, family members, providers, DMH and other state agency staff attended these conferences. DMH Recovery Support Specialists work with stakeholders to design, plan and convene annual consumer conferences in each DMH region. These conferences typically have a well-known national speaker who delivers the keynote address and who sets the "tone of recovery" for the conference.

- Eighty (80) new individuals received WRAP certification training in FY2007. Since the inception of the Wellness Recovery Action Plan (WRAP) Initiative in Illinois in FY 2003, nearly 200 individuals (including consumers currently receiving services) have completed training to receive Certificates as WRAP Facilitators through completion of a 40-hour intensive course. Refresher and Continuing Education courses are held bi-annually for Certified WRAP Facilitators. Additionally, training on WRAP for providers who work with teens through Child and Adolescent agencies and the Mental Health Juvenile Justice Initiative began in FY 2007. Four WRAP Facilitators Training events were held during FY-2007. Three of these events were held for new Facilitators of Adult WRAP classes. One event was held for Facilitators of new Teen WRAP classes.

- Thirty (30) new WRAP and Recovery Education groups were established in FY-2007.

- Approximately 30% of DMH funded community agencies now have WRAP and Recovery Education groups and 50% of state operated hospitals now have WRAP and Recovery Education groups.

The provision of mental health care that is consumer and family driven is an important priority of the Illinois Division of Mental Health. This priority is consistent with the President’s New Freedom Commission recommendations to involve consumers and
families in orienting the mental health system towards recovery, and to improve access to, and accountability for mental health services. Several years ago, in an effort to create uniformity in consumer participation across the state, the DMH Office of Recovery Services (formerly known as the Office of Consumer Affairs), working in collaboration with DMH Regional Managers and consumer specialists, developed a statewide consumer participation plan. The plan was founded on the identification of successful practices in various parts of the state that have led to increased consumer participation. These practices were incorporated into the strategic planning efforts of the DMH regions. Also, in an effort to assure more consumer and family voice in planning efforts, representation by consumers and parents of children with serious emotional disturbances has increased on the Mental Health Planning Advisory Council.

Objective A1.2: Continue to provide training system to all interested stakeholders that support the role of consumers as advocates and participants in the mental health service delivery.

Indicator:
- Number of recovery oriented training sessions provided to stakeholders.

This objective has been completed. Training on the fundamental principles of recovery and the implementation of a recovery-oriented mental health system was provided to stakeholders at twelve training events occurring in a variety of groups and educational settings.

During FY 2007, in-service training on the fundamental principles of recovery and the implementation of a recovery-oriented mental health system was provided to the following groups and educational settings: Illinois Community College Nursing Students, Cross-Divisional MISA Training, Community Hospital of Ottawa, NAMI-Macomb, Faces and Voices of Recovery, Region 5-South Advisory Council, Region 1-Central Provider’s Meeting, South Side Office of Concerned Board of Directors Annual Retreat, Mental Health Juvenile Justice Liaisons, IAODAPCA Annual Conference, and the GROW in Illinois and Region 1 Joint Advisory Council. The training information was enriched with the addition of data outcomes of Consumer Focus Groups. During FY 2008, there will be a continued focus on providing training to stakeholders to support consumer participation in mental health planning and service delivery efforts.

Objective A1.3 Engagement Services - Enhance access to Engagement Services by increasing the number of community mental health agencies funded to employ recovered consumers as engagement specialists to engage other consumers to participate in available services.

Indicators:
- Funding allocation for services
- Number of agencies funded
- Number of consumer positions filled in FY 2007
This objective has been completed. In FY2007, one agency was allocated funding in the amount of $61,200. The DMH has also undertaken an initiative to certify recovery support specialists with CRSS credentialing. It is hoped that professional credentialing will result in more consumers being hired as service providers.

Objective A1.4. With stakeholders in the mental health service system, continue assessment of the feasibility of implementing and utilizing the outcome and performance measures associated with the federal Center for Mental Health Services (CMHS) Data Infrastructure Grant for Quality Improvement.

Indicators:
- Number of meetings with stakeholders including consumers and family members to review and discuss the DIG QI performance measures
- Number of stakeholders participating in training provided in the use of DIG QI and other DMH performance measures for planning.

This objective has been completed. The DIG Principal Investigator has discussed some of the DIG QI performance measures with members of the Mental Health Planning & Advisory Council (MHPAC) in two meetings during the course of the year. More discussion is warranted and this topic will continue to be addressed in MHPAC meetings. Since the initiation of Data Infrastructure Grants (2000), project staff have provided education to stakeholders regarding outcome and performance measures and have actively engaged them in planning and implementing these efforts. Structures have been established for obtaining ongoing stakeholder input at both the State and Regional level.

Objective A1.5 Medication Algorithms - To continue and increase training and implementation of medication algorithms which is an evidence-based practice.

Indicators
- Number of agencies completing training at each level
- Number of consumers enrolled in algorithm treatment
- Completion of revisions to the depression and bipolar algorithms
- Construction of a website that will provide downloads of educational and other materials that support algorithm use

This objective was largely completed and exceeded in terms of the training provision. During FY 2007, seven (7) agencies completed Level 1 Education regarding CIMA and Medical Algorithms as an EBP. Four agencies participated in Level 2-Implementation Planning and then completed Level 3-Clinical Training. Although plans were made to collect data on the number of consumers enrolled in algorithm treatment, data collection was not undertaken in FY2007 because funding was not available to establish a database. The schizophrenia, depression and bipolar algorithms were updated and approved during FY 2007. A training and education conference on the use of medication algorithms was conducted on June 6, 2007 in Springfield followed by a presentation at the DMH EBP Conference that was held in July 2007. A website that provides downloads of educational and other materials that support algorithm use was

The Center for the Implementation of Medication Algorithms (CIMA) is a DMH-funded initiative to disseminate empirically informed medication algorithms, patient and family education, and outcomes assessment systems that support the psychopharmacotherapeutic treatment of schizophrenia, major depression, and bipolar disorder, consistent with recommendations of the President’s New Freedom Commission on Mental Health. Since its inception in July 2004, CIMA has provided education, implementation planning, and clinical training to personnel in mental health treatment agencies across the state using a three-stage education model. Level 1 educates interested service providers about the role of CIMA and the training and implementation requirements for implementing medical algorithms as an EBP. Level 2, the second stage, is implementation planning during which a provider completes an assessment to determine the changes that would be required for the conversion of existing service delivery practice to the use of medical algorithms. Level 3 is the actual training of the service provider to implement medication algorithms. The cumulative total of facilities participating in the CIMA project through FY 2007 is: Level 1 (Education)-40; Level 2 (Implementation Planning)-22; and Level 3 (Training)-19.

During FY 2008, CIMA will focus more effort on medication algorithm coordination between Community Mental Health Centers and State Operated Hospitals for continuity of care purposes. Consistency in medication management practices can improve patient outcomes in the continuum of treatment that begins in state operated facilities and continues with community mental health providers.

**Objective A1.6  Supported Employment - Continue to expand the implementation of evidence-based practices that are provided for persons seeking employment.**

**Indicators:**

- Number of consumers receiving supported employment who are employed in competitive jobs
- Implementation of objectives specified for the Supported Employment Planning and Implementation grant funded by the Johnson & Johnson/Dartmouth Community Mental Health Program
- Implement evidence-based supported employment in 3 or 4 new sites. For each new site, establish a base-line fidelity assessment and ongoing fidelity reviews. (To ensure it is evidence-based supported employment)
- Establish agreed upon outcome measures for Supported Employment (between DRS & DMH).

**This objective has been completed.** Eleven mental health agencies, in partnership with their local DRS offices, are piloting the implementation of Evidence-Based Supported Employment (EBSE). From September 1, 2006 to June 30,2007, 1,096 individuals were enrolled in the program and received EBSE services. During that time 32% of the enrollees worked in a competitive job which resulted in over 17,000 days of employment during the 6 month period from September 1, 2006 to March 31, 2007 and, with the 187
additional enrollees in the following quarter, persons enrolled in EBSE held a competitive job for 19,159 days between April 1 and June 30, 2007. Four new pilot sites were established after consensus was reached within the agencies to implement EBSE. An outcome measurement system for use with the pilot sites was established.

Supported Employment is an evidence-based practice that has been shown to improve employment rates of persons with serious mental illness by as much as 60%. The DMH currently has two grants to assist in implementing this model in Illinois: a NIH/SAMHSA Planning grant to address state infrastructure issues and a Johnson & Johnson/Dartmouth Community Mental Health Program Grant to support implementation at four pilot sites. The NIMH/SAMHSA grant officially ended in September 2007 while DMH is now entering Year Three of the Johnson and Johnson/Dartmouth grants. The DMH and the DHS/Division of Rehabilitation Services (DRS) are jointly collaborating to implement this evidence-based practice initiative. Additionally, the DMH tracks employment status of adults seeking community mental health services on an on-going basis (see system performance indicators A1.4 and A1.5).

**FY2007 Outcomes and Accomplishments**

Seven goals were established under the NIH/SAMHSA and Johnson and Johnson/Dartmouth Grants for FY2007. The goals and their respective outcomes are described below:

1. *Work with four pilot sites to establish consensus to implement EBSE (J & J/Dartmouth):*
   **Outcome:** Four new pilot sites were established after reaching consensus to implement EBSE.

2. *Establish a financing plan for EBSE (NIH/SAMHSA)*
   **Outcome:** The plan has been completed and will be piloted in FY2008.

3. *Adapt EBSE fidelity criteria for inclusion into DMH service standards (NIH/SAMHSA)*
   **Outcome:** Service and billing codes related to EBSE have been incorporated in the DMH service taxonomy. EBSE fidelity criteria has also been included in the FY2008 pilot agency contracts.

4. *Establish a statewide EBSE steering committee (NIH/SAMHSA):*
   **Outcome:** During FY 2007 the committee, which is comprised of a wide range of stakeholders was established. The committee will continue into FY2008.

5. *Build state capacity to provided technical assistance (TA) for EBSE (NIH/SAMHSA and J & J/Dartmouth):*
   **Outcome:** A technical assistance model for EBSE has been developed and work will continue on refining the model in FY2008. Staff from the early adopter community mental health agencies have as well as two DMH staff and one DRS staff person have received training from Dartmouth to provide Technical Assistance. Varying levels of TA are being provided to the 11 pilot agencies.

6. *Establish a protocol for ongoing evaluation of EBSE implementation (NIH/SAMHSA)*
   **Outcome:** The SHAY, which is an organizational assessment evaluation tool, has been implemented. Baseline data was collected and follow-up data has been collected during Year 1 and Year 2 (FY 2006 and FY 2007) of the implementation.
Submit an implementation proposal for funding (NIH/SAMHSA):

**Outcome:** A structure has been developed for the proposal. It is expected that a proposal will be developed and submitted in FY 2008.

Additional accomplishments this past year also include:

- The development of clear guidelines for community mental health agencies on how to bill for EBSE services
- Establishment of billing/service codes
- DRS & DMH agreement on how to blend funding to support full implementation and reward milestone outcomes
- A well-established statewide steering committee
- Ongoing learning of technical assistance needs and strategies to guide mental health agencies and their local DRS offices on how to implement
- Provision of training and technical assistance to the 11 pilot sites
- Frequent presentations to stakeholder groups at consumers conference, NAMI conferences as well as in other venues
- Establishment of an outcome measurement system for use with the pilot sites

**Objective A1.7.** Assertive Community Treatment - Maintain Illinois’ Assertive Community Treatment initiative by developing a plan to assess and monitor the delivery and quality of ACT services.

**Indicators.**

- Plan developed to monitor fidelity of ACT services

**This objective has been completed.** During FY 2007, the block grant objective to develop a plan to monitor the fidelity of ACT services was accomplished.

Fifty ACT teams are currently operating statewide. During FY 2007, the Illinois ACT model was revised as part of the State Medicaid Plan Amendment to bring it into line with the national ACT Model. As the monitoring plan is implemented in FY2008 more emphasis will be placed on achieving fidelity in concert with the national ACT model. During FY 2008, DMH will provide additional technical assistance to agencies that elect to provide ACT services to help them to make the transition in meeting the national ACT fidelity requirements. If agencies do not have the capacity to deliver the evidence-based ACT model, they will be able to adopt a step-down model of the Community Support Team, an intensive approach to community support and case management which is being established statewide.

ACT is the most intensive specialized model of case management in which a team of mental health professionals takes responsibility for a small group of program participants’ day-to-day living and treatment needs. These individuals typically require assertive outreach and support to remain connected with the necessary mental health services to maintain their stability in the community. Often these consumers have a history of repeated admission to psychiatric inpatient or excessive use of emergency services. Previous efforts to provide linkage to necessary services have failed and the need for multiple services requires extensive coordination. The active participation of
Objective A1.8. Continue implementation of the SAMHSA grant to implement and evaluate the SAMHSA Integrated Dual Diagnosis Treatment Resource Implementation Toolkit.

Indicators:
- Number of IDDT training sessions provided to participating agencies
- Number of technical assistance consultations provided
- Number of consumers enrolled in project evaluation component

This objective was exceeded. Thirty-five (35) training sessions and 103 individualized consultations and technical assistance visits were provided to participating agencies to increase their capability to treat clients with co-occurring disorders. One hundred and thirteen (113) consumers have been enrolled in the evaluation component of the project. Additionally, three agencies began the process of implementing Integrated Dual Diagnosis Treatment (IDDT), six agencies using the Dual Diagnosis Capability in Addiction Treatment (DDCAT) scale, improved their capability measures and are in the Dual Diagnosis Capable range, and one agency has become Dual Diagnosis Enhanced.

The Division of Mental Health continued with its work on the three year Training and Evaluation grant funded by SAMHSA CMHS in FY 2004. Training and evaluation in the IDDT model continued in FY2007 with nineteen agencies (17 community-based agencies and 2 state hospitals) located in Chicago. During the past fiscal year it was established that consultation and technical assistance were the key means of strengthening the ability of agencies to move toward providing Integrated Dual Diagnosis Treatment services.

During the FY 2007 fiscal year, the IDDT project continued to use the Integrated Dual Diagnosis Treatment Fidelity Scale; a component of the IDDT Resource Implementation Kit published by SAMHSA and added the Dual Diagnosis Capable in Addiction Treatment (DD-CAT) Scale developed by Mark McGovern from Dartmouth University. Both instruments provided the IDDT project with the opportunity to assess agency capabilities to improve and to provide integrated treatment services. Those DMH staff and consultants trained to use the fidelity scales were able to assess participating agencies and provide tailored technical assistance and consultation geared toward strengthening each agency’s ability to move toward providing IDDT. As a result, agencies were provided the opportunity to assess their capability to commit to implementation of the IDDT model or to move forward with the necessary changes that would enhance their capability to provide IDDT services.

During FY 2007, the following accomplishments were completed with the participating agencies:
• Seventeen Assessments were completed with agencies to determine their readiness to implement IDDT, their fidelity to the IDDT model or their level of dual diagnosis capability in addiction treatment.
• Thirty-five training sessions and one hundred and three individualized consultations and technical assistance visits were provided to participating agencies to increase their capability to treat clients with co-occurring disorders.
• One hundred and thirteen consumers have been enrolled in the evaluation component of the project.
• Three agencies have actually begun the process of implementing IDDT.
• Six agencies using the Dual Diagnosis Capability in Addiction Treatment (DDCAT) scale, improved their capability measures and are in the Dual Diagnosis Capable range.
• One agency has become Dual Diagnosis Enhanced.

Also during the FY 2007 fiscal year, the IDDT project increased its quality improvement approach with additional statewide education and leadership to promote IDDT. The project advisory committee continued to meet and provide valued feedback on promoting IDDT and recovery.

