**FY2019**

**COMMUNITY MENTAL HEALTH SERVICES**

**BLOCK GRANT IMPLEMENTATION REPORT\***

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**ILLINOIS DEPARTMENT OF HUMAN SERVICES**

**DIVISION OF MENTAL HEALTH**

**\*NARRATIVE REPORT OF PROGRESS AND ACHIEVEMENTS IN FY2019 TOWARD THE IMPLEMENTATION OF THE SFY2018-SFY2019** **COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT APPLICATION AND PLAN WHICH WAS SUBMITTED ON SEPTEMBER l, 2017**

Introduction

This implementation report covers the second year of a two-year Mental Health Block Grant plan for FY2018-FY2019 which was submitted to SAMHSA on September 1st, 2017. In general, this report describes our achievements, continuing progress, and documents the challenges we encountered during FY2019 as we worked on 20 strategies supported by performance measures that related to DMH priorities and goals.

In accordance with formatting requirements by SAMHSA, each strategy is presented separately in a table which provides information about the priority, the goal that is being addressed, the strategy itself, the performance measure evaluating achievement and outcome, a description of how the data for the performance measure is collected and how changes are measured, and, finally, the state’s report as to whether or not the strategy was achieved. Following each table, a brief review of background information, a description of our progress in FY2019, and other pertinent data are provided.

FY2019 IMPLEMENTATION REPORT

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**Priority #1- Design of Public Mental Health Services**

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| 1. Priority Area:  **Continue to develop and improve the array of clinical and support services available for adults and children.** | 2. Priority Type: MENTAL HEALTH SERVICES |
| 3. Population(s) SMI, SED: | |
| 4. Goal of the priority area: *Assure the clinical quality and effectiveness of community-based mental health services available to adults and youth and assure the comprehensiveness of the public mental health service system design.* | |
| 5. Objective: Conduct ongoing evaluation of the quality and outcome of community-based services in Illinois. | |
| 6. Strategies to attain the objective:   * Identify, develop and establish outcome measures (indicators) for the evaluation of community services. * Design a system to process the components and data of the evaluation. * Implement the system. * Analyze the resulting data to: (a) inform the publicly funded community service system; (b) facilitate decision making and planning; and (c) improve the quality and effectiveness of services and service delivery. | |
| 7. Annual Performance Indicators to measure goal success:  **Indicators: (1) Number of outcome measures ready for use.**  **(2) Percent of providers that demonstrate their capacity for use of the outcome measures in reporting.** | |
| a) Baseline measurement (Initial data collected prior to and during SFY 2017): N/A | |
| b) First-year target/outcome measurement (Progress to end of SFY 2018): **Completion of a draft set of outcome measures for the evaluation of community services and initiation of stakeholder discussion, input, and review.** | |
| c) Second-year target/outcome measurement (Final to end of SFY 2019): **Completion of a prioritized list of outcome measures and initial implementation of a system of reporting which processes the data and components of the evaluation.** | |
| d) Data source: DMH information system | |
| e) Description of data:  Generally, registration data is submitted directly to the DMH information system which is operated by the DMH’s Administrative Services Organization (ASO). Claims data, which is submitted to the State Medicaid agency, Healthcare and Family Services (HFS), is returned to the ASO after processing where it is stored with registration information in the DMH data warehouse. This information is used as a basis for developing reports and for analytic purposes. While this data is the basis for reporting in many of the URS tables and can be processed through this system for some specific outcome measures, the development of outcome measures requires working with an evaluative data platform that serves to identify the most critical and successful outcomes. | |
| f) Data issues/caveats that affect outcome measures: Contrary to interagency plans in FY2017, a joint working data platform for the identification of outcome measures by DHFS in collaboration with DMH could not be fully completed in FY2018 and a draft set of measures to be employed by both agencies was not produced. | |
| **8. Report of Progress toward goal attainment**  **Second year target: \_\_\_\_\_ Achieved \_\_\_X\_\_ Not Achieved (If not achieved, explain why)** | |

***Due to administrative changes at the state level it has not been possible to develop the necessary components to evaluate community services across the State. However, DHS/DMH is moving forward in FY2020 and FY2021 with the tools now provided through the certification of community mental health centers to establish the database needed for the evaluation of the public mental health service system in Illinois.***