This FY 2007 objective was met but this initiative will not have an FY 2008 objective. The DMH will assess the feasibility of realigning these activities with new funding. This may result in the restructuring of the activities or the redistribution of individual components through working agreements.

**Objective A1.9. Family Psychoeducation - Develop planning and implementation activities that focus on the dissemination of family psychoeducation, which is an EBP.**

**Indicator:**
• Number of DMH Regions with family psychoeducation planning committees established in FY 2007

**This objective has been accomplished and is continuing in FY2008.**

Although three regions were initially involved in planning for the implementation of Family Psychoeducation, only one was able to sustain its planning committee, which evolved as a public/private Family Psychoeducation (FP) implementation group. The activities of this committee have resulted in the formation of a number of family psychoeducation programs. Staff from community agencies, along with DMH Region One and central office staff, continue to meet and provide mutual consultation on clinical, financial, and implementation issues, and to report on progress in individual program growth. These collaborative efforts to implement EBP FP in Illinois have resulted in an increased number of providers who have adjusted their treatment focus to extend services to more families, when doing so would clearly benefit the person with the illness, and additional formal EBP-model FP programs.
It is expected that stability for FP may be achieved after: 1) Providers understand that the practice is consistent with the new DMH and Medicaid funding; and 2) DMH identifies the resources for training, assisting, and monitoring providers’ fidelity to the FP model. The objective for FY 2008 will focus on continuing EBP implementation efforts and mental health system monitoring of the variables that shape Illinois’ ability to expand FP as an evidence-based practice.

**Objective A1.10.** Initiate a public awareness campaign to reduce the stigma associated with mental illnesses.

**Indicators:**
- Collaborative working relationships will be developed with interested stakeholders (MHPAC, pharmaceutical companies etc) who can assist with the project
- Work will be undertaken to explore the establishment of a consumer speaker bureau to address stigma issues; the number of presentations by consumers to address stigma issues when the bureau is established
- Materials developed for dissemination that address stigma issues

**This objective was accomplished.** During FY 2007, the Division of Mental Health allocated $200,000 to implement an anti-stigma campaign targeting adults. The DMH used this funding to develop public service brochures, and T-shirts, buttons, and a variety of other items that carry the anti-stigma message and DMH phone and web contact information to access services. Ad concepts and promotional materials and the distribution plans and marketing methodology will be completed by end of calendar 2007. The establishment of a Speakers Bureau was deferred until after the actual launch of the anti-stigma campaign (March- April 2008) which will incorporate local presentations at professional meetings, press conferences, media interviews, and consumers real life stories live and on the website to promote the campaign theme.

The Report of the President's New Freedom Commission on Mental Health noted that the "stigma that surrounds mental illnesses is one of three major obstacles preventing Americans with mental illnesses from getting the excellent care that they deserve". One way in which to address this issue is to implement strategies geared toward reducing the stigma associated with mental illness. During FY 2007, the Division of Mental Health allocated $200,000 to implement an anti-stigma campaign targeting adults. Early in the year DMH developed and distributed a series of three information brochures (in English and Spanish) which outlined the Services available through DMH and its contracted community agencies; provided information about how to access these services and what to expect in care delivery; and described the Evidence-Based Services available in Illinois. All brochures were to designed to increase the awareness of the public as to the benefits of securing MH services and the expectation of recovery that the DMH advances as its Mission. The Division is also distributing materials developed and supported by SAMHSA for the national “What a Difference a Friend Makes” anti-stigma campaign. A public relations firm has been contracted to insure that public service announcements and opportunities to distribute anti-stigma information occur at large public entertainment events and through mass media outlets. The Department of Human
Services is also expanding exposure of the anti-stigma message by insuring that the materials are distributed at the conferences and other public activities that are sponsored by other DHS Divisions.

A contract was awarded in March, 2007 to a vendor to develop and produce a comprehensive statewide anti-stigma campaign targeting persons with mental illnesses, persons related to them through a personal or professional contact, those persons who have influence on decision making for persons with mental illnesses, especially minor children, and the general public. In early Fall of 2007, a series of six community meetings and 14 focus groups (comprising a total of 300 persons in attendance) were held with various separate constituencies to assist in the selection of marketing and promotional concepts for the anti-stigma campaign. Collaborative networking has been accomplished (and continues) with the Illinois Children’s Mental Health Partnership, MH 708 boards, advocacy and trade associations and other interested stakeholders to cooperatively participate in the campaign's future launch and local roll out activities.

In general, the goals of the campaign are to:

• Reduce the stigma of mental illness that prevents people from seeking or offering help and support, and
• Build a larger and stronger base of support for people with mental health challenges, and for an effective network of services and programs to meet their needs.

Strategies to achieve these goals include:

• Reframing mental health by raising the subject in non-threatening and strength-based manner.
• Creating “virtual” and real contact opportunities to interact and share experiences with each other, with influencers, with people who have mental illnesses.
• Transmitting reliable and valued information.
• Delivering relevant, valued, and culturally competent messages.
• Acknowledging existing disparities in access to services for underserved populations.
• Facilitating pathways to resources and services.
• Strengthening the capacity of influencers.
• Educating policymakers and others.
• Actively pursuing and inviting participation by consumers, parents, and mental health professionals.

The planned activities for the Campaign include the use of public service ads on the radio, out-of-doors, and online; a Web site; media outreach/public relations, and a variety of materials such as posters, brochures, and printed fact sheets which are available to download. Most important, the campaign will focus on the development of partnerships and the pursuit of events, speaking opportunities, and outreach efforts to spread knowledge about mental illnesses, the difficulties faced by mental health consumers as a result of stigma, and to develop an effective network of services and programs to meet their needs.

**Objective A1.11. In collaboration with the Illinois Department On Aging (IDOA), improve access to Mental Health and Aging services through:**
• Continued DMH leadership of the Geriatric Advisory Council, the DMH and Department on Aging Systems Integration Task Force, and the Geropsychiatric Project.
• Continued provision of training using the Geropsychiatric training manual at regional forums convened across the state.

Indicators
• Number of training sessions scheduled and held
• Number of geropsychiatric specialists providing treatment to persons receiving publicly funded mental health services across the state

This objective has been accomplished.
The Geropsychiatric Initiative focuses on three key areas: systems integration, mental health services/consultation and training/education.
• More than thirty (30) training sessions using the Geropsychiatric training manual were scheduled and held at regional forums convened across the state.
• In FY 2007 there were five (5) funded positions for Geriatric Specialists that cover 27 counties throughout the southern part of the state. The Geriatric Specialists provided treatment and education resources for mental health services to the aging throughout the state and gave presentations at the national American Society of Aging/National Coalition on Mental Health and Aging. They also assisted in the cross training of the Illinois Department on Aging staff regarding domains on the Comprehensive Case Management Assessment.
• The Division of Mental Health and the Illinois Department of Aging also collaborated with resources and expertise to develop, market and present three conferences: the Annual Statewide Mental Health and Aging Conference; the Behavioral Health, Aging and Wellness Conference; and the Rural Aging Conference.

More than 1.9 million persons over the age of 60 reside in Illinois, representing nearly 20% of the state population. It is conservatively estimated that 15-25% of individuals over age 60 experience symptoms of mental disorders as they are considered to have a higher incidence than other age groups due to increasing number of life stressors and increased vulnerability to experiencing mental health problems. Despite this fact they often do not seek, or are not successful, at linking with needed mental health services. Several systems of care play a role in the delivery of mental health services to the older adult including mental health, aging, primary medical care, and public health. In recognition of the importance of coordinating services for this population, the Division of Mental Health convenes an Advisory Committee on Geriatric Services jointly with the Illinois Department on Aging (DOA). This advisory committee has focused its efforts on the assessment of the mental health needs of elderly persons, identification of model programs and best practices and identifying the competencies needed to serve this population. The Council also promotes increased awareness of geriatric mental health concerns and has provided training, consultation and technical assistance in the area of mental health and aging issues. The Geriatric Advisory Council developed a position paper on issues of Self-Neglect that was used widely throughout the state including a
Self-Neglect Forum and the Self-Neglect Task Force. The Division of Mental Health contributes staff to participate in the Self-Neglect Task Force, and the “Aging is an Asset” project convened by the Illinois Department on Aging. The DMH also serves in an advisory capacity to the statewide, Northern and Southern Mental Health and Aging Coalition. The Illinois Department on Aging has developed a proposal to fund a statewide expansion of the Gero-Psychiatric Project through the Division of Mental Health.

Geropsychiatry Services: This mental health and aging systems initiative establishes a geropsychiatric specialist in a comprehensive community mental health center with access to a psychiatrist, board certified in geropsychiatry, to improve access, availability and quality of mental health services for older adults (age 60 and older) with mental health needs. The program strives to positively enhance integration of mental health, aging, primary medical care and public health systems to enhance the effectiveness of mental health service delivery to this population.

Objective A1.12. Maintain the tracking system for persons adjudicated Not Guilty by Reason of Insanity (NGRI) who have been released to the community.

Indicator:
- Number of persons adjudicated as NGRI who have been released and maintained in the community

This objective continues to be accomplished. The tracking system has been maintained. In FY2007 sixteen persons were adjudicated as NGRI and released and maintained in the community. In FY2007, 76 individuals conditionally released under Not-Guilty-by-Reason of Insanity statutes were and are currently being monitored in the community by DMH forensic services. Agency compliance rates for progress reports to the court are 100%. There has been only one revocation of conditional release status due to improved communication between DMH and service providers.

Objective A1.13 Improve linkage services for individuals with serious mental illness released from Illinois jails. Evaluate the outcome goals of the implementation stage of the CRC grant initiative.

Indicators:
- Evaluate the outcome goals of the Data-Link Phase II initiative.
- Assess success of efforts to sustain linkage and jail diversion mental health initiatives in Illinois.

This objective has been accomplished. The Data Link Phase II Initiative and the CRC grant initiative have both made substantive progress toward meeting their planned outcome goals in FY2007.

The current phase of the Jail Data Linkage Project began in FY 2006 with funding of $374,000. It is funded by the Federal Anti-Drug Abuse Act and is administered by the Illinois Criminal Justice Information Authority. In contrast to Phase 1, dedicated case managers have been hired, under contract to community mental health agencies in Phase 2, so that better coordinated services can be provided and the web-based database has
been significantly upgraded. The Jail data Link Phase II initiative (JDL2) has been successful in developing information sharing agreements between DMH, DMH providers, and four county jails. An automated Client Information Form (CLIF) was initiated to enable case management, jail administrative, and DMH administrative staff to communicate with each other regarding identified cases, and provide permanent data records future reference and program analysis. JDL2 Jail and case management staff have been trained in the linkage process and provided with regular supervision. From April 1, 2006 to September 30th, 2007 the Data-Link Phase II initiative has identified 2856 unduplicated individuals with open DMH cases in the participating counties of Will, Peoria, Jefferson, and Marion. 493 of these individuals were determined to be eligible for services and 238 were successfully linked to community services. Linkage rates for the four counties averaged 42% for eligible individuals.

FY2007 data collection has demonstrated a need for additional follow-up procedures to insure an accurate measurement of the referral and linkage of jail inmates to services. The referral process was voluntary for inmates and DMH relied on CMHCs to maintain systems for reporting when referred jail inmates sought out services. The Jail Data Link Project continues to be a primary DMH initiative for linking adults in Illinois’ county jails with SMI to mental health services. Improved reporting will be a goal for FY 2008 and the FY 2008 dataset will be used as the baseline for measuring future progress.

DMH has collaborated with two community providers (Thresholds and TASC), the Chicago Police Department, and the University of Illinois on a Jail Diversion Targeted Expansion Grant funded by SAMHSA that is referred to as the Community Re-Integration Collaborative (CRC). The CRC includes the Crisis Intervention Team Program (CIT) that uses specially trained police officers to respond to mental health crisis. The objectives of CRC continue to be: (1) to support community based mental health services for individuals who have a mental illness or co-occurring disorder who are diverted from the criminal justice system; (2) assure that jail diversion programs are based on best practices; (3) form and support interagency collaboration between the appropriate criminal justice, mental health and substance abuse systems; and (4) engage in policy analysis and developmental activities at a local level to promote implementation and sustenance of diversion activities. In meeting these goals CRC has successfully completed its Year Two implementation phase and expanded Cook County Mental Health Court services. In FY 2007, coinciding with the second year of the SAMHSA jail diversion grant, the Community Re-integrative Collaborative has expanded its linkage efforts and is on course to provide services to an additional 115 clients through community agencies or CIT interventions. Efforts to sustain the expanded mental health court initiative in Cook County include the successful application and award of a grant from the Bureau of Justice Administration (BJA). In addition the CRC grant has led to the training of over 400 CIT officers for Cook County that re-direct hundreds of cases each month from arrest and incarceration.

During FY 2008, the Division of Mental Health will continue efforts to improve its linkage and support of persons with SMI released from Illinois’ jails to: (1) reduce the length of time involved in processing and treating UST referrals in inpatient facilities, (2)
improve transition and follow-up monitoring with community services and (3) develop and maintain a tracking system for UST patients who require a continuation of outpatient fitness restoration services. As of this writing, a formal evaluation of the CRC initiative is being conducted by the University of Illinois at Chicago. The evaluation will be completed early in the next fiscal year.

**DMH Jail Linkage Project.** The Jail Linkage Project is a data integration initiative that collects and compares county jail intake information with DMH mental health client registration. Phase 1 began in June 1999 with funding from a federal Technology Opportunity Program (TOPS). The DMH and the Cook County Department of Corrections collaborated to link Cook County Jail detainee records with DMH community mental health client treatment records (ROCS). State legislation and special data sharing agreements made the web-based database, which contained both DMH mental health and criminal justice information, possible. The resulting files, made available daily to county jail and community mental health agency staff, are used as a supplement to the efforts directed towards identifying new detainees who need special mental health attention and as a means through which an offender’s treatment needs are updated. As a result of this project, improved discharge planning has occurred for detainees from the entire Cook County area, and made it more likely that detainees will successfully transition to the community and follow-up mental health services. Although the TOPS grant ended in October 2004, DMH IT staff have made upgrades to the Cook County database, and data sharing agreements remain in force.

**Mental Health Court Initiatives.** Mental Health Courts adjudicate cases where there is a question of mental health fitness to stand trial or establish accountability for behavior. When mental health fitness cannot be established criminal offenders may be determined Unfit to Stand Trial (UST) or Not Guilty by Reason of Insanity (NGRI). The DMH is directly involved in expanding the Cook County Mental Health Court through a Federal award for jail diversion that targets between 185 to 265 consumers over three years (2006 - 2008) at $399,000 annually. During FY 2007, 30 new referrals were made and there were 35 new admissions to the Cook County Mental Health Court Program. Two cases were terminated and re-sentenced. Twelve cases were accepted into Thresholds ACT services. Thus far, five Illinois Mental Health Courts have been established that work with DMH funded agencies in their local areas: Cook, DuPage, Winnebago, Madison and Kane Counties. McLean County is also considering the development of a Mental Health Court.

**Objective 1.14. Provide continuity of care for individuals found unfit to stand trial (UST) that are restored to fitness in state operated inpatient forensic programs.**

**Indicators:**
- Number of discharged UST patients linked to community services.
- Number of discharged UST patients that follow-through with appointments in community agencies within thirty days of release from jail custody.

**This objective has been completed for FY2007 and continues in FY2008.** Continuity of care continues to be the focus of services to individuals found unfit to stand trial (UST) that are restored to fitness in state operated inpatient forensic programs. In FY2007 396
UST patients were returned to court. Of these, 180 individuals made appointments for community services within thirty days of release from jail custody and kept their appointment. 161 individuals followed through with further services.

Currently, DHS provides fitness restoration services on an inpatient and outpatient basis. These services are focused on providing treatment that will allow individuals found unfit to stand trial to be restored to fitness and complete their trial process. The service involves psycho-educational and clinical treatments that will assist a person in understanding the legal process of their trial and/or working with their attorney. Current efforts are aimed at increasing the amount of these services in least restrictive community settings and monitoring the performance of outpatient providers that agree to provide fitness restoration services.

**Objective A1.15** Reduce the length of stay from the time that court orders are received to the discharge of patients referred to DHS/DMH under UST statutes.  
**Indicators:**
- the period of time between DHS receipt of court orders to placement of patients in forensic inpatient programs.
- the period of time from inpatient admission to recommendation for a court hearing based on resolution of fitness issues.
- the period of time between recommendation for a court hearing and discharge from the inpatient program.

This objective is partially accomplished and is continuing. In FY 2007 the average length of time individuals wait in custody after DHS receives a court order until placement in a DHS/DMH inpatient forensic program is twenty days with numerous outliers over 30 days. Mechanisms for the collection of evaluative data on inpatient length of stay (L.O.S) until there is a recommendation for return to court and for the length of stay between the recommendation for court hearing and discharge are being established during FY2008.

**Objective A1.16** Jointly with the DHS Division of Alcoholism and Substance Abuse (DASA), continue to facilitate services delivered through existing MISA consortiums

**Indicators:**
- Participation by DMH staff in continued work associated with the DMH/DASA Policy Academy
- Number of regional meeting convened jointly with DASA that are held with community providers to promote the use of co-occurring treatment strategies

This objective has been completed.
- In FY2007, DMH and DASA continued work associated with Policy Academy and four regional meetings were held. DMH and DASA staff attended the Policy Academy meetings convened by SAMHSA and subsequently collaborated to submit a draft plan to SAMHSA which addressed services to individuals with co-occurring disorders.
Regional meetings are held quarterly to continue work on the DASA/DMH co-location project in which providers with substance abuse expertise provide consultation to DMH staff in state hospitals. The focus of the project is to facilitate linkages to substance abuse service providers as a part of aftercare planning.

Addressing the treatment needs of individuals with co-occurring disorders requires the collaboration of mental health and substance abuse agencies at both the state, and the local level. The DMH and the DASA have collaborated diligently over the years to develop and implement initiatives which focus on consumers with co-occurring disorders. These collaborations have included:

- The addition of a sixth geographically-based Consortium focusing on integrated treatment. In each of the six areas, mental health and substance abuse providers have come together to develop and plan for the implementation of integrated services.
- Co-location projects have been established at four DMH hospitals: Elgin, Chicago Read, Madden, and McFarland state hospitals. DASA funded providers perform screening and assessment for consumers on-site, and provide consultation to DMH staff regarding substance abuse treatment needs of consumers for whom these services are warranted. DMH and DASA collaborated on the submission of a SAMHSA Grant renewal application focusing on training and evaluation of the implementation of the SAMHSA Co-Occurring Disorder Toolkit. DMH was awarded the grant, and implementation of this project continued through FY 2007 and is reported above under Objective A1.8.
- Administrators and providers from DASA and DMH participated in the SAMHSA Co-Occurring Disorder Policy Academy held in Washington DC in January 2005. The objective of the meeting was to develop a state plan to address policy and operational issues regarding the treatment of co-occurring disorders. Staffing changes prevented Illinois from continued participation in this process at the national level but plan development activities continued through cooperative efforts between DMH and DASA within the state.

OBJECTIVES RELATED TO NATIONAL OUTCOME MEASURES/PERFORMANCE INDICATORS – CRITERION I

The following objectives relate to the SAMHSA CMHS National Outcome Measures (NOMS):

Performance Objective A1.1 Continue efforts to increase the implementation of EBPs.

Indicator:
- Number of EBPs implemented

This objective continues to be accomplished. During the year, the DMH continued five major initiatives to adopt and implement evidence-based practices in various areas across the state. Work continues to implement Supported Employment (SE), Family
Psychoeducation, Integrated Dual Diagnosis Treatment (IDDT), Medication Algorithms and Wellness Recovery Action Planning. As an early adopter of Assertive Community Treatment (ACT), the DMH continues to work with agencies to ensure that the evidence-based ACT model is utilized within the State. Additionally, exploratory and planning efforts were undertaken in FY2007, to develop Illness Management Recovery (IMR) and Permanent supportive Housing (PSH) in the State.

The DMH has made significant strides in implementing and planning for the implementation of EBPs in the last few years. Efforts are underway to pilot each of the adult EBPs identified by SAMHSA. In July 2007, the DMH convened a statewide conference, entitled Evidence-Based Practices in Illinois: A State of Change. Experts on each of the EBPs made presentations on focusing on implementation, organizational and financing issues that should be taken into consideration when planning for implementation. Approximately 300 individuals (consumers, family members, advocate, providers and state agency staff) attended the two day conference. These efforts address SAMHSA’S National Outcome Measure of Implementing Evidence-Based Practices.

**Performance Objective A1.2 Continue efforts to decrease 30 day and 180 day readmission rates to DMH state hospitals**

**Indicators:**
- Percentage of adults readmitted to state hospitals within 30 days of being discharged
- Percentage of adults readmitted to state hospitals with 180 days of being discharged.

**This objective continues:** In FY2007 15.9% of the 11,165 consumers who were discharged from state hospitals were readmitted within 30 days and 11.4% (1276) were readmitted within 180 days of their discharge.

**Performance Objective A1.3 The percentage of consumers reporting positive outcome will increase in FY 2007 (See State Capacity Checklist in Appendix 2.)**

**Indicator:**
- Percentage of consumers reporting positively about outcomes

**This objective is currently in process.** Data is currently being collected from the MHSIP Consumer Survey (DRAFT Version 1.2, February 17, 2006) which was mailed out on November 15, 2007. Results will be reported in February, 2008.

**CRITERION II:**

**Performance Indicator A2.1 Increased Access to Services by the DMH Target Population**

**Indicator:**
- Percentage of the DMH adult target population receiving services
This objective continues to be successfully achieved. Over the past four years, the percentage of adults receiving services who met the criteria for the target population has remained at 56%.

In FY 2004, 56.1% of adults receiving services met DMH criteria; in FY 2005, the percentage increased very slightly to 56.5%. The figure obtained in FY2006 was 56.6% and now, for FY2007, the figure is 56.43%. However, it is to be noted that the actual numbers of target population has increased from 69,135 in FY2005 to 80,060 in FY2007, an increase of 15.8% in two years accounting for almost 11,000 additional persons receiving the services required by and designed for individuals with serious mental illnesses. From FY2006 to FY2007, the total number of adults served increased by 12,300 while the target population grew by an additional 6,727 individuals (54.7%). Efforts of DMH to increase access to services by adults with serious and persistent mental illnesses is amply demonstrated in this data.

Performance Indicator A2.2 Increased Access to Services by the DMH Eligible Population.
Indicator:
- Percentage of the DMH adult Eligible Population receiving services

This objective continues to be achieved. The definition of the DMH eligible population is somewhat broader than the definition for the target population. In FY 2004, 95.3% of adults receiving services met the eligible population criteria, while in FY 2005, the percentage was 94.8%. The tentative percentage for FY 2006 represents a slight decrease to 94.2%. We continued to focus on this indicator in FY 2007 and the eligible population is now 93.6% of the total served (132,787 of 141,864), an increase of over 10,500 individuals from FY2006 when 122,209 were reported to have met the eligible population criteria.

CRITERION IV:

Objective 4.1: Utilizing Illinois' funding in federal Project for Assistance in the Transition from Homelessness (PATH) funding, further enhance case management services for persons who are PATH eligible.
Indicators:
- Number of persons receiving services under the PATH initiative

This objective continues to be achieved. In Federal FY2006 (October 1, 2005 through September 30, 2006), the last period for which data is fully available, 1,681 persons who meet PATH eligibility were served with PATH funds. Data for FFY 2007 is currently being compiled with a due date of December 17, 2007 and should be available in January, 2008.

Illinois has a history of working with homeless persons. Since 1988, Illinois has been a recipient of the former S.B. McKinney federal funding through the Department of Health and Human Services, Center for Mental Health Services, Project for Assistance in Transition from Homelessness (PATH) programs. These specialized services target
individuals who are homeless or at risk of homelessness with a serious mental illness or homeless with a serious mental illness and co-occurring alcohol and substance abuse problems. In Illinois, providers have developed an array of services that include in vivo case management, a drop-in-center, transitional residential support service, and a mobile assessment unit in Chicago.

Yearly increases in Illinois’ PATH allocations have been used to expand and enhance services to homeless persons with mental illness. In FY 2006, the funding for PATH was increased by $249,000 from $2,192,000 to $2,441,000. While PATH funding has remained in the maintenance mode for the past several years, efforts have been ongoing to increase case management services for homeless persons. The PATH allocation decreased by more than $25,000 in FY2007, from $2,441,000 to $2,414,000. However, due to the closure of a program, $236,000 is being re-directed in FY2008 to increase case management services, resulting in three new agencies being added to the PATH provider roster.

In FY2008, 7.5 FTE staff will be hired to serve an estimated additional 185 individuals who meet PATH eligibility criteria. Two agencies will serve 100 clients by hiring 2 FTE staff in each agency to serve 50 new clients, one will hire one FTE to serve 25 new clients, and one will hire 2.5 FTE staff, including a half-time recovered consumer, to serve 60 new clients. The increase in case management is being targeted to homeless persons with mental illnesses being released from jail. Subsequent to this redirection all PATH funding is used for the provision of case management services with the exception of $54,000 for a drop-in center (Rockford) and $400,000 in the Mobile Assessment Unit (Chicago) operated by Thresholds - which does in vivo outreach and engagement. In Federal FY2006 (October 1, 2005 through September 30, 2006), the last period for which data is fully available, 1,681 persons who meet PATH eligibility were served with PATH funds. The targeted number of PATH eligible consumers to be served in FY2008 is estimated at 1,866.

CRITERION V:

Objective A5.1. Increase Medicaid funding for the Illinois mental health service system. This will be accomplished by:

- Simplifying and clarifying DMH Medicaid policies and procedures.
- Developing and maintaining a system for utilization management within the Medicaid program.
- Identifying and eliminating internal barriers to increasing Medicaid billing and to enhancing eligibility for clients who use DMH funded mental health services (including patients in state psychiatric hospitals).
- Streamlining the documentation requirements of providers
- Beginning implementation of fee-for-service funding

Indicators
- Amount of FFP generated by the community mental health system

This objective has been accomplished. The Illinois Medicaid State Plan Amendment
was approved by CMS on March 14, 2007. The revised Medicaid Rule (132) was approved in the State on April 18, 2007. These products were based on extensive work directed toward simplifying and clarifying DMH Medicaid policies and procedures, reducing and eliminating barriers to increasing Medicaid billing, and clarifying service definitions. A major training effort was undertaken in Spring of 2007 to educate providers and stakeholders on the new definitions and requirements and to prepare providers to use revised and updated billing procedures. By the end of FY2007, DMH had completed more than three years of work on the System Restructuring Initiative (SRI) and conversion to a fee for service payment mechanism. The process has shifted from primarily input and planning to initial statewide implementation. Input from stakeholders was extensive during this period with more than 27 consumer and family focus groups, task-oriented workgroups with over 300 participants, and the ongoing work of an SRI Task Group. By the end of FY2007, 89 agencies had received Technical Assistance which included 25 site visits by expert consultants. An analysis of consumers served by DHS/DMH contracted community providers for FY2005 and FY2006 showed a 14% increase in total consumers served in one year. The analysis also examined the number of consumers served grouped by Medicaid, non-Medicaid, adults, youth, target and eligible and each group showed an increase in consumers served from FY2005 to FY2006. Total Medicaid billing FFP grew from $150 million in FY04 to $176.5 million in FY06 and was projected at $185 million in FY2007.

In addition to revising Medicaid reimbursement procedures, DMH developed a fee for service approach to additional services not qualified under Medicaid including outreach and engagement, stakeholder education, vocational services, and forensic services. Concurrently, new recovery-oriented services and definitions were developed. A new means of system administration utilizing an Administrative Service Organization (ASO) was planned in FY2007 and will be introduced in FY2008. The ASO will be responsible for developing and maintaining a system for utilization management, and evaluation of the service and operational processes of the system with the aim of further streamlining the documentation requirements and increasing access to FFP.

Medicaid Billing For The Adult Population

Medicaid billing has risen substantially over the years. In FY2004 Medicaid billing for adults had risen to $123,821,924, in FY 2005 it was $129,028,640 and in FY 2006 it was $149,599,641. (See System Performance Indicators A5.1, A5.2). Updated information is not yet available for FY 2007.

Allocation of Block Grant Dollars

For adults, dollars were directed toward those individuals with serious mental illness requiring supportive and supervised residential programs, community consumer support which is a component of psychosocial rehabilitation, crisis care and psychiatric leadership. A complete listing of agencies receiving block grant dollars is attached.
Objective C1.1. Continue to work with parents and parent-led organizations to facilitate parent-to-parent support, encouraging substantive feedback on enhancing the quality of services at all levels of care. This objective will be attained by working with Family Resource Developers.

Indicator:
- Number of FRDs hired by SASS programs to facilitate parent-to-parent support
- Percentage of FRD positions filled in FY 2007

This objective has been satisfactorily achieved. During FY2007, 42 FRDs were hired by SASS agencies to provide parent-to-parent support services. An annual survey of SASS agencies yielded noteworthy results in clearly showing that a majority of agencies (93%) hired FRDs. As SASS agencies often hired more than one FRD-sometimes three or four, the number of positions was not fixed except the minimum requirement of at least one FRD. Only three agencies did not meet this requirement.

DMH requires Family Resource Developers (FRDs) to be hired in SASS agencies. Increasing value has been placed on the expertise FRDs bring to the SASS teams. Of the 54 agencies providing SASS services, only three of the agencies have never hired a FRD. There is generally a modest level of turnover in the FRD staff, and at the point that the FY 2007 FRD survey was conducted 41 of 44 reporting agencies (93%) had FRDs employed. Thirty-one (76%) were FTE positions. Similar results occurred in FY2006.

At the point that the FY 2006 FRD survey was conducted 39 of 44 agencies (88%) had FRD’s employed. While the survey results could not specify the number of FRD positions that were FY 2007 new hires, it was noted that their support role has expanded as some agencies are using FRDs to assist with Individual Care Grant application processes and service planning. Monthly meetings are held for the FRDs in order to provide education, resource development and support for the positions. FRDs from the federally funded Systems of Care demonstration grants also attend these meetings.

The participation of parents/caregivers and adolescents in planning and evaluating the quality of mental health services is an important aspect of the Illinois Mental Health System. This effort has been a continuing priority during FY2007. Activities directed toward increasing family voice and participation in the provision of C&A services statewide and in DMH Regions include:

- Supporting the establishment of Family Resource Developers within Screening Assessment and Support Services (SASS) programs.
- Increasing family participation in Regional Planning Councils, and the MHPAC.
- Increasing parent-to-parent support in the Mental Health Juvenile Justice Initiative.
- Assisting and partnering with the parent-led support group that is concerned with the enhancement of the quality of services in the Individual Care Grant (ICG)
program through the provision of technical assistance.

Additional support will be given to the C&A leadership team with the hiring of parents as staff (1.5 FTE) to further these goals.

**Objective C1.2. Continue efforts to develop the DMH C&A Teen Advisory Group**

**Indicator:**
- Monthly meetings of the teen advisory group in FY 2007

**This objective was accomplished.** Meetings were held each month in FY 2007 to provide feedback to the C & A Network regarding quality of care.