***In FY2018, DMH partially achieved the target, through the development of a set of performance measures used in the monitoring of community provider contracts. Full development of a draft set of outcome measures could not be completed until the Rules governing certification and service delivery were fully revised and adopted. After a prolonged process due to unanticipated delays over many months, the Medicaid Rule (Rule 132) which contained the certification requirements and process for Community Mental Health Centers and defines the Medicaid Services they provide was fully revised in conjunction with Department of HealthCare and Family Services (DHFS) into two Rules that separated the service definitions from the certification process. The new 59Ill Adm. Code 132 containing revised certification requirements and processes became effective on January 1, 2019. HFS has filed a corresponding amendment- 89Ill. Admin. Code 140 - which now includes the service definitions.***

***Contrary to expectations a joint working data platform for the identification of outcome measures by DHFS in collaboration with DMH has not been fully realized. A prioritized list of outcome measures and initial implementation of a system of reporting which processes the data and components of the evaluation is yet to be completed. Through the ongoing certification processes now required in Rule 132 that include periodic review, monitoring, and recertifications of Certified Community Specialty Providers and Certified Community Mental Health Centers, DHS/DMH can now identify and evaluate service shortfalls. Planning for the design and implementation of a database to process the components and data of the evaluation is now underway and has been included in the FY2020-FY2021 Plan. In FY2020 DMH will move forward with the analysis of resulting data to: (a) identify areas where access and availability of services needs to be improved; (b) inform the publicly funded community service system; and (c) facilitate decision making and planning.***

**Priority #2 - Evidence Based Practices: Assertive Community Treatment (ACT)**

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| 1. Priority Area #2:  **Promote Provision of Evidence Based and Evidence-Informed Practices** | 2. Priority Type:  MENTAL HEALTH SERVICES |
| 3. Population(s) SMI, SED | |
| 4. Goal of the priority area: *Promote Evidence Based Practices for individuals served in DMH funded agencies and advance the implementation of evidence-informed practices in the child and adolescent service system.* | |
| 5. Objective: Continue to reach expected outcomes for individuals in need through provision of Assertive Community Treatment (ACT). | |
| 6. Strategy to attain the objective: Development of a set of outcome measures designed to assess the progress of individuals served. | |
| 7. Annual Performance Indicators to measure goal success:  **Indicator**:  **Number of active service slots filled in the State for persons with SMI to receive Assertive Community Treatment in FY2018 and FY2019 (National Outcome Measure).** | |
| a) Baseline measurement (Initial data collected prior to and during SFY2017): Baseline for 2017 not applicable to FY2018 or FY2019 as indicator has been revised to reflect service access capacity. See 7e-Description of Data. | |
| b) First-year target/outcome measurement (Progress to end of SFY 2018): **1,100** | |
| c) Second-year target/outcome measurement (Final to end of SFY 2019): **1,100** | |
| **d) Data Source:** DMH funded providers by contract must submit demographic, clinical information and claims data for all individuals receiving services funded using DMH dollars. The DMH provides data specifications to assure consistency of reporting. | |
| e) **Description of data:** Providers of ACT services submit monthly reports of team capacity to DMH, which is monitored for system sufficiency. This information is used as a basis for developing reports, analytic purposes, and is the basis for reporting the data used to populate the URS tables**.** | |
| f) **Data issues/caveats that affect outcome measures:** Most ACT Teams currently operate within areas where services to individuals are reimbursed through Managed Care Contracts. Limited and indirect access to MCO data prevents thorough analysis of service data and outcomes. In FY 2017 the number of available service slots in the State totaled 1,321. The figures for FY2018 were as follows: 2,150 available service slots in the State and 1,779 individuals were served in during the year. Planning to improve the interoperability of data systems is continuing and DMH is looking forward to tracking outcomes with greater accuracy. | |
| **8. Report of Progress toward goal attainment**  **Second year target: \_\_X\_\_\_ Achieved \_\_\_\_\_ Not Achieved (If not achieved, explain why)** | |

***This objective has been successfully accomplished! The target was exceeded!***

***In FY2019, 1,532 persons were served by Illinois ACT Teams, exceeding the target of 1,100 by 39.3%.***

***DMH introduced three new ACT teams and was successful in maintaining 33 ACT teams in FY2019. The service capacity report from providers of ACT shows 1,532 individuals being served, significantly exceeding the target of 1,100 for the fiscal year. The statewide capacity of available and active ACT service slots as of 6/24/1*9 *was 1,989 with a 23% vacancy rate.***

**Background:**

Illinois adopted and began to implement the Assertive Community Treatment (ACT) model in 1992. ACT is the most intensive specialized model of outpatient community mental health care in which a team of mental health professionals takes responsibility for a small group of program participants’ day-to-day living and treatment needs. Often these consumers have a history of repeated admission to psychiatric inpatient services or excessive use of emergency services and typically require assertive outreach and support to remain connected with necessary community mental health services. Usually, previous efforts to provide linkage to necessary services have failed and their need for multiple services requires extensive coordination. The active participation of nurses, psychiatrists, and specialists trained in substance abuse is crucial to the success of the ACT model.