The Teen Advisory Group consists of youth who are currently, or have previously, utilized C & A services. The group consists of eight (8) members who meet monthly and publish a Newsletter. Members of the group are compensated for each meeting they attend. During FY2007, the group conducted a survey of mental health counselors in the system regarding their perceptions of the counseling services they provide the problems they encounter and their clinical roles. As part of the analysis and report to the C&A Advisory Council, they are comparing their own experiences with counseling to identify differing perceptions of issues involved in access and treatment. Work with the Teen Advisory Group is a continuing objective in FY 2008.

**Objective C1.3. Continue to advance implementation of evidence-based practices in the child and adolescent service system through the System of Care-Illinois project.**

**Indicator:**
- Number of training sessions using the curriculum that are scheduled and held

**This objective has been exceeded.**

During FY 2007, the DMH/ Child and Adolescent Service System worked to increase the adoption of evidence-informed practice statewide in Illinois. The scope and range of training efforts exceeded the stated expectations. Training in child and adolescent evidence based practices was provided to C&A agency leadership on a statewide basis and comprised nine sessions – a series of three sessions held in each of three accessible locations across the State. The staff of ten child-serving community mental health centers were trained in evidence based skill sets in a comprehensive training series over the course of the year. These trainings were provided on an ongoing basis and were centered on cognitive behavioral treatment and behavior parent training. In FY2007, three university masters programs developed the curriculum and established specialty certification programs in evidence based practice for children. The Schools of Social work in the University of Illinois at Chicago (UIC) and the University of Illinois in Urbana, and the Graduate Counseling education program at Northern Illinois University in DeKalb are currently offering the certification in the 2007-2008 academic year. Two conferences on evidence-based practices, one in Chicago and one in Springfield were convened especially for parents of children with serious emotional disturbance. These events were attended by nearly 100 parents. Additionally, staff of the Statewide C&A Services collaborated with the national NAMI organization on educating families of
children on the subject of evidence based practice. This collaboration included the Illinois Federation of Families, the Individual Care Grant Parents Group and the FACES committee. The collaboration held two meetings in Chicago with parents and a national expert on C & A evidence based practices.

**Focus on Evidence-Informed Practices**

In order to broaden the application of solid and proven clinical practice with children, the DMH C&A Statewide Office is actively promoting Evidence Informed Practice (EIP). Evidence Informed Practice is defined as “a collaborative effort by children, families and practitioners to identify and implement practices that are appropriate to the needs of the child and family, reflective of available research, and measured to ensure the selected practices lead to improved meaningful outcomes”. A broad coalition of members of the Illinois C & A Advisory Committee has been assembled which includes community mental health providers (e.g. academic partners, university professors, consumer parents, advocacy groups, and a sister state agency - DCFS) to address the issue of implementing evidence-informed practices within the Illinois children’s mental health system. Training on evidence-informed practices was provided for community mental health providers, educators, and staff from other child-serving agencies involved to increase the effectiveness of the clinical services provided.

The events noted above reflect the consistent effort to actualize a five-pronged strategy, which was adopted in FY2006, for moving Illinois forward in its use of Evidence-informed practice for children and adolescents:

1. Educate C & A agency leadership on an Evidence Based Practice Paradigm.
2. Train providers in specific evidence-based treatments
3. Develop partnerships between universities that train the C & A workforce and the community provider, agencies. Develop the ability of training institutions to teach evidence based practice during the early training of practitioners
4. Review the extent to which Illinois Division of Mental Health policy supports or impedes evidence based practices.
5. Provide education to consumers on evidence-based practice.

To address the policy issues involved in moving the system ahead, the EBP Advisory Council developed a comprehensive list of action steps to be addressed at each level of the system. These steps begin at the level of the Division of Mental Health and move down to the University, agency, clinician, consumer advocacy groups and individual consumer family.

**Objective C1.4. Continue to review and strengthen community service options in the DMH ICG program and transitional programming as alternatives to residential placement for children with serious emotional disturbances.**

**Indicators:**
- Number of children served through ICG community service options in FY 2007.
This objective has been and continues to be accomplished.

The ICG program received and processed 1,201 applications in FY 2006, awarding 114 grants. In FY2006, there were 449 ICG residential placements, and 185 children and adolescents received community services under the ICG program. The percentage of youth receiving community based ICG services had increased by 23% over FY 2005. In FY2007 the ICG program served 570 youth of whom 38.5% (219 individuals) received community services.

The DMH Individual Care Grant (ICG) Program provides funds for residential treatment or intensive community treatment for children and adolescents with serious emotional disturbances who meet the criteria of severe mental illness and impaired reality testing. The ICG program is family driven, meaning that families make the decision regarding whether they wish to utilize their grant for residential or community based services. These decisions are generally made with consultation from the mental health providers working with the family. Services provided include intensive, home-based support, treatment, and respite care that allows the child to remain at home. The ICG program is unique in the sense that parents do not have to relinquish custody of their children to obtain these services.¹

Community-based ICG services are coordinated through agencies funded to provide SASS services. Agency staff work with families to identify appropriate support services. Proposed service plans are submitted by SASS to the DMH ICG community-based services coordinator, who reviews them for clinical necessity, and approves plans for a period of no longer than six months. The SASS agency then serves as a fiscal agent purchasing services as specified in the approved plan. ICG services are available across the state.

The Community Based ICG program serves as an excellent "step down" transition from residential care and as an effective transitional support for the movement from child and adolescent services to adult services. Considerable efforts have gone into providing up to twelve months of post ICG funding to facilitate transitional integration into the community and into the adult service system. The program offers a number of supports, including child support services, case coordination services, behavior management services, and therapeutic stabilization services. Collaborations have been developed between special recreation associations and community SASS programs to assist youth in developing supportive relationships and new behavior patterns in the community.

Objective C1.5. In collaboration with the Children’s Mental Health Partnership, initiate a public awareness campaign to reduce stigma associated with mental illnesses.

Indicators:
- Collaborative working relationships developed with interested stakeholders (MHPAC, The Illinois Children's Mental Health Partnership, pharmaceutical companies etc)
- Establishment of consumer speaker bureaus to address stigma issues
- Number of presentations by consumers to address stigma issues
- Materials developed that address stigma

This objective was accomplished. In FY2007, funds totaling $300,000 were allocated to implement strategies geared toward reducing the stigma families and children experience when afflicted with serious emotional disturbances and mental disorders. The DMH used this funding to develop public service brochures, and T-shirts, buttons, and a variety of other items that carry the anti-stigma message and DMH phone and web contact information to access services. Ad concepts and promotional materials and the distribution plans and marketing methodology will be completed by end of calendar 2007. The establishment of a Speakers Bureau was deferred until after the actual launch of the anti-stigma campaign (March-April 2008) which will incorporate local presentations at professional meetings, press conferences, media interviews, and consumers’ real life stories live and on the website to promote the campaign theme.

The Report of the President's New Freedom Commission on Mental Health noted that the "stigma that surrounds mental illnesses is one of three major obstacles preventing Americans with mental illnesses from getting the excellent care that they deserve". One way in which to address this issue is to implement strategies geared toward reducing the stigma associated with mental illness. During FY 2007, the Division of Mental Health and the Illinois Children’s Mental Health Partnership allocated $300,000 to implement an anti-stigma campaign targeting adults. Early in the year DMH developed and distributed a series of three information brochures (in English and Spanish) which outlined the Services available through DMH and its contracted community agencies; provided information about how to access these services and what to expect in care delivery; and described the Evidenced based Services available in Illinois. All brochures were designed to increase the awareness of the public as to the benefits of securing MH services and the expectations of recovery and resilience that the DMH advances as its Mission.

In collaboration with the Illinois Children’s Mental Health Partnership, a contract was awarded in March, 2007 to a vendor to develop and produce a comprehensive statewide anti-stigma campaign targeting persons with mental illnesses, those person related through a personal or professional contact with persons with mental illnesses, those persons who are 'influencers' on decision making for persons with mental illnesses, especially minor children, and the general public. In early Fall of 2007, a series of six community meetings and 14 focus groups (comprising a total of 300 persons in attendance) were held with various separate constituencies to assist in the selection of marketing and promotional concepts for the anti-stigma campaign. Collaborative networking has been accomplished (and continues) with the Illinois Children’s Mental Health Partnership, MH 708 boards, advocacy and trade associations and other interested stakeholders to cooperatively participate in the campaign's future launch and local rollout activities.
For further details on the goals, strategies and activities of the anti-stigma campaign, see Objective A1.10 above.

CRITERION II:

**Performance Indicator C2.1 Increased Access to Services by the DMH Child/Adolescent Target Population**

**Indicator:**
- Percentage of the DMH C&A target population receiving services

This objective has been exceeded. The FY2007 target was surpassed. In FY 2004, the percentage of children and adolescents meeting the DMH target population criteria was 33.7%. The percentage decreased in FY 2005 to 30.4%. Data for FY 2006 reflected a slight increase to 32%. However, the percentage of children and adolescents meeting the DMH target population criteria in FY2007 was 33.5% which represents an increase of 1,354 youth from 11,225 youth in FY2006 to 12,579 in FY2007. The effort of DMH to increase access to services for children with very serious emotional disturbances and their families is clearly demonstrated in this data.

**Performance Indicator C2.2 Increased Access to Services by the DMH Eligible C&A Population**

**Indicator:**
- Percentage of the DMH C&A eligible population receiving services

This objective was exceeded. The FY2007 goal was surpassed by more than 3%. In FY 2004, the percentage of children and adolescents meeting the DMH eligible population criteria was 91.3%. The percentage decreased in FY 2005 to 89.5%, further decreasing to 86.5% in FY 2006. In FY2007, the percentage increased to 88.2% representing 33,158 youth meeting the criteria, an increase from FY2006 of more than 2800 additional children and adolescents.

CRITERION III:

**Objective C3.1.** In collaboration with Chicago Public Schools, the Illinois State Board of Education (ISBE), University of Illinois at Chicago, and the Illinois Department of Children and Family Service (IDCFS), continue establishment of an integrative approach for providing a range of prevention, early identification, and intervention activities as components of the emerging “mental health in schools” model

**Indicator:**
- Continued meetings to establish an integrative approach across service systems
This objective has been achieved. Meetings between the agencies continued in FY2007. Both the System of Care programs in Chicago and in McHenry have multiple meetings monthly. Each has a governing body which serves as the primary arena for collaboration and integration work which met at various times during the year. As systems work is a continual work in progress, the progress of these initiatives reflects ongoing efforts.

FY 2007 was the fifth year of this grant. The SOCC Initiative met the majority of its established goals for FY 2007 and will work to strengthen its governance council and solidify a family organization and consumer groups in FY 2008. A Federal Department of Education Grant was awarded to increase the integration of school mental health services and community mental health centers.

In FY-2003, the DMH Metro C&A Network applied for and received an award from SAMHSA for $9.5 million for a period of six years to develop comprehensive community mental health services for children and their families. The primary goal of this federally funded initiative is to promote the development of a system of care involving all child-serving systems and partnerships in the Chicago area. At the service delivery level, collaboration has been fostered through the implementation of the Positive Behavioral Interventions and Supports (PBIS) model as it has been adapted to the Chicago-PBIS model. Staff from mental health agencies participating in the project have actively partnered with staff of the seven participating schools to support the PBIS model that is universal (school-wide), targeted (special populations) and intensive (identified children and youth with serious emotional disturbance needing individualized supports) within the school setting.

In FY 2006, a new award was made by SAMHSA to expand System of Care principles and practices to McHenry County, thus providing the opportunity to expand the System of Care model to other areas in Illinois. Family CARE stands for Child/Adolescent Recovery Experience and is a $9 million, six year federal grant designed to involve families and youth in decision making related to treatment, goal-setting, designing and implementing programs, monitoring outcomes and determining the effectiveness of efforts that promote the well-being of children and youth. The grant will improve access to services for four underserved populations: preschoolers with serious social/emotional problems, youth with serious emotional disturbances and co-occurring substance abuse problems, young adults 18-21 years old with mental illnesses, and Latino children. FY 2007 was the second year of the grant which involves parents across systems to support families in navigating mental health and education systems. Family Resource Developers have been hired through the grant to assist parents across the county. Committees have been organized and are currently meeting with the aim of involving agencies, clinicians, school administrations, families and youth in designing effective mental health services which build on the strengths of consumers and address cultural and linguistic needs. The committees include: the Youth Council, the Family Council, the Early childhood Council, the Transitional Youth council, a Resource committee, and the Latino Council. A governing board, called the Family CARE Governance Council, will help to shape policies to improve the mental health care system and will strategize on the development of a comprehensive system of care for McHenry County. The Governance Council
includes professionals, family members and youth and will ensure that the project is family driven, youth guided and culturally competent.

**Objective C3.2. Build on the work of the System of Care Chicago Grant to address the mandate for social learning in schools**

**Indicator:** Planning meetings are held to begin extending the system of care model to other communities in Illinois.

**This objective has been accomplished.** The System of Care model has been extended through planning meetings and there have been multiple planning meetings with local and national leaders to develop the Illinois Social and Emotional Learning (SEL) training. The "Train the trainers" phase has been completed and the trainers are now beginning to set up trainings to local school districts on the implementation of SEL in their local school systems. Trainers are based all across the State and responsible for different portions of the State.

As noted above under Objective C3.1, a new award was made by SAMHSA to expand System of Care principles and practices to McHenry County, which provided an opportunity to expand the System of Care model to other areas in Illinois.

In reference to the Illinois model for Social and Emotional Learning (SEL), DMH has a relationship with the Children's Mental Health Partnership that continued its on-going collaborative efforts in FY 2007. The Illinois Children’s Mental Health Partnership (ICMHP) was established in FY 2003 and charged with developing a comprehensive, multi-year Children’s Mental Health Plan. The plan that was developed included requirements for the Illinois State Board of Education (ISBE) to incorporate social and emotional development standards as part of the Illinois Learning Standards. The ISBE and ICMHP partnered with the Collaborative for Academic, Social and Emotional Learning (CASEL) and a team of twenty five educators to develop 10 standards aligned with the following three goals: (1) students should develop self-awareness and self-management skills, (2) students should develop social awareness and interpersonal skills and (3) students should demonstrate decision making skills and responsible behavior. One hundred developmentally appropriate benchmarks and 600 performance descriptors are now posted on the ISBE web site. This partnership effort was supported by small grants to school districts to offset the costs of enhancing mental health services in schools and implementing a Statewide Professional Development Plan to support leadership teams for schools as they draft SEL implementation plans. During FY 2007 the focus has been on developing and implementing training in SEL for local school districts.

**Objective C3.3. Through the Mental Health Juvenile Justice Initiative (MHJJ), continue to identify youth with serious emotional disturbances that are exiting juvenile detention centers statewide and are appropriate for services under the initiative.**

**Indicators:**

- Number of youth served by the program statewide.
- Number linked to services, and
• Number of youth re-arrested

This objective has been completed.
The table displayed below displays information for each of the indicators for the MHJJ objectives for FY 2006, as well as information for FY 2007. The number of youth re-arrested is presented as a percentage.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>FY 2006</th>
<th>FY 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of youth receiving MHJJ services</td>
<td>684</td>
<td>689</td>
</tr>
<tr>
<td>Number of youth linked to services</td>
<td>655</td>
<td>559</td>
</tr>
<tr>
<td>Percentage youth re-arrested</td>
<td>24.6%</td>
<td>22.78%</td>
</tr>
</tbody>
</table>

Research has demonstrated that the majority of juveniles in detention centers meet the criteria for a psychiatric diagnosis and one in six has a serious mental illness. Many of those also have a co-morbid substance abuse disorder (Teplin, et al. 2005). The juvenile justice system frequently either fails to identify these youth or fails to provide the necessary mental health treatment. The Mental Health Juvenile Justice (MHJJ) program was conceived and implemented to address this critical need. MHJJ provides an alternative to incarceration for juvenile detainees with serious mental illnesses, by arranging for the necessary mental health services to address individual clinical needs. Initiated as a pilot project in 2000 in just seven counties, MHJJ has expanded to each of the 17 Illinois counties with a detention center and one county without a detention center. The program involves 19 community agencies and over 60 MHJJ program staff.

MHJJ liaisons screen the youth for the presence of serious mental illness. For the purposes of this program, serious mental illness is defined as a psychotic or affective disorder. Once found eligible, youth are enrolled in the program and are linked with appropriate community-based treatments consistent with their current clinical needs and individual strengths. After being linked to services, MHJJ liaisons continue to provide case management services and monitor progress for a period of six months.

In FY 2006, 1,064 youth were referred to MHJJ programs; 924 were screened and 754 were found to be eligible for services and 684 were enrolled. In FY 2007, 1,320 youth were referred to MHJJ programs; of these, 918 were screened, 785 were found to be eligible and 689 youths were enrolled in the program.

A notable finding is that in FY 2007, minority enrollment in the MHJJ program continues to increase. This is a significant finding in light of data for previous years which identified disproportionate minority contact associated with MHJJ services.

In FY 2008, The MHJJ program will continue to identify and screen juvenile detainees with serious mental illnesses and link them with appropriate community-based services. An evaluation of the MHJJ program has found that these services result in overall clinical improvement, decreased functional impairment and reduced rates of recidivism for youths enrolled in the program. The following initiatives will be undertaken in FY 2008.
based on findings of the FY 2006 evaluation of the program and an initial analysis of FY 2007 data. Efforts will be undertaken to:

- Increase the clinical services provided to youth that have been found to be most strongly associated with positive outcomes. Such services include: Individual therapy, school consultation, psychiatric hospitalization, psychiatric medication and case management services.

- Increase the number of service sessions provided, particularly for Black and Hispanic youth (note: in FY 2006, the average number of treatment sessions provided to Black and Hispanic youth was less than the number of sessions provided to Caucasian youth (16.77 and 16.16 versus 22.75). A finding in the 2006 evaluation of the program revealed that the number of service sessions is associated with positive outcomes. FY 2007 data are being analyzed to determine if this trend continues.

- Increase the number of minority youths referred to the MHJJ program. In FY 2006, 488 White youth, 283 Black youth and 58 Hispanic youth were referred to the program. In FY 2007, 414 White youth, 408 Black youth and 77 Hispanic youth were referred to the MHJJ program.

OBJECTIVES RELATED TO NATIONAL OUTCOME MEASURES/ PERFORMANCE INDICATORS – CRITERION 3

Performance Objective C.1.1 The percentage of caregivers of youth receiving treatment reporting positive outcome will increase in FY 2007. (See State Capacity Checklist - Appendix 2)

Indicator:
- Percentage of caregivers reporting positively about outcomes

This objective is currently in process. Data is currently being collected from the Youth Services Survey for Families (YSS-F) Draft URS/DIG Revised Version: February 17, 2006, which was mailed out on November 28, 2007. Results will be reported in February, 2008.

Performance Objective C1.2 and C1.3 Continue efforts to decrease 30 (C1,2)day and 180 (C1.3) day readmission rates to DMH state hospitals

Indicator:
- Percentage of children/adolescents readmitted to state hospitals within 30 days of being discharged
- Percentage of children/adolescents readmitted to state hospitals within 180 days of being discharged

This objective was achieved: In FY2007, 3 of the 94 youth (3.19%) discharged from DMH child and adolescent inpatient programs were readmitted within 30 days. This was a decrease from FY2005 when 5.2% were readmitted in 30 Days but also a slight increase over FY2006 when the rate was nearly 2%. The FY2007 percentage for 180 days (6.30%) clearly reflects stability and a trend of slight decrease from 6.9% in FY2005 and 6.8% in FY2006 and surpassed the target for FY2007 of 6.8%. This data reflects the
continuous focus on reducing the readmission of children and adolescents to state facilities.

Performance Objective C1.4: Expand the use of EBPs for youth in Illinois.
Indicator:
- Number of training sessions in which information about children’s EBPs are disseminated

This objective continues to be achieved. See Objective C1.3 above for a description of the training and education efforts which were completed in FY 2007 and a discussion of DMH efforts to promote and disseminate evidence-informed practice (EIP).

CRITERION V:

Objective C5.1. Increase Medicaid funding for the Illinois mental health service system. This will be accomplished by:
- Simplifying and clarifying DMH Medicaid policies and procedures.
- Developing and maintaining a system for utilization management within the Medicaid program.
- Identifying and eliminating internal barriers to increasing Medicaid billing and to enhancing eligibility for clients who use DMH funded mental health services (including patients in state psychiatric hospitals).
- Streamlining the documentation requirements of providers.
- Beginning implementation of fee-for-service funding.

Indicators
- Amount of FFP generated by the community mental health system.

This objective has been accomplished. The Illinois State Plan Amendment for Medicaid was approved by CMS on March 14, 2007. The revised Medicaid Rule (132) was approved in the State on April 18, 2007. These products were based on extensive work directed toward simplifying and clarifying DMH Medicaid policies and procedures, reducing and eliminating barriers to increasing Medicaid billing, and clarifying service definitions. A major training effort was undertaken in Spring of 2007 to educate providers and stakeholders on the new definitions and requirements and to prepare providers to use revised and updated billing procedures. More than 120 staff from child serving community mental health centers and other agencies participated in this training.

By the end of FY2007, DMH had completed more than three years of work on System Restructuring Initiative (SRI) and conversion to a fee for service payment mechanism. The process has shifted primarily input and planning to initial statewide implementation. Input from stakeholders was extensive during this period with more than 27 consumer and family focus groups, task-oriented workgroups with over 300 participants, and the ongoing work of an SRI Task Group. By the end of FY2007, 89 agencies had received Technical Assistance which included 25 site visits by expert consultants. An analysis of consumers served by DHS/DMH contracted community providers for FY2005 and FY2006 showed a 14% increase in total consumers served in one year. The analysis also examined the number of consumers served grouped by Medicaid, non-Medicaid, adults,
youth, target and eligible and each group showed an increase in consumers served from FY2005 to FY2006. Total Medicaid billing FFP grew from $150 million in FY04 to $176.5 million in FY06 and was projected at $185 million in FY2007.

In addition to revising Medicaid reimbursement procedures, DMH developed a fee for service approach to additional services not qualified under Medicaid including outreach and engagement, stakeholder education, vocational services, and forensic services. Concurrently, new recovery-oriented services and definitions were developed. A new means of system administration utilizing an Administrative Service Organization (ASO) was planned in FY2007 and will be introduced in FY2008. The ASO will be responsible for developing and maintaining a system for utilization management, and evaluation of the service and operational processes of the system with the aim of further streamlining the documentation requirements and increasing access to FFP.

**Medicaid Billing For The Children And Adolescent Population**

Medicaid billing has risen considerably for services for children and adolescents in the past several years. In FY 2004, the billings reached a total of $22,609,272 (see System Performance Indicator C5.1). In FY 2005, the total decreased to $19,960,808. This decrease is attributable to the loss of data reporting of the SASS program as described earlier, which has resulted in a loss of information (services and dollars) for this program. Medicaid billing increased to $22,005,772 in FY 2006. Final figures are not yet available for FY 2007.

**Allocation of Block Grant Dollars**

For FY 2007, block grant funds were directed toward the following community-based services for youths with serious emotional disturbances: psychiatric services, residential and crisis services. A list of the agencies and the awards projected for FY 2008 is attached. The child and adolescent funding allocation of mental health block grant dollars is consistent with the State Mental Health Plan for Children and Adolescents.
SECTION III. Illinois Quantitative Targets for the Comprehensive System of Care, System Specific Performance Measures and National Outcome Measures (NOMS)

This section contains: (1) Illinois specific indicators that contain quantitative targets for monitoring and planning service delivery as it relates to the Comprehensive System of Care as outlined in Criterion I, and (2) Indicators that provide information for SAMHSAs National Outcome Measures (NOMS). Indicators are organized by criterion and within criterion by population. State specific indicators are presented first; these are followed by presentation of indicators based on the National Outcome Measures (NOMS) indicators. Data is presented for FY 2007 (July 1, 2006 – June 30, 2007) where available.
Criterion 1. Comprehensive Community-based Mental Health System

Quantitative Targets and System Specific Indicators Relating to the Adult Comprehensive Mental Health System

Indicator A1.1 EMPLOYMENT
Percentage of adults engaged in full or part time employment, which is unsubsidized, including self-employment, at the time of case opening.

<table>
<thead>
<tr>
<th>Value</th>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>FY2007 Target</th>
<th>FY2007 Actual</th>
<th>FY2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>20.5%</td>
<td>20.5%</td>
<td>20.5%</td>
<td>20.73%</td>
<td>20.5%</td>
</tr>
<tr>
<td>Denominator</td>
<td>26,388</td>
<td>26,491</td>
<td>29,406</td>
<td>128,732</td>
<td>129,564</td>
</tr>
</tbody>
</table>

Numerator: Number of adults reported as employed full or part time in unsubsidized employment at the time of case opening.
Denominator: Total number of adults served in the fiscal year.
Goal: To continue tracking employment status of consumers at case opening.
Data Source: Reporting of Community Services (RoCS) System
Population: Adults with mental illnesses.

Significance: Employment is a key issue relating to recovery and resilience. At intake in FY 2007, employment rates were slightly above 20%. This descriptive data collected at intake, before services are initiated, is not expected to change. These low levels are consistent with national findings and indicate the importance of further developing employment and supported employment.

Action Plan:
Performance Indicators A1.1, A1.2. DMH plans to continue tracking this data while developing specialized employment services.
Indicator A1.2  

VOCATIONAL PLACEMENT

Percentage of adults engaged in full or part time employment in subsidized, supported, or sheltered employment at the time of case opening.

<table>
<thead>
<tr>
<th>Value</th>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>FY2007 Target</th>
<th>FY2007 Actual</th>
<th>FY2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>3.38%</td>
<td>3%</td>
<td>3%</td>
<td>2.67%</td>
<td>3%</td>
</tr>
<tr>
<td>Denominator</td>
<td>4,005</td>
<td>3,880</td>
<td>3,791</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>118,465</td>
<td>129,564</td>
<td>141,864</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Numerator: Number of adults reported as employed full or part time in subsidized, supported, or sheltered employment at the time of case opening.

Denominator: Total number of adults served in the fiscal year.

Goal: To track demographic information on employment for adult consumers.

Data Source: Reporting of Community Services (RoCS).

Population: Adults with mental illnesses.

Significance: Employment is a key issue relating to recovery and resilience. At intake in FY 2007, employment rates were slightly above 20%. This descriptive data collected at intake, before services are initiated, is not expected to change. These low levels are consistent with national findings and indicate the importance of further developing employment and supported employment.

Action Plan: DMH plans to continue tracking this data while developing specialized employment services.
### Indicator A1.3  LIVING INDEPENDENTLY

Percentage of adults living in private residences*, unsupervised, and considered to be living independently at the time of case opening.

<table>
<thead>
<tr>
<th></th>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>FY2007 Target</th>
<th>FY2007 Actual</th>
<th>FY2008 Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value</td>
<td>63.6%</td>
<td>65.1%</td>
<td>Track</td>
<td>79%</td>
<td>Track</td>
</tr>
<tr>
<td>Numerator</td>
<td>81,905</td>
<td>84,379</td>
<td>112,380</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator</td>
<td>128,732</td>
<td>129,564</td>
<td>141,864</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Numerator:** Percentage of adults living in private residence, unsupervised, and considered to be living independently at the time of case opening.

**Denominator:** Total number of adults served in the fiscal year.

**Goal:** To track demographic information on living arrangements of adult consumers.

**Data Source:** Reporting of Community Services (RoCS).

**Population:** Adults with mental illnesses.

**Significance:** The proportion of individuals living independently at intake has been close to 63% for several years. This demonstrates the need for ongoing attention to housing services for individuals with mental illnesses.

**Action Plan:** DMH will continue to assess living arrangements at intake as a means of having baseline data on this indicator regarding the individuals who access DMH funded services.

* private residence (e.g., structure with accommodations for sleeping in which some individual knowingly owns or rents for the purpose of housing the client) and the client is unsupervised (considered to be living independently).
Indicator A1.4  FORENSIC OUTPATIENT
Percentage of adult clients who had been court ordered into treatment due to not guilty by reason of insanity, found unfit to stand trial, or by criminal court at the time of case opening.

<table>
<thead>
<tr>
<th></th>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>FY2007 Target</th>
<th>FY2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value</td>
<td>1.6%</td>
<td>1.7%</td>
<td>1.7%</td>
<td>1.83%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Numerator</td>
<td>2,004</td>
<td>2,244</td>
<td>2597</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator</td>
<td>128,732</td>
<td>129,564</td>
<td>141864</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Numerator: Number of adults reported as unfit to stand trial, not guilty by reason of insanity or court ordered into treatment at the time of case opening.

Denominator: Total number of adults served in the fiscal year.

Goal: To track forensic status of adult consumers served by the Mental Health system.

Data Source: Reporting of Community Services (RoCS).

Population: Adults with mental illnesses.

Significance: Community mental health staff track both forensic outpatient status and correctional history at the time of case opening. Slightly over 1% of persons with mental illness are forensic outpatients.

Action Plan: DMH plans to continue tracking forensic outpatient information at intake. Efforts to link databases with county jails are ongoing and provide another means of identifying persons with current involvement in the criminal justice system, as well as facilitating service provision.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>A1.5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HISTORY OF INVOLVEMENT WITH THE CRIMINAL JUSTICE SYSTEM</strong></td>
<td></td>
</tr>
<tr>
<td>Percentage of adult consumers reporting involvement with the Department of Corrections at the time of case opening.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Value</th>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>FY2007 Target</th>
<th>FY2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>2.39%</td>
<td>2.3%</td>
<td>2.30%</td>
<td>2.27%</td>
<td>2.30%</td>
</tr>
<tr>
<td>Denominator</td>
<td>3,080</td>
<td>2,872</td>
<td>3215</td>
<td>128,732</td>
<td>129,564</td>
</tr>
<tr>
<td></td>
<td>128,732</td>
<td>129,564</td>
<td>141864</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Numerator:** Number of adults reported as Department of Corrections clients (e.g. probation, parole) at the time of case opening.

**Denominator:** Total number of adults served in the fiscal year.

**Goal:** To track forensic status of adult consumers served by the Illinois Mental Health system.

**Data Source:** Reporting of Community Services (RoCS).

**Population:** Adults with mental illnesses.

**Significance:** Identifying individuals experiencing involvement with the correctional system at time of case opening can increase coordination of services that increase chances of recovery from mental illness and decrease the rate of recidivism in the criminal justice system. Slightly over 2% of persons with mental illness have a correctional history.

**Action Plan:** DMH plans to continue tracking correctional history information at intake. Efforts to link databases with county jails are ongoing and provide another means of identifying persons with current involvement in the criminal justice system, as well as facilitating service provision.
### Indicator A1.6  
**CO-OCCURRING DISORDERS - ADULTS**

Percentage of adults served with a co-occurring disorders based on diagnostic category*.