**Priority #3 Evidence Based Practices-Individual Placement and Support (IPS)**

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| 1. Priority Area:  **Promote Provision of Evidence Based and Evidence-Informed Practices** | 2. Priority Type:  MENTAL HEALTH SERVICES |
| 3. Population(s) SMI | |
| 4. Goal of the priority area: *Promote Evidence Based Supportive Employment for individuals served in the publicly funded mental health service system.* | |
| 5. Objective: During FY2018 and FY2019, maintain and support the statewide implementation of Evidence Based Supportive Employment. | |
| 6. Strategies to attain the objective: (1) Continue the development of the state infrastructure required to support implementation and sustainability of IPS Evidence Based Supported Employment. (2) Continue to develop the integration of physical and behavioral health with employment supports and peer support statewide. (3)By the end of FY 2019, contingent upon additional funding resources, target an additional 500 consumers to acquire competitive employment in their local communities. | |
| 7. Annual Performance Indicators to measure goal success:  **Indicator: Number of consumers receiving supported employment in FY2018 and FY2019. (National Outcome Measure)** | |
| a) Baseline measurement (Initial data collected prior to and during SFY 2017):  **- FY2016 2,208 consumers served in 45 IPS sites with fidelity to the model and 222 in 9 sites working towards fidelity =2,430 consumers.**  **- FY2017 3,003 consumers served in 56 IPS sites with fidelity to the model and 183 in 6 sites working towards fidelity =3,275 consumers.** | |
| b) First-year target/outcome measurement (Progress to end of SFY 2018): **To serve 3,375 consumers in IPS. 3,413 were served in FY2018.** | |
| c) Second-year target/outcome measurement (Final to end of SFY 2019): **To serve 3,775 consumers in IPS. 3,228 were served on FY2019** | |
| d) **Data source:** Data for this indicator are generated through a special web-based database created specifically for the DMH SE initiative. Fidelity and outcomes data are submitted to the DMH SE coordinator. | |
| e) **Description of data:** As always, DMH has developed specifications for reporting that DMH funded providers must use when submitting data. | |
| f) **Data issues/caveats that affect outcome measures:** DMH only reports data for teams that have been found to exhibit fidelity to the evidenced based practice model. DMH is working to promote fidelity in all IPS agencies and thereby expand the database. | |
| **8. Report of Progress toward goal attainment**  **Second year target: \_\_\_ Achieved \_\_X\_\_\_ Not Achieved (If not achieved, explain why)** | |

##### Supported Employment has continued to be substantively addressed. The numerical target for FY2019 was 85.5% attained. The program experienced a 5.4% decrease from the total number served in FY2018 due to the serious setbacks cited below but continues to be robust and looking forward towards increasing activity and numbers served in FY2020. 3,228 individuals received and benefitted from IPS services in FY2019.

##### While staff turnover has historically been a problem issue for IPS Providers, it appeared staff turnover was at a record high during FY2019. Many IPS provider agencies not only had major employment specialist turnover during this period, but also had senior IPS team leader and IPS program director turnover as well. At any IPS provider, the IPS Team Leader is the most vital position and strongest advocate in referring clients to IPS and filling IPS caseloads. So, without fully staffed IPS teams to serve clients, and lacking the strong leadership advocacy of IPS due to those vacant key leadership positions, many IPS caseloads at providers agencies did not increase with new IPS intakes. IPS providers chose to limit (and in some cases closed) IPS program intake until employment specialist and IPS team leader positions were filled. With the skill set of an employment specialist position being so unique, it took IPS providers 3 to 4 months to fill all open positions – which stopped expansion of IPS. DMH believes that with new IPS provider agencies implementing IPS and tenured IPS providers now having filled key IPS staff positions, the number of clients served in IPS should increase in FY2020.

##### In FY2019, a total of 41 IPS sites with fidelity to the model served 2,863 unduplicated consumers. An additional 12 sites that were working toward fidelity but had not yet met fidelity standards served 365 consumers. In all, 3,228 consumers received supported employment services.