<table>
<thead>
<tr>
<th>Value</th>
<th>FY2005 Actual</th>
<th>FY2006 Target</th>
<th>FY 2007 Target</th>
<th>FY2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>11.5%</td>
<td>12.1%</td>
<td>12.1%</td>
<td>12.36%</td>
<td>12.1%</td>
</tr>
<tr>
<td>Denominator</td>
<td>14,837</td>
<td>15,610</td>
<td>17532</td>
<td>141864</td>
<td></td>
</tr>
</tbody>
</table>

**Numerator:** Number of adults served in the community with a mental health substance abuse diagnosis at intake.

**Denominator:** Total number of adults served in the fiscal year.

**Goal:** To increase community-based mental health service for persons who have co-occurring mental health and substance abuse disorders.

**Data Source:** Reporting of Community Services (RoCS).

**Population:** Adults with mental illnesses.

**Significance:** DMH reporting of community services data shows that a little over 12% of DMH consumers have been identified at intake as having a substance abuse and a mental health diagnosis. This is likely to be an under-estimated and demonstrates the importance of ongoing training in identifying and treating persons with dual disorders (MISA).

**Action Plan:** DMH plans to continue encourage and support increased training for community mental health professionals in the identification, reporting and treatment of co-occurring disorders.

*MISA is defined as any DSM-IV or ICD-9 mental disorder diagnosis plus a diagnosis in the "Substance Abuse" group EXCEPT those in the categories of "Mental Retardation, Autism and Specific Development" or "Dementia, Delirium and Other Related Disorder" or "No Diagnosis, Deferred, Not Available".*
## Indicator A1.7. ACT SERVICE HOURS IN COMMUNITY

**Percentage of service hours for adults being served by the DMH-funded Assertive Community Treatment (ACT) Programs, who receive services outside of the provider’s offices or clinics.**

<table>
<thead>
<tr>
<th>Value</th>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>FY 2007 Target</th>
<th>FY2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>68%</td>
<td>65%</td>
<td>65%</td>
<td>67%</td>
<td>65%</td>
</tr>
<tr>
<td>Denominator</td>
<td>171,585</td>
<td>144,441</td>
<td>143,527</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>252,117</td>
<td>221,360</td>
<td>214,280</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Numerator:** The number of hours of service provided by the DMH-funded (ACT) Programs which occur outside of the provider’s offices or clinics.

**Denominator:** The total number of hours of service provided by the DMH-funded (ACT) Programs.

**Goal:** To assure that a significant portion of the service delivered within the (ACT) programs are provided in the most normalized settings possible in the individual’s community, rather than within the provider’s offices or clinics.

**Data Source:** Reporting of Community Services (RoCS).

**Population:** Adults with serious mental illnesses.

**Significance:** Although DMH does not conduct a complete fidelity assessment, the provision of service in the community versus the office is a key component of the ACT programs that are monitored. In FY 07, 67% of ACT service hours were provided in the community, suggesting fidelity to this key aspect of the ACT model.

**Action Plan:** DMH will continue to monitor service provision of ACT programs in order to maintain current levels of services delivered in community settings outside the providers offices or clinics.
**Indicator A1.8  CASE MANAGEMENT**

Percentage of adults being served by the DMH-funded community-based service system with an initial DSM-IV diagnosis of 295.xx or 296.xx who receive case management services.

<table>
<thead>
<tr>
<th>Value</th>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>FY2007 Target</th>
<th>FY2007 Actual</th>
<th>FY2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>48.44%</td>
<td>48.6%</td>
<td>50%</td>
<td>46.9%</td>
<td>45%</td>
</tr>
<tr>
<td>Denominator</td>
<td>38,042</td>
<td>38,491</td>
<td>40,423</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator</td>
<td>78,350</td>
<td>79,245</td>
<td>86,161</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Numerator:** Adults being served by the DMH-funded community-based service system with an initial DSM-IV diagnosis of 295.xx or 296.xx receiving case management services.

**Denominator:** All adults being served by the DMH-funded community-based service system with an initial DSM-IV diagnosis of 295.xx or 296.xx.

**Goal:** To maintain or expand access to case management services to individuals with specific serious mental illnesses being served in the DMH-funded community-based service system.

**Data Source:** Reporting of Community Services (RoCS).

**Population:** Adults with serious mental illnesses.

**Significance:** DMH has recently revamped its services taxonomy. There is an expectation that many case management services will be subsumed in “Community Support Services”. We will also continue to track the amount of case management services provided in FY 2008.

**Action Plan:** DMH will continue to track the amount of case management services provided and reestablish its baseline in FY 2008.
### Indicator A1.9 FACE-TO-FACE SCREENINGS-ADULTS

Percent of persons presenting for admission to a state hospital, who have received a face-to-face screening by a DMH-funded community provider or their designee.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Value</td>
<td>95.7%</td>
<td>92%</td>
<td>95%</td>
<td>*</td>
<td>95%</td>
</tr>
<tr>
<td>Numerator</td>
<td>10,606</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator</td>
<td>11,087</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Numerator:** Number of persons presenting for admission to a state hospital who have received a face-to-face screening by a DMH-funded community provider or their designee.

**Denominator:** Number of persons presenting for admission to a state hospital.

**Goal:** To maintain admission screening services in the community in order to minimize state hospitalization and reduce the extrusion of individuals from their home communities when local community-based services and facilities are adequate to meet their mental health needs.

**Data Source:** Inpatient Clinical Information System.

**Population:** Adults with mental illnesses.

**Significance:** The vast majority of persons presenting for admission to state operated mental health facilities, close to 95%, have been screened in recent years, reducing the number of hospital admissions where community services could be determined to be a more appropriate alternative.

**Action Plan:** DMH plans to continue the provision of face-to-face screenings for people presenting for admission at state hospitals in order to reduce unnecessary hospitalizations.

*Data not available.*
Criterion 1. Comprehensive Community-based Mental Health System -
ADULT NATIONAL OUTCOME MEASURES/PERFORMANCE INDICATORS

Performance Indicator A1.1. NUMBER OF EBPS IMPLEMENTED
Number of EBPs implemented in Illinois
Population: Adult SMI

<table>
<thead>
<tr>
<th></th>
<th>FY 2006 Target</th>
<th>FY 2006 Actual</th>
<th>FY 2007 Target</th>
<th>FY 2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Integrated Dual Diag Tx</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Family Psychoeducation</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Illness Self-Management</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Supported Housing</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Medication Management</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Indicator: Number of EBPs Implemented in Illinois
Goal: To increase the availability of EBPs within the state
Data Source: Structured program reports collected by DMH staff from community agencies
Population: Adults with mental illnesses.

Action Plan: DMH has a goal of increasing the number and type of EBPs provided within the state. During FY 2007, DMH has focused on Supported Employment (SE), Integrated Dual Diagnosis Treatment, Illness-Self-Management, and Medication Algorithms. Grant funding from SAMHSA and other sources has been largely used for these efforts. We will continue to maintain this focus in FY 2008. Currently we are working with NRI to develop a strategy for expanding the implementation of these practices. During FY 2008, we expect to finalize this planning.
Performance Indicator A1.2. READMISSIONS WITHIN 30 DAYS - ADULTS
Percent of persons readmitted to a state hospital within thirty days of being discharged from a state hospital.

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>FY 2007 Target</th>
<th>FY2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>11.4%**</td>
<td>13.4%</td>
<td>11%</td>
<td>15.9%</td>
<td>15%</td>
</tr>
<tr>
<td>Denominator</td>
<td>9,410</td>
<td>11,402</td>
<td>11,165</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Numerator:** Number of adults readmitted to a state hospital within thirty days of being discharged from a state hospital.

**Denominator:** Number of persons discharged from a state hospital in a fiscal year.

**Goal:** To encourage assurance of sufficient clinical stabilization of individual from the state hospital though planning and preparation of post-hospital community-based mental health services prior to being discharged so that rapid “revolving door” admissions are minimized.

**Data Source:** Inpatient Clinical Information System (CIS)

**Population:** Adults with mental illnesses.

**Action Plan:** DMH will continue to monitor the number of adults readmitted to state hospitals within 30 days of discharge with a FY 2008 goal of decreasing the level of re-hospitalization by maintaining services in the community that provide alternatives to re-hospitalization.

*Includes Children
** Includes Adults Only
### Performance Indicator A1.2. READMISSIONS WITHIN 180 DAYS -ADULTS

Percent of persons readmitted to a state hospital within one hundred eighty days of being discharged from a state hospital.

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>FY2005 Actual</th>
<th>FY2006 Actual***</th>
<th>FY 2007 Target</th>
<th>FY2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>9.7%**</td>
<td>10.6%</td>
<td>11%</td>
<td>11.4%</td>
<td>11%</td>
</tr>
<tr>
<td>Denominator</td>
<td>919</td>
<td>1218</td>
<td>1276</td>
<td>11165</td>
<td></td>
</tr>
</tbody>
</table>

**Numerator:** Number of persons readmitted to a state hospital within 180 days of being discharged from a state hospital.

**Denominator:** Number of persons discharged from a state hospital in a fiscal year.

**Goal:** To encourage assurance of sufficient clinical stabilization of individual from the state hospital though planning and preparation of post-hospital community-based mental health services prior to being discharged so that rapid “revolving door” admissions are minimized.

**Data Source:** Inpatient Clinical Information System.

**Population:** Adults with mental illnesses.

**Action Plan:** DMH will continue to monitor the number of adults readmitted to state hospitals within 180 days of discharge with a FY 2008 goal of maintaining or decreasing the level of re-hospitalization by maintaining services in the community that provide alternatives to re-hospitalization.

*Includes Children  
**Includes Adults Only
### Performance Indicator A1.3. PERCEPTION OF TREATMENT OUTCOME

Percentage of adult consumers reporting positively about outcomes

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>FY2005 Projected</th>
<th>FY2006 Actual</th>
<th>FY2007 Target</th>
<th>FY2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>70%*</td>
<td>76.27</td>
<td>75%</td>
<td>**</td>
<td>77%</td>
</tr>
<tr>
<td>Denominator</td>
<td>*</td>
<td>768</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>*</td>
<td>1007</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Goal:** To assess the proportion of persons served by the DMH-funded community-based mental health service system who report positively about outcomes for adults.

**Data Source:** MHSIP survey from Table 11, the Summary Profile of Client Evaluation of Care, the Illinois Uniform Data Report

**Population:** Adults with mental illnesses.

*Not conducted in FY 2005

**FY 2007 not yet completed; Will be reported in early 2008**

---

**Performance Indicator A1.3: Client Perception of Care.** Table 11, the Summary Profile of Client Evaluation of Care, will be reported in the Illinois Uniform Data Report. DMH has a goal of increasing the percentage of consumer reporting positive treatment outcomes.
Criterion 1. Comprehensive Community-based Mental Health System

CHILDREN & ADOLESCENTS ILLINOIS SPECIFIC SYSTEM
PERFORMANCE INDICATORS

Indicator C1.1 LIVING ARRANGEMENTS-C&A
Percentage of children and adolescent clients living with parents or other relatives in private residences at the time of case opening.

<table>
<thead>
<tr>
<th>Value</th>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>FY 2007 Target</th>
<th>FY2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>93.4%</td>
<td>92.9%</td>
<td>93%</td>
<td>94.25%</td>
<td>93%</td>
</tr>
<tr>
<td>Denominator</td>
<td>30,897</td>
<td>32,613</td>
<td>35438</td>
<td>33,080</td>
<td>35,104</td>
</tr>
</tbody>
</table>

Numerator: Number of reported as living with parents or other relatives in private residence at the time of case opening.

Denominator: Total number of children and adolescents served in the fiscal year.

Goal: To track demographic information on living arrangements for children and adolescent clients.

Data Source: Reporting of Community Services (RoCS).

Population: Adults with mental illnesses.

Significance: Community mental health staff track living arrangements at intake for child and adolescents to assess service needs. At the time of case opening in FY 2007, the vast majority of children and adolescents lived with parents or other relatives in a private residence (94%). Nevertheless, services are needed to help those children who do not reside with their families.

Action Plan: DMH will continue to track these percentages in FY 2008.
### Indicator C1.2  FORENSIC OUTPATIENT-C&A

Percentage of children and adolescent clients who had been court ordered into treatment due to not guilty by reason of insanity, found unfit to stand trial, or by criminal court at the time of case opening.

<table>
<thead>
<tr>
<th>Value</th>
<th>FY2005 Projected</th>
<th>FY2006 Actual</th>
<th>FY 2007 Target</th>
<th>FY2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>0.71%</td>
<td>.8%</td>
<td>.8%</td>
<td>.81%</td>
<td>.8%</td>
</tr>
<tr>
<td>Denominator</td>
<td>226</td>
<td>280</td>
<td>303</td>
<td>37600</td>
<td></td>
</tr>
</tbody>
</table>

**Numerator:** Number of children and adolescent clients reporting as unfit to stand a trial, not guilty by reason of insanity, criminal, court ordered treatment at the time of case opening.

**Denominator:** Total number of children and adolescents served in the fiscal year.

**Goal:** To track forensic status of children and adolescents served by the Illinois Mental Health system.

**Data Source:** Reporting of Community Services (RoCS).

**Population:** Children and adolescents with serious emotional disturbances.

**Significance:** The service needs of this high risk group need to be determined and adequate services provided.

**Action Plan:** DMH will continue to track these percentages in FY 2008.
# Indicator C1.3  
**CORRECTIONS HISTORY - C&A**

Percentage of children and adolescent clients reporting involvement with the Department of Corrections/Juvenile Justice at the time of case opening.

<table>
<thead>
<tr>
<th>Year</th>
<th>Actual</th>
<th>Target</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY2005</td>
<td>1.3%</td>
<td>1.04%</td>
<td>1.04%</td>
<td>.92%</td>
</tr>
<tr>
<td>FY2006</td>
<td>429</td>
<td>380</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY2007</td>
<td>33,080</td>
<td>35,104</td>
<td>347</td>
<td></td>
</tr>
</tbody>
</table>

**Numerator:** Number of children and adolescents reported as Department of Corrections clients (e.g. probation, parole) at the time of case opening.

**Denominator:** Total number of children and adolescents served in the fiscal year.

**Goal:** To track forensic status of children and adolescents served by the Illinois Mental Health system.

**Data Source:** Reporting of Community Services (RoCS).

**Population:** Children and adolescents with serious emotional disturbances.

**Significance:** Tracking this information helps to insure coordination of services between the mental health system and juvenile corrections.

**Action Plan:** Community mental health staff track the number of children and adolescents who are forensic outpatients as well as those who are on probation or parole at the time of case opening (slightly less than 1%). DMH will continue to track these percentages in FY 2008.
**Indicator C1.4**  
**CASE MANAGEMENT-C & A**

Percentage of children identified as members of the DMH “target” population being served by the DMH-funded community-based service system who receive case management services.

<table>
<thead>
<tr>
<th></th>
<th>FY2005 Projected</th>
<th>FY2006 Actual</th>
<th>FY 2007 Target</th>
<th>FY2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Value</strong></td>
<td>15.26%*</td>
<td>14.9%</td>
<td>15%</td>
<td>15.77%</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>1,579</td>
<td>1,672</td>
<td></td>
<td>1984</td>
<td></td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>10,345</td>
<td>11,225</td>
<td></td>
<td>12579</td>
<td></td>
</tr>
</tbody>
</table>

**Numerator:** Children identified as members of the DMH “target” population being served by the DMH-funded community-based service system who receive case management services.

**Denominator:** All children identified as members of the DMH “target” population being served by the DMH-funded community-based service system.

**Goal:** To maintain case management services as a key core service to children with specific serious mental illnesses being served in the DMH-funded community-based service system.

**Target:** A target is not set because the data source does not capture complete information.

**Data Source:** Reporting of Community Services (RoCS).

**Population:** Children and adolescents with serious emotional disturbances.

**Special Issues:** In prior years, DMH funded agencies providing SASS services, which includes case management services as a key component, reported these services directly through the DMH community mental health services reporting system (RoCS); however beginning in FY 2005, Community providers began reporting services directly to the Medicaid agency. As a result, we are unable to accurately determine the total number of children and adolescents receiving case management services because we do not have access to the SASS data.

**Significance:** Tracking services provided to the child and adolescent population is an important aspect of planning.

**Action Plan:** DMH will retain this indicator, however, we anticipate that the information will continue to underrepresent the percent of children and adolescents receiving services.
### Indicator C1.5: SASS SERVICE HOURS IN COMMUNITY

Percent of children identified as members of the DMH “target population being served by the DMH-funded community-based service system who receive Screening Assessment and Support Services (SASS) services.

<table>
<thead>
<tr>
<th>Value</th>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>FY 2007 Target</th>
<th>FY2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>69.185</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Denominator</td>
<td>100,865</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Numerator:** Number of hours of service provided by the DMH-funded SASS Programs which occur outside of the provider’s offices or clinics.

**Denominator:** Total number of hours of service provided by the DMH-funded SASS Programs.

**Goal:** To assure that a significant portion of the service delivered within the SASS programs are provided in the most normalized settings possible in the individual’s community, rather than within the provider’s offices or clinics.

**Target:** A target is not set because the data source does not capture complete information.

**Data Source:** Reporting of Community Services (RoCS).

**Population:** Children and adolescents with serious emotional disturbances.

**Special Issues:** This data is no longer reported directly to the DMH. Data was not available for FY 2005, FY 2006 and FY 2007.

**Significance:** SASS programs aim to provide services in the most normalized settings possible in the individual’s community, rather than within the provider’s offices or clinics.

**Action Plan:** DMH is working to retrieve this information for FY 2007 and will continue to retain this indicator as a place holder pending re-acquisition of this data as it is important to monitor delivery of these critical services.

*Note:* During FY 2005, a statewide SASS initiative was implemented as a collaboration between the DMH, DCFS and DHFS. As a result of this initiative, DMH providers stopped reporting SASS services to DMH. DMH has also been negotiating for the collection of data, however this strategy has not yet been successful.
Indicator C1.6  PRE-ADMISSION SCREENINGS - C&A

Percent of persons, ages 17 and under, presenting for admission to a state hospital who have received a face-to-face screening by a DMH-funded community provider or their designee.

<table>
<thead>
<tr>
<th></th>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>FY2007 Target</th>
<th>FY2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>129</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator</td>
<td>129</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Numerator: Number of children and adolescents presenting for admission to a state hospital who have received a face-to-face screening by an DMH-funded community provider or their designee.

Denominator: Number of children and adolescents presenting for admission to a state hospital.

Goal: To maintain admission screening services in the community in order to minimize state hospitalization and the extrusion of children and adolescents from their families and home communities when local community-based services and facilities are adequate to meet their mental health needs.

Data Source: Inpatient Clinical Information System.

Population: Children and adolescents with serious emotional disturbances.

Significance: Tracking this information is important in terms of assuring that services are provided in the least restrictive setting.

Action Plan: The DMH goal is to maintain this level of community-based service provision for FY 2008.

*Data not available for FY 2006 and FY 2007
CRITERION 2: MENTAL HEALTH SYSTEM DATA EPIDEMIOLOGY
ESTIMATES OF PREVALENCE AND TREATED PREVALENCE AND
MENTAL HEALTH SYSTEMS DATA

ADULT SERVICES
QUANTITATIVE TARGETS AND NATIONAL OUTCOME
MEASURES/INDICATORS

STATE SPECIFIC QUANTITATIVE TARGETS (A2.1 and A2.2)

<table>
<thead>
<tr>
<th>Performance Indicator A2.1</th>
<th>TARGET POPULATION - ADULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of individuals being served by DMH-funded community-based providers who meet the established criteria for “target population” at the time of entry into services.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Value</th>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>FY2007 Target</th>
<th>FY2007 Actual</th>
<th>FY2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value</td>
<td>56.52%</td>
<td>56.6%</td>
<td>57%</td>
<td>56.4%</td>
<td>57%</td>
</tr>
<tr>
<td>Numerator</td>
<td>69,135</td>
<td>73,323</td>
<td>80,060</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator</td>
<td>122,323</td>
<td>129,564</td>
<td>141,864</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Numerator:** Number of adults being served by DMH-funded community-based providers who meet the established criteria for “target population” at the time of entry into services.

**Denominator:** All adults being served by DMH-funded community-based providers.

**Goal:** To assure resources and services are provided to the priority population of the publicly funded mental health system.

**Data Source:** Reporting of Community Services (RoCS).

**Population:** Adults with serious mental illnesses.

**Significance:** The target group of adults with serious mental illnesses (SMI) is the priority population for the delivery of community mental health services.

**Action Plan:** DMH continues to monitor service provision to assure that individuals with serious mental illnesses receive priority services.
Performance Indicator A2.2. ELIGIBLE POPULATION - ADULTS

Percent of adults being served by DMH-funded community-based providers who meet the established criteria for “eligible population” at the time of entry into services.

<table>
<thead>
<tr>
<th></th>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>FY2007 Target</th>
<th>FY2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value</td>
<td>94.79%</td>
<td>94.2 %</td>
<td>95%</td>
<td>94%</td>
<td>95%</td>
</tr>
<tr>
<td>Numerator</td>
<td>122,028</td>
<td>122,029</td>
<td>132,787</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator</td>
<td>128,732</td>
<td>129,564</td>
<td>141,864</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Numerator:** Number of adults being served by DMH-funded community-based providers who meet the established criteria for “eligible population” at the time of entry into services.

**Denominator:** All adults being served by DMH-funded community-based providers.

**Goal:** To assure resources and services are provided to the priority population of the public mental health system.

**Data Source:** Reporting of Community Services (RoCS).

**Population:** Adults with mental illnesses.

**Significance:** State mental health resources and services should be provided to the priority populations of the public mental health system.

**Action Plan:** DMH aims to maintain or increase the proportion of persons served who meet the established criteria for “eligible population” at the time of entry into services.
NATIONAL OUTCOME MEASURES ACCESS-ADULTS

NOM Performance Indicator A2.3. NUMBER OF ADULTS SERVED BY GENDER (Access to Services)

<table>
<thead>
<tr>
<th></th>
<th>FY2005 Projected</th>
<th>FY2006 Actual</th>
<th>FY 2007 Target</th>
<th>FY2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>53,806</td>
<td>56,456</td>
<td>55,000</td>
<td>62311</td>
<td>62000</td>
</tr>
<tr>
<td>Females</td>
<td>68,523</td>
<td>73,111</td>
<td>70,000</td>
<td>79496</td>
<td>75000</td>
</tr>
</tbody>
</table>

Indicator: Number of adult males and females receiving services from DMH-funded community-based providers.

Goal: To monitor access to services.

Data Source: Reporting of Community Services (RoCS).

Population: Adults with mental illnesses.

NOM Performance Indicator A2.3: There has been an increase in the number of males and females receiving services from FY 2006 to FY 2007.

NOM Performance Indicator A2.4. NUMBER OF ADULTS SERVED BY RACE/ETHNICITY. (Access to services)

<table>
<thead>
<tr>
<th></th>
<th>FY2005 Projected</th>
<th>FY2006 Actual</th>
<th>FY 2007 Target</th>
<th>FY2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Ind/Alaskan</td>
<td>319</td>
<td>382</td>
<td>*</td>
<td>366</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>1,362</td>
<td>1,483</td>
<td>*</td>
<td>1504</td>
<td></td>
</tr>
<tr>
<td>African/American</td>
<td>31,934</td>
<td>42,105</td>
<td>*</td>
<td>35520</td>
<td></td>
</tr>
<tr>
<td>Nat Haw/Pac Islander</td>
<td>234</td>
<td>407</td>
<td>*</td>
<td>223</td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>78,864</td>
<td>105,843</td>
<td>*</td>
<td>93052</td>
<td></td>
</tr>
<tr>
<td>Multi-racial</td>
<td>212</td>
<td>568</td>
<td>*</td>
<td>300</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>7,830</td>
<td>12,879</td>
<td>*</td>
<td>10842</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>1180</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>9,697</td>
<td>15,072</td>
<td>*</td>
<td>12258</td>
<td></td>
</tr>
</tbody>
</table>

Indicator: Number of adults by race/ethnicity receiving services from DMH-funded community-based providers.

Goal: To monitor access to services.

Data Source: Reporting of Community Services (RoCS).

*No targets set for access by ethnicity; we will continue to track over time.

Population: Adults with mental illnesses.
NOM Performance Indicator A2.5. NUMBER OF ADULTS RECEIVING SERVICES BY AGE (Access to services)

<table>
<thead>
<tr>
<th></th>
<th>FY2005 Projected</th>
<th>FY2006 Actual</th>
<th>FY2007 Target</th>
<th>FY2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-20</td>
<td>6627</td>
<td>7,055</td>
<td>*</td>
<td>8528</td>
<td>*</td>
</tr>
<tr>
<td>21 – 64</td>
<td>109522</td>
<td>116,304</td>
<td>*</td>
<td>126185</td>
<td>*</td>
</tr>
<tr>
<td>65 – 74</td>
<td>4057</td>
<td>4,145</td>
<td>*</td>
<td>4744</td>
<td>*</td>
</tr>
<tr>
<td>75 +</td>
<td>2117</td>
<td>2,060</td>
<td>*</td>
<td>2351</td>
<td>*</td>
</tr>
</tbody>
</table>

Indicator: Number of adults by age receiving services from DMH-funded community-based providers.

Goal: To monitor service access.

Data Source: Reporting of Community Services (RoCS).

Population: Adults with mental illnesses.

NOM Performance Indicator A2.5: No targets are set for FY 2007 or 08; We will continue to track service by age.
Performance Indicator C2.1  TARGET POPULATION - C & A  
Percentage of individuals being served by DMH-funded community-based providers who meet the established criteria for “target population” at the time of entry into services.

<table>
<thead>
<tr>
<th>Value</th>
<th>FY2005 actual*</th>
<th>FY2006 Actual</th>
<th>FY2007 Target</th>
<th>FY2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>30.4%</td>
<td>32.0%</td>
<td>32%</td>
<td>33.45%</td>
<td>33%</td>
</tr>
<tr>
<td>Denominator</td>
<td>10,063</td>
<td>11,225</td>
<td>12579</td>
<td>37600</td>
<td></td>
</tr>
</tbody>
</table>

**Numerator:** Number of children and adolescents being served by DMH-funded community-based providers that meet the established criteria for “target population” at the time of entry into services.

**Denominator:** All children and adolescents being served by DMH-funded community-based providers.

**Goal:** To assure resources and services are provided to children and adolescents in the priority population of the public mental health system.

**Data Source:** Reporting of Community Services (RoCS).

**Population:** Children and adolescents with serious emotional disturbances (SED).

**Significance:** Children and adolescents with serious emotional disturbances (SED) are the first priority target for state funded mental health services.

**Action Plan:** DMH aims to maintain or increase the proportion of children and adolescents served who meet the criteria for the target population.
**Performance Indicator C2.2**

ELIGIBLE POPULATION - C&A

Percent of individuals being served by DMH-funded community-based providers who meet the established criteria for “eligible population” at the time of entry into services.

<table>
<thead>
<tr>
<th></th>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>FY 2007 Target</th>
<th>FY2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value</td>
<td>89.5%</td>
<td>86.5%</td>
<td>85%</td>
<td>88.19%</td>
<td>88%</td>
</tr>
<tr>
<td>Numerator</td>
<td>29,614</td>
<td>30,353</td>
<td></td>
<td>33158</td>
<td></td>
</tr>
<tr>
<td>Denominator</td>
<td>33,080</td>
<td>35,104</td>
<td></td>
<td>37600</td>
<td></td>
</tr>
</tbody>
</table>

**Numerator:** Number of children and adolescents being served by DMH-funded community-based providers who meet the established criteria for “eligible population” at the time of entry into services.

**Denominator:** All children and adolescents being served by DMH-funded community-based providers.

**Goal:** To assure resources and services are provided to children and adolescents in the priority population of the public mental health system.

**Data Source:** Reporting of Community Services (RoCS).

**Population:** Children and adolescents with mental illnesses.

**Significance:** This indicator is part of the monitoring process to insure that mental health services are accessible and accessed by those who need them most.

**Action Plan:** DMH has a goal to maintain or increasing the proportion of children and adolescents served who meet the criteria for the eligible population.

* Projected less due to loss of SASS data
**CRITERION 3. CHILDREN’S SERVICES**

**ILLINOIS SPECIFIC INDICATORS**

<table>
<thead>
<tr>
<th>Indicator C3.1</th>
<th>C&amp;A WRAPAROUND SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funds spent through Screening Assessment and Support Services (SASS) agencies to support interagency wraparound plans with specialized mental health services.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>FY2007 Target</th>
<th>FY2007 Actual</th>
<th>FY2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

**Goal:** To increase the integration of services at the local level so that a child with multiple challenges can obtain individualized service and support in her or his home by providing flexible funding to purchase alternative therapeutic services.

**Population:** Clients who meet the criteria for the DMH Target or Eligible population who are registered in a C&A outpatient program, in a SASS program at an DMH-funded agency, or referred by their local area network of providers whose alternate sources of funding are exhausted.

**Service Elements:** The wraparound approach is a team driven process involving the family, child, and natural supports, with representatives from the life domains that are currently presenting the greatest challenges to the child and family. For many children, this will mean active participation of the child’s school.

**Data Source:** Program Code 131 C&A Wraparound Services Fiscal Data Base.

*Funding is provided to augment traditional mental health services or to purchase mental health services that the agency does not have the capacity to provide such as respite care, substance abuse services, culturally specific mental health services, therapeutic recreational activities, child and family support services, emergency psychotropic medication of the client/family, and transportation to access mental health and other therapeutic services.

*Not currently available

**Performance Indicator C3.1.** DMH has a goal of maintaining or expanding funding to Wraparound Services for FY 2007.
### Indicator C3.2: Co-Occurring Disorders-C&A

Percentage of Child and Adolescents (C&A) served with a mental health and substance abuse diagnosis*.

<table>
<thead>
<tr>
<th></th>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>FY 2007 Target</th>
<th>FY2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Value</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numerator</td>
<td>1.1%</td>
<td>1.15%</td>
<td>1%</td>
<td>1.05%</td>
<td>1%</td>
</tr>
<tr>
<td>Denominator</td>
<td>389</td>
<td>403</td>
<td>395</td>
<td>37600</td>
<td></td>
</tr>
</tbody>
</table>

**Numerator:** Number of child and adolescent consumers served in the community with a substance abuse diagnosis.

**Denominator:** Total number of all child and adolescents receiving services.

**Goal:** To increase community-based mental health service for persons who have co-occurring disorders of mental illness and substance use.

**Data Source:** Reporting of Community Services (RoCS).

**Population:** Children and adolescents with a mental illness and a co-occurring substance use disorder.

**Significance:** Many individuals with serious mental illnesses have co-occurring substance abuse disorders.

**Action Plan:** DMH will continue to track this information in FY 2008 with a goal of increasing the capacity for identification of dually diagnosed youth.

*A child with co-occurring disorders would have any DSM-IV or ICD-9 mental disorder diagnosis plus a diagnosis in the "Substance Abuse" group EXCEPT those in the categories of "Mental Retardation, Autism and Specific Development" or "Dementia, Delirium and Other Related Disorder" or "No Diagnosis, Deferred, Not Available".*
### NOM Performance Indicator C3.1. - PERCENTAGE OF CAREGIVERS REPORTING POSITIVE OUTCOMES OF TREATMENT FOR CHILDREN/ADOLESCENTS RECEIVING SERVICES

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>FY2007 Target</th>
<th>FY2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator</strong></td>
<td>48%</td>
<td>*</td>
<td>50%</td>
<td>**</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>35</td>
<td></td>
<td></td>
<td>72</td>
<td></td>
</tr>
</tbody>
</table>

**Goal:** To assess the proportion of persons served by the DMH-funded community-based mental health service system that report positively about outcomes for children and adolescents.