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| **Total # of Fidelity Sites:** | **41** |
| **Total unduplicated # of consumers who received IPS at the fidelity sites:** | **2,863** |
| **Total # of Sites not at Fidelity:** | **12** |
| **Total unduplicated # of consumers who received IPS at the non-fidelity sites:** | **365** |
| **Total unduplicated # of consumers who received IPS:** | **3,228** |

**Background**

Since 2007, DMH and DHS/Division of Rehabilitation Services (DRS) have partnered in a joint effort to increase access to Individual Placement and Support (IPS) supportive employment for persons with serious mental illnesses and to improve the coordination of psychiatric and vocational services. Locally, services are obtained through joint planning and service efforts by community mental health centers (CMHCs) and local offices of DRS. Supported Employment Services in Illinois are based on the integration of DHS Division of Rehabilitation Services (DRS) funded vocational services/resources with DMH funded mental health treatment and supportive services.

Accomplishments in FY2019 included:

* DMH completed the fifth and final year of the Mental Health Transformation Grant (MHTG) from SAMHSA to enhance state and community capacity to provide and expand evidence-based supported employment programs (EB-SE)/Individual Placement and Support (IPS). The Grant focused on the development of the state infrastructure required to support implementation and sustainability of IPS Supported Employment. The two grant sites, Thresholds Woodlawn and Trilogy Edgewater, focused on recruiting efforts to increase the number of participants served with IPS in Edgewater and Woodlawn in Year 5 of the Grant and have successfully served 336 participants in IPS. Both sites also continued to enhance the current IPS model through the integration of physical and behavioral health for IPS clients including *Working and Wellness Groups, SAMHSA 8 Dimensions of Wellness Groups, Wellness Recovery Action Plan [WRAP] for Work, and Nutrition and Exercise for Wellness and Recovery [NEW-R] groups, and financial literacy groups.* DMH continued to work with the UIC Center on Mental Health Services and Research Policy to collect and analyze data.
* The Illinois Employment First Interagency Council continued to meet on a regular basis with the goals of increasing employment opportunities for persons with disabilities in Illinois.
* DMH continues to focus on engaging MCOs [in conjunction with HFS] on the business case for IPS by demonstrating cost-savings and healthier outcomes credited to IPS.
* DHS, DMH and DRS created an Administrative Directive for implementing IPS to citizens of Illinois with mental illnesses. This Administrative Directive establishes the terms and conditions that will guide the partnership and strengthen the collaboration between the Divisions targeted at developing, expanding, and improving opportunities for competitive integrated employment ***by making*** IPS ***accessible to*** citizens of Illinois with serious mental illnesses.
* The Illinois Web Portal, “Pathways to Employment – Putting Illinois to Work” is continuing to see fantastic use -- <http://www.illinoisips.org>. We added more resources to the Web Portal as we view it as a strong IPS workforce development tool and training resource for IPS providers [and community mental health centers wanting to learn more about IPS] to use in addition to the one-on-one technical assistance they receive from Statewide DMH IPS Trainers. We also added to the “IPS for Families and Natural Supporters” section as we want the section to explore the many ways that family, friends, and clients help others to gain and maintain employment. We believe engaging people’s natural support systems is key for both mental health recovery and long-term career success. We see the portal as a lasting support from the five-year grant, that will continue to be available to providers, employers, state trainers, and other stakeholders as we sustain the progress made from the grant now that the grant has ended.
* DMH hosted a very successful Illinois IPS Conference in April of 2019. It was the first such conference Illinois has hosted since June of 2013. The conference successfully built momentum and enthusiasm for IPS in Illinois with IPS Providers, Stakeholders, and State Agencies. The Conference, entitled “Be Part of Something Greater - IPS” provided an opportunity to build upon the scalability of IPS through attendance of a wide variety of participants, including current IPS providers, community mental health centers and their executive leadership who do not currently provide IPS, as well as our state leadership and partners within other Divisions. The conference included an introductory to IPS for participants new to the model, key note speakers, breakout sessions, and a recognition dinner. The various breakout sessions focused on different principles of IPS as well as other resources available to IPS teams. The conference was held over two days, and registration was near capacity for the venue. Evaluations by attendees were overwhelmingly positive, and plans are underway to establish the IPS conference as an annual event, either as a free-standing conference or as a component of a larger evidence-based practices conference.