**Data Source:** MHSIP survey from Table 11, the Summary Profile of Client Evaluation of Care, the Illinois Uniform Data Report
Table 11, the Summary Profile of Client Evaluation of Care, was reported in the Illinois Uniform Data Report.

**Action Plan:** DMH aims to increase the percent reporting positively about outcomes for the Child and Adolescent Consumer Survey Results.

*Not conducted in FY 2006.

**Not Completed; will be reported in early 2008.
### NOM Performance Indicator C3.2. READMISSIONS WITHIN 30 DAYS – C&A

Percent of children/adolescents readmitted to a state hospital within thirty days of being discharged from a state hospital.

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>FY 2005 Actual</th>
<th>FY 2006 Actual</th>
<th>FY 2007 Target</th>
<th>FY 2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>5.2%</td>
<td>1.94%</td>
<td>2%</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Denominator</td>
<td>6</td>
<td>2</td>
<td>3</td>
<td>94</td>
<td></td>
</tr>
</tbody>
</table>

**Numerator:** Number of children/adolescents readmitted to a state hospital within thirty days of being discharged from a state hospital.

**Denominator:** Number of children/adolescents discharged from a state hospital in a fiscal year.

**Goal:** To encourage assurance of sufficient clinical stabilization of individuals released from a state hospital through planning and preparation of post-hospital community-based mental health services prior to being discharged.

**Data Source:** Inpatient Clinical Information System.

**Population:** Children and adolescents with serious emotional disturbances (SED).

**Action Plan:** DMH will continue to track the number of children and adolescents readmitted within 30 days of discharge from state hospitals for FY 2008.

*FY 2006 served as baseline data*
**NOM Performance Indicator C3.3. READMISSIONS WITHIN 180 DAYS – C&A**

Percent of children/adolescents readmitted to a state hospital within 180 days of being discharged from a state hospital.

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>FY 2005 Actual</th>
<th>FY 2006 Actual</th>
<th>FY 2007 Target</th>
<th>FY 2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>6.8%</td>
<td>6.8%</td>
<td>7%</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>Denominator</td>
<td>8</td>
<td>7</td>
<td></td>
<td>6</td>
<td>94</td>
</tr>
</tbody>
</table>

**Numerator:** Number of children/adolescents readmitted to a state hospital within 180 days of being discharged from a state hospital.

**Denominator:** Number of children/adolescents discharged from a state hospital in a fiscal year.

**Goal:** To encourage assurance of sufficient clinical stabilization of individual from the state hospital though planning and preparation of post-hospital community-based mental health services prior to being discharged so that rapid “revolving door” admissions are minimized.

**Data Source:** Inpatient Clinical Information System.

**Population:** Children and adolescents with serious emotional disturbances (SED).

**Action Plan:** DMH will continue to track the number of children and adolescents readmitted within 180 days of discharge from state hospitals for FY 2008.

---

**NOM Performance Indicator C3.2 and C3.3 –** There was a slight increase in readmissions within 30 days and a small decrease in readmissions within 180 days. DMH will continue to track this indicator.
NOM Performance Indicator C3.4  NUMBER OF CHILDREN/ ADOLESCENTS SERVED BY GENDER (Increased access to services)

<table>
<thead>
<tr>
<th></th>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>FY2007 Target</th>
<th>FY2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>19,177</td>
<td>21,112</td>
<td>*</td>
<td>18148</td>
<td>*</td>
</tr>
<tr>
<td>Females</td>
<td>12,941</td>
<td>14,158</td>
<td>*</td>
<td>12371</td>
<td>*</td>
</tr>
</tbody>
</table>

**Indicator:** Number of child/adolescent males and females receiving services from DMH-funded community-based providers.

**Goal:** To monitor access to services

**Data Source:** Reporting of Community Services (RoCS).

NOM Performance Indicator C3.4 There has been a slight decrease in the number of males and females served in the last year. This may be attributable to the SASS data collection problem referenced previously.

*No target set for FY 2007 or 08; we will need to determine if we can gain access to SASS data; For now we propose to track the data.

NOM Performance Indicator C3.5  NUMBER OF CHILDREN/ ADOLESCENTS SERVED BY RACE/ETHNICITY (Increased access to services)

<table>
<thead>
<tr>
<th></th>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>FY 2007 Target</th>
<th>FY2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Ind/Alaskan</td>
<td>63</td>
<td>60</td>
<td>*</td>
<td>55</td>
<td>*</td>
</tr>
<tr>
<td>Asian</td>
<td>133</td>
<td>106</td>
<td>*</td>
<td>139</td>
<td>*</td>
</tr>
<tr>
<td>African/American</td>
<td>8476</td>
<td>8,922</td>
<td>*</td>
<td>3696</td>
<td>*</td>
</tr>
<tr>
<td>Nat Haw/Pac Islander</td>
<td>66</td>
<td>*</td>
<td>64</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>19641</td>
<td>21,706</td>
<td>*</td>
<td>23095</td>
<td>*</td>
</tr>
<tr>
<td>Multi-racial</td>
<td>110</td>
<td>94</td>
<td>*</td>
<td>176</td>
<td>*</td>
</tr>
<tr>
<td>Unknown/Not available</td>
<td>2976</td>
<td>180</td>
<td>*</td>
<td>4660</td>
<td>*</td>
</tr>
<tr>
<td>Hispanic</td>
<td>3601</td>
<td>4,335</td>
<td>*</td>
<td>5137</td>
<td>*</td>
</tr>
</tbody>
</table>

**Indicator:** Number of children/adolescents by race/ethnicity receiving services from DMH-funded community-based providers.

**Goal:** To assure access to services

**Data Source:** Reporting of Community Services (RoCS).

NOM Performance Indicator C3.5: The numbers in nearly every category are projected to decrease in FY 2005; some of this may be attributable to the SASS problem referenced previously.

*No target set for FY 2007; we will continue to track the data.
NOM Performance Indicator C3.6. NUMBER OF CHILDREN/ADOLESCENTS SERVED BY AGE (Increased access to services)

<table>
<thead>
<tr>
<th>Age</th>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>FY2007 Target</th>
<th>FY2007 Actual</th>
<th>FY2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 3</td>
<td>407</td>
<td>321</td>
<td>*</td>
<td>315</td>
<td>*</td>
</tr>
<tr>
<td>4 – 12</td>
<td>16099</td>
<td>17,653</td>
<td>*</td>
<td>18249</td>
<td>*</td>
</tr>
<tr>
<td>13 - 17</td>
<td>16612</td>
<td>17,306</td>
<td>*</td>
<td>19209</td>
<td>*</td>
</tr>
</tbody>
</table>

**Indicator:** Number of children/adolescents by age receiving services from DMH-funded community-based providers.

**Goal:** To monitor access to services.

**Data Source:** Reporting of Community Services (RoCS).

NOM Performance Indicator C3.6 There was an increase in the number of children and adolescent seen for treatment in FY 2008.

*No target set for FY 2008; we will continue to track the data.

NOM Performance Indicator C3.7 Use of Evidence-Based Practices

We will not be reporting on this indicator for FY 2008. Please see state capacity checklist in Appendix 2.
**CRITERION 4: TARGETED SERVICES TO HOMELESS POPULATIONS AND TARGETED SERVICES TO RURAL POPULATIONS**

**ADULT ILLINOIS SPECIFIC PERFORMANCE INDICATORS**

<table>
<thead>
<tr>
<th>Indicator A4.1 HOMELESS PERSONS SERVED - ADULTS</th>
<th>Number of individuals being served by DMH-funded community-based providers are reported as undomiciled or homeless at the time of entry into service.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal:</strong></td>
<td>To assure that individuals with mental illness who are also homeless are accessing the DMH-funded community-based mental health service system.</td>
</tr>
<tr>
<td><strong>Target:</strong></td>
<td>A target number of 6500 is an estimate based on the number of homeless persons who were identified as receiving mental health services in previous fiscal years.</td>
</tr>
<tr>
<td><strong>Data Source:</strong></td>
<td>Reporting of Community Services (RoCS).</td>
</tr>
<tr>
<td><strong>Population:</strong></td>
<td>Adults with mental illnesses.</td>
</tr>
<tr>
<td><strong>Significance:</strong></td>
<td>Individuals with mental illnesses should have access to affordable permanent housing.</td>
</tr>
<tr>
<td><strong>Action Plan:</strong></td>
<td>DMH aims to maintain or expand access to the DMH-funded community-based mental health service system by persons with mental illnesses who are homeless.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>FY 2007 Target</th>
<th>FY2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>6,498</td>
<td>6,635</td>
<td>6,500</td>
<td>7639</td>
<td>6,500</td>
</tr>
</tbody>
</table>
Indicator A4.2  RURAL RESIDENTS SERVED - ADULTS
Number of individuals being served by DMH-funded community-based providers who are residents of rural areas at the time of entry into services.

<table>
<thead>
<tr>
<th></th>
<th>FY2005 Actual</th>
<th>FY2005 Actual</th>
<th>FY2007 Target</th>
<th>FY2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>30,607</td>
<td>30,607</td>
<td>32,000</td>
<td>34807</td>
<td>32,000</td>
</tr>
</tbody>
</table>

**Goal:**  To assure that individuals with mental illnesses who reside in rural areas are accessing the DMH-funded community-based mental health service system.

**Data Source:**  Reporting of Community Services (RoCS).

**Population:**  Adults with mental illnesses.

**Significance:**  The geography of rural areas adds challenges to the timely and consistent access to services for both service providers and persons with mental illnesses.

**Action Plan:**  DMH aims to maintain or expand access to community mental health services for persons residing in rural areas.
### CRITERION 4: TARGETED SERVICES TO HOMELESS POPULATIONS AND TARGETED SERVICES TO RURAL POPULATIONS

#### CHILDREN & ADOLESCENTS

**ILLINOIS SPECIFIC SYSTEM PERFORMANCE INDICATORS**

<table>
<thead>
<tr>
<th>Indicator  C4.1</th>
<th>HOMELESS YOUTH SERVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of children being served by DMH-funded community-based providers who are reported as undomiciled or homeless at the time of entry into services.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>FY2007 Target</th>
<th>FY2007 Actual</th>
<th>FY2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>450</td>
<td>365</td>
<td>350</td>
<td>300</td>
<td>325</td>
</tr>
</tbody>
</table>

**Goal:** To assure that children with emotional disturbances who are also homeless are accessing the DMH-funded community-based mental health service system.

**Data Source:** Reporting of Community Services (RoCS).

**Target:** Reduction in the number of children and adolescents who are mentally ill and homeless through appropriate delivery of mental health services.

**Population:** Children and adolescents with serious emotional disturbances (SED).

**Action Plan:** DMH aims to maintain or expand access the DMH-funded community mental health service system by children and adolescents who are homeless at intake.
**Indicator C4.2**  RURAL RESIDENTS SERVED - C&A  
Number of children being served by DMH-funded community-based providers who are residents of rural areas at the time of entry into services.

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Actual</th>
<th>Actual</th>
<th>Target</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY2005</td>
<td>10,247</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY2006</td>
<td>11,014</td>
<td></td>
<td>10,500</td>
<td>11,590</td>
<td>10,500</td>
</tr>
</tbody>
</table>

**Goal:** To assure that children with emotional disturbances who reside in rural areas are accessing the DMH-funded community-based mental health service system.

**Data Source:** Reporting of Community Services (RoCS).

**Population:** Children and adolescents with serious emotional disturbances (SED).

**Significance:** The geography of rural areas adds challenges to the timely and consistent access to services for both providers and persons with mental illnesses.

**Action Plan:** DMH aims to maintain or expand access to community mental health services for children and adolescents residing in rural areas.
## CRITERION 5: MANAGEMENT SYSTEMS

### ADULTS

#### ILLINOIS SPECIFIC PERFORMANCE INDICATORS

<table>
<thead>
<tr>
<th>Indicator</th>
<th>MEDICAID BILLING - ADULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total dollars billed to Medicaid for adults.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>FY2005 Actual</td>
</tr>
<tr>
<td></td>
<td>$129,028,640</td>
</tr>
</tbody>
</table>

**Goal:**
To assure prudent administration of resources through appropriate matching of federally available dollars for mental health services.

**Data Source:**
Reporting of Community Services (RoCS).

**Population:**
Adults with mental illnesses.

**Significance:**
A measurement of the state’s capacity to fund and provide mental health services. Resources must be maximized to support delivery of mental health services.

**Action Plan:**
DMH has a goal of increasing Medicaid billing for community mental health services provided to adults in FY 2008.

*Not yet available*
### Indicator A5.2  ACTUAL MEDICAID REIMBURSEMENT  
**(FEDERAL FINANCIAL PARTICIPATION)**

Total dollars approved and paid by Medicaid.

<table>
<thead>
<tr>
<th></th>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>FY 2007 Target</th>
<th>FY2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Target:</strong></td>
<td></td>
<td></td>
<td></td>
<td>*</td>
<td>$75,000,000</td>
</tr>
</tbody>
</table>

$64,514,230 $74,799,820 $75,000,000

*Not yet available

**Goal:** To assure prudent administration of resources through appropriate matching of federally available dollars for mental health services.

**Target:** Maximum appropriate reimbursement through Federal Financial Participation (FFP).

**Data Source:** Reporting of Community Services (RoCS).

**Population:** Adults with mental illnesses.

**Significance:** A measurement of the state’s capacity to fund and provide mental health services. Resources must be maximized to support delivery of mental health services.

**Action Plan:** DMH aims to continue to enhance resources through matching federally available dollars for community mental health services. This effort will be enhanced through improved data collection and monitoring of service delivery.
CRITERION 5: MANAGEMENT SYSTEMS

CHILDREN & ADOLESCENTS
ILLINOIS SPECIFIC SYSTEM PERFORMANCE INDICATORS

Indicator C5.1  MEDICAID BILLING - C&A
Total dollars billed for children and adolescents (C&A).

<table>
<thead>
<tr>
<th></th>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>FY 2007 Target</th>
<th>FY2007 Actual</th>
<th>FY 2008 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$19,960,808</td>
<td>$22,005,772</td>
<td>$22,000,000</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

Goal: To assure prudent administration of resources through appropriate matching of federally available dollars for mental health services.

Data Source: Medicaid Clinic Option (MCO), Medicaid Rehabilitation Option (MRO) and Reporting of Community Services (RoCS).

Population: Children and adolescents with serious emotional disturbances.

Significance: A measurement of the state’s capacity to fund and provide mental health services. Resources must be maximized to support delivery of mental health services.

Action Plan: DMH has a goal of increasing Medicaid billing for community mental health services provided to children and adolescents in FY 2008.

*Not yet available.

System Performance Indicator C5.1
DMH aims to increase Medicaid billing for fees for community mental health services provided to children and adolescents in FY 2007.
FY2007 IMPLEMENTATION REPORT

Part E OF THE FY2007
BLOCK GRANT
COMMUNITY MENTAL HEALTH SERVICES
APPLICATION

Uniform Reporting Tables
(See IL 2007 URS Report)
FY2007 IMPLEMENTATION REPORT

BLOCK GRANT
COMMUNITY MENTAL HEALTH SERVICES
APPLICATION

State Capacity Checklist
FY2007 IMPLEMENTATION REPORT

BLOCK GRANT
COMMUNITY MENTAL HEALTH SERVICES
APPLICATION

Letter – Mental Health Planning Advisory Council
Planning Committee