* The Division of Mental Health continued to fund 3 DMH IPS Trainer Positions [through agency contracts] to provide IPS technical assistance to IPS Agencies in Regions 1 & 2 in FY 2018 and for FY2019. Two IPS Trainers continue to help implement and provide technical assistance in Regions 1 & 2 and the other IPS Trainer continues to help Agency Drop-In Center Staff improve their skills on engagement on employment, and the role it plays in recovery as part of the Williams/Colbert Consent Decrees. In addition, we have 3 DMH state employees who are also trained and equipped to provide IPS technical assistance to IPS Agencies in Regions 3, Region 4, and Region 5 [one trainer in each Region]. Illinois has a total of 6 IPS Trainers Statewide.
* Technical assistance to increase fidelity to the IPS Supported Employment Model as well as to increase the sustainability and scalability of IPS has increased from 1,695 hours provided to the IPS sites in FY2010 to approximately 7,200 hours provided to over 2,100 staff [including agency IPS provider staff, clinical staff and support personnel, state employees of DHS, HFS, DCEO, DCFS, DJJ and community stakeholders] for IPS across the State in FY2019. IPS Technical Assistance Team activities have included:
  + Providing face-to-face individual consultation, teleconference/phone, and large group in-person trainings.
  + Monitoring the performance of IPS Provider Agencies and providing feed-back to improve employment outcomes.
  + Presenting at Statewide Behavioral Health Conferences and National IPS Conferences to increase the knowledge of IPS.
  + Assisting with the development of the web-based IPS Web Portal to further extend training resources.
  + Development of a CY2019 curriculum for Monthly State-wide Technical Assistance Calls and facilitating those calls with topics that focused on improving employment outcomes and integrating employment with Wellness and Recovery.
  + Working with Williams/Colbert Agency Drop-In Center Staff to better educate them on the IPS Model, educate them on the role IPS plays in recovery, and helping improve their engagement skills on talking to consumers about employment.
  + Working to implement Nutrition and Exercise for Wellness and Recovery [NEW-R] statewide by training IPS providers and community mental health centers [CHMCs] to offer NEW-R groups.
  + Collecting and analyzing IPS Data from IPS Providers entered on the DHH IPS/EBSE Web-Based Data System and using that data to improve IPS performance Statewide.
* Many community mental health centers have started to show an interest in offering IPS services to their clients and becoming an IPS Provider. DMH made 30 IPS presentations to community mental health centers considering implementing IPS. Some of those CMHC’s included: Josselyn Center, Kenneth Young Center, Envision Unlimited, Grand Prairie, Habilitative Systems Inc. and Association House in Region 1[Chicago Land Area]; Association for Individual Development, Alexian Brothers, NorthPointe Resources, Ecker Center, NAMI DuPage and NAMI Barrington Area in Region 2 [Northern Illinois]; Mental Health Centers of Western Illinois and Heartland Human Services in Region 4 [Central Illinois]. Josselyn Center, Envision Unlimited, Heartland Human Services and Association for Individual Development have adopted the IPS model and all started to implement IP services during FY19. DMH is hopeful that other agencies will adopt the IPS model and become IPS Providers as well.
* The Nutrition and Exercise for Wellness and Recovery [NEW-R] State Steering Committee has continued to develop and help implement NEW-R services throughout the entire State of Illinois. DMH staff, DMH IPS Trainers, DMH CRSS Staff, both SAMHSA Site IPS Team Leaders and Employment Recovery Specialists, and other statewide recovery leaders are on the steering committee. 30 CMHCs [20 of them being IPS sites] are currently offering 36 NEW-R groups to consumers.
* During the 2019 tax season, both SAMHSA IPS Teams [with assistance from the University of Illinois at Chicago (UIC) Grant Evaluation Team], again partnered with Volunteer Income Tax Assistance [VITA] sites at the City Colleges of Chicago to help working clients get their income tax paperwork completed free of charge. A total of 35 consumers utilized the free VITA sites. This is a significant increase of working clients that used the services last year. We believe due to our improved marketing of the VITA program and due to more financial literacy education being offered to clients, we had this great increase.
* DMH worked with the Illinois Office of the Treasurer to promote Achieving a Better Life Experience [ABLE] accounts with IPS providers for working consumers in IPS. These accounts allow those with disabilities and their families to save for many daily, disability-related expenses on a tax-deferred basis – without limiting their ability to benefit from SSI, Medicaid and other federal programs. A representative from this program attended the IPS Regional meetings to share information and ask questions for all participants, and a presentation was also made during the IPS Conference in April 2019.
* Using an increase in the technical assistance funds received from the final year of the SAMHSA Transformation Grant, DMH was able to send five of the IPS trainers, the IPS Program Manager, and the DMH Deputy Director with IPS leadership responsibility to the International Learning Community Meeting in May 2019 for advanced training and technical assistance. Several members of the Illinois delegation provided presentations during the two-day collaboration.

Evidence Based Supportive Employment **(**EBSE**)** is still confronting several challenges:

* State infrastructure issues continue to make it difficult to expand access to IPS, including its funding model, data systems, quality monitoring (fidelity reviews), training, and reaching at risk populations.
* There is still frequent turnover of employment specialists and IPS Supervisors who have had the extensive training and experience required to implement IPS successfully, as well as community support workers and case managers who are instrumental in integrating rehabilitation with mental health treatment thru regular team member contact. This continues to be a challenge to program sustainability.
* Current resources to provide IPS technical assistance are still insufficient to meet the needs of the growing number of IPS teams in the State. It is becoming more challenging to provide IPS trainings, conduct IPS fidelity reviews, and provide one-to-one field mentoring of IPS.
* The DMH IPS Web-based Data System still needs modernization to keep up with growth and data needs.

**P****riority #4: FEP SET-ASIDE**

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| 1. Priority Area:  **Use of the 10% Block Grant Set-Aside to implement Specialized Programming and Evidence – Based Services for persons experiencing First Episode Psychosis.** | 2. Priority Type:  MENTAL HEALTH SERVICES |
| 3. Population(s) SMI, SED, ESMI: | |
| 4. Goal of the priority area:  *Sustain and expand the infrastructure for evidence-based clinical programs for persons with FEP****.*** | |
| 5. Objective#1: (a) Sustain the 12 teams developed in FY2017 and contingent on available funding, identify a location to develop a new FEP team by the end of FY2019. | |
| 6. Strategies to attain the objective:  Provide education, training, and ongoing consultation to staff involved in FEP programs that includes:   * Strategies for Outreach and community-based education to attract and retain clients who have recently begun experiencing symptoms of psychosis or serious mental illness; * Assessment and individualized treatment planning with these individuals in the most supportive and least intrusive manner; * Psychiatric evaluation and medication management * Individual Placement and Support (IPS) programs geared towards accessing employment, job retention, and smooth transitional experiences in work life that can increase self-esteem, confidence, and stability in persons experiencing early episodes of serious mental illness. * Supportive education that helps the individual to initiate or continue in his/her educational process. * Individual Resiliency Training and Support * Family Psychoeducation * Case Management/Recovery Support Specialists * Cognitive Behavioral Therapy for Psychosis * Analyze needs of geographic areas to identify the best location of a new program * Determine the potential for success and the capacity of the candidate provider based upon criteria for Providers Selection previously formulated by the DMH FEP Team | |
| 7. Annual Performance Indicators to measure goal success:  **Indicator #1: (a) Number of sites in the State with funded FIRST.IL Programs.**  **(b) The total set-aside expenditures by the State for each site** | |
| a) Baseline measurement (Initial data collected prior to and during SFY 2017):  **12 funded sites** | |
| b) First-year target/outcome measurement (Progress to end of SFY 2018): **12 Funded sites** | |
| c) Second-year target/outcome measurement (Final to end of SFY 2019): **13 Funded Sites** | |
| d) Data source: The DMH contractual process for this initiative included specified goals, performance measures and performance standards for each participating provider. Data is collected from participating FIRST.IL sites on an ongoing basis by statewide coordinators of the program using the Enrollee Outcomes Form which documents the outcomes in terms of number of referrals and number of clients enrolled at each participating site. | |
| e) Description of data: The Enrollee Outcomes format that lists all active sites in the State is now incorporated into the DMH FIRST.IL Web-based Data System. Agencies began directly entering enrollment and other data including Employment and IPS/Supported Education into this new system in FY2019. Records of contracts and funding awards for each agency are maintained by the DMH Fiscal Office. Quarterly Report Performance Forms track training and team composition. Monthly Expenditure Reports are also completed by FIRST.IL agencies and provided to DMH. | |
| f) Data issues/caveats that affect outcome measures: The full potential of the FIRST.IL Program may be affected by changes in federal guidelines. | |
| **8. Report of Progress toward goal attainment**  **Second year target: \_\_\_X\_\_ Achieved \_\_\_\_\_ Not Achieved (If not achieved, explain why)** | |

***This objective was successfully accomplished by the end of FY2018 with the establishment of three additional sites. These fifteen funded sites have been successfully maintained and enhanced through FY2019. The target of 13 funded sites being operational by the end of FY2019 was exceeded.***

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| **5. Objective #2:** Improve and maintain quality of clinical services received by FIRST.IL clients |
| **6. Strategies to obtain objective;** Training in key clinical approaches such as CBT-p, Family Psychosocial Education (FPE), Case Management, Counseling (See strategies for Objective #1) and ongoing technical assistance.  Strategies specific to CBT-psychosis:   * Training will be 1 full day of CBT-p Skills Training at 2 sites – 1 in Chicago and 1 in Springfield for Downstate Agencies in FY 18. * Follow-up Monthly CBT-p Training calls for all 12 FEP Teams |
| **7. Indicators: (1) Number of training events held each year to increase knowledge and clinical competence in the delivery of FIRST.IL services in community agencies statewide. (2) Number of technical assistance meetings and teleconferences conducted by the statewide coordinators.** |
| **a) Baseline measurement (Initial data collected prior to and during SFY 2017)***:* During the fiscal year (July 2016 through June 2017), there were a total of 223 Technical Assistance and Consultative meetings between DMH coordinators, the BeST Center, and the 11 provider agencies in various combinations. These meetings included Consultations with each team once every two weeks and a regular conference call with all the team leaders once a month. Additionally, the BeST Center Consultant directly provided 18 FEP Trainings for all newly hired FEP agency staff twice monthly and weekly telephone consultation to the DMH statewide coordinators. The BeST Center’s consulting psychiatrist provided three teleconference training sessions and nine learning collaborative calls in psychiatric evaluation and medication management. All meeting calls and training were 1 hour in length. |
| **b) First-year target/outcome measurement (Progress to end of SFY 2018):** (a)Training events: 21 including 1 universal event (CBT-p): 12 events for newly hired staff; and 8 training events in Family Psychoeducation. Total = 21 Trainings, (b) TA contacts = 327 including 39 individualized follow-up events for CBT-p |
| **c) Second-year target/outcome measurement (Final to end of SFY 2019):** (1) Trainings- 8 Clinical Training events, including 1 CBT-p Training for the 3 new FIRST.IL Providers, New Clinical staff IRT Training will occur 4 times during the year. Other new EBP Clinical Training will occur on the topics of Trauma Informed Care and Recovery Support Specialists. (2) TA contacts = 400 (including 50 individualized CBT-p monthly clinical follow-up calls to clinical staff) for 15 Providers and up to 3 state coordinators in various combination. |
| d) Data source: Records of teleconference calls and attendance are maintained by statewide coordinators**.** |
| e) Description of data: See Above |
| f) Data issues/caveats that affect outcome measures: |
| **8. Report of Progress toward goal attainment**  **Second year target: \_\_X\_\_\_ Achieved \_\_\_\_\_ Not Achieved (If not achieved, explain why)** |

***This objective was achieved in FY2019 and the targets were met. Eight training events with follow-up technical assistance as needed were conducted during the year, including 1 CBT-p Training for the 3 new FIRST.IL Providers, New Clinical staff IRT Training occurred 4 times during the year, and training events were conducted on the integration of Trauma Informed Care, Recovery, and the role of Recovery Support Specialists on Clinical Teams, and the use of the newly established Web-based Data System.***

***The three state coordinators tracked 408 TA contacts that included 50 individualized CBT-p monthly follow-up calls to clinical staff for all 15 Providers and up to 3 state coordinators in various combination.***

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| **Objective #3** Increase number of FIRST.IL enrollees statewide. |
| **Strategies to obtain the objective:**   * Expand outreach efforts and provide public information about FIRST.IL. * Each FIRST.IL Site to achieve five Marketing and Outreach events per month * Each FIRST.IL Site will achieve a minimum of five new Enrollees per Fiscal Year. * Add at least one additional FEP Site by the end of FY2019. |
| **Indicator #3: Number of clients meeting criteria for FIRST.IL enrolled in team services statewide.** |
| a) Baseline measurement (Initial data collected prior to and during SFY 2017): 123 enrolled by 11/30/2017 |
| b) First-year target/outcome measurement (Progress to end of SFY 2018): 150 by June 30, 2018 |
| c) Second-year target/outcome measurement (Final to end of SFY 2019): 225 by June 30, 2019 **243 were enrolled as of 6/27/19.** |
| d) Data source: Enrollment data from each participating site aggregated by statewide coordinator retrieved from Enrollees Outcome Form at Baseline and every 6 months. |
| e) Description of data: Number of persons meeting eligibility criteria for FIRST.IL program enrolled at each site. |
| f) Data issues/caveats that affect outcome measures: NONE |
| **8. Report of Progress toward goal attainment**  **Second year target: \_\_X\_\_\_ Achieved \_\_\_\_\_ Not Achieved (If not achieved, explain why)** |

***The target for Objective #3 was achieved and exceeded in FY2019. 225 enrollees were targeted. 243 were enrolled as of 6/27/19.***

***In FY2018, the three objectives for FIRST.IL were accomplished and two (Objectives 1 and 3) significantly surpassed the targets! Twelve (12) FEP Teams were projected but 15 Teams had become operational by June 30, 2018. The target was achieved at 125%! The program targeted 150 enrollees and 201 were enrolled by June 30, the end of the fiscal year. Additionally, the program reported 25 individuals who had been enrolled but either graduated or moved out of their service areas and were not carried as enrolled on June 30, 2018. The target was thus achieved at 150.6%!***

*The targets for training and technical assistance were also met and exceeded. The program provided 24 actual training events (21 were projected) that included 1 universal event (CBT-p): 15 events for newly hired staff; and 8 training events in Family Psychoeducation. There were 327 Technical Assistance consultations provided by the state coordinator staff and staff of the BeST Center in various combinations also significantly surpassing the program expectations for 288 during the year.*

*Additionally, the program expanded to serving the ESMI population as of January 1, 2018, and 36 individuals with Bipolar Disorder with Psychotic features, Major Depressive Disorder with Psychotic features and Post Traumatic Stress Disorder with Dissociative Symptoms were enrolled by June 30, 2018. The transition of several individuals who moved to areas of another FEP Team was monitored this year. Continuity of care has been smooth, well-planned, and caringly implemented so that these persons continued to be successfully served.*

Background

Early in FY2017, with technical assistance and consultation of the Best Center, DMH developed the basic infrastructure to initiate and sustain evidence-based clinical programs for persons with FEP in Illinois. By the end of October 2016, programs for persons having experienced an initial psychotic episode were established at 11 mental health agencies in the State. The statewide program has been named FIRST.IL. Outreach, engagement, treatment, and coordination of support services are currently ongoing at each site. Each participating agency site has an identified team leader, and a team that consists of at least one therapist, one case manager, an administrative lead from agency administration, and a medication prescriber. All teams have specialists that provide supported employment and supported education services. Each agency has responded to uniform requirements of contracting with DMH while uniquely developing their team compositions and strengths in their service environments which range from the urban Chicago Metropolitan Area to county-based rural service agencies in Greater Illinois.

In the second year of operation (FY2018), technical assistance, consultation, and formal trainings were both intensive and extensive. There were a total of 327 Technical Assistance and Consultative meetings between DMH, the BeST Center, and the 15 provider agencies. These meetings included Consultations with each team once every two weeks and a regular conference call with all the team leaders once a month. The BeST Center Consultant directly provided 24 training sessions for all newly hired FEP agency staff twice monthly and weekly telephone consultation to the DMH statewide coordinators. The BeST Center’s consulting psychiatrist provided three teleconference training sessions and nine learning collaborative calls in psychiatric evaluation and medication management. All meeting calls and training were 1 hour in length.

By the end of SFY2018 the program had expanded to 15 sites and reported a cumulative enrollment of 201 clients who met criteria of eligibility for the program. These 15 sites have been successfully maintained through FY2019.

The participating sites and the cumulative number of referrals and enrollees reported by each site are presented in the table below:

|  |  |  |
| --- | --- | --- |
| **Agency** | **Number of**  **Referrals**  **As of 6/27/2019** | **Number of**  **Clients Enrolled**  **As of 6/27/2019** |
| Advocate Illinois Masonic Behavioral  Health Services, Chicago | 58 | 34 |
| Bridgeway MHC, | 46 | 15 |
| Centerstone | 49 | 26 |
| Chestnut Granite City | 61 | 15 |
| Chestnut Bloomington | 11 | 4 |
| Grand Prairie | 88 | 21 |
| Human Resources Development Institute | 61 | 11 |
| LifeLinks | 35 | 2 |
| Memorial Behavioral Health | 65 | 12 |
| Robert Young Mental Health Center | 57 | 19 |
| Trilogy | 141 | 23 |
| Thresholds – Chicago | 88 | 25 |
| Thresholds – Westmont | 68 | 15 |
| Transitions of Western Ill | 13 | 8 |
| Human Service Center of Peoria | 29 | 13 |
| **TOTAL** | **870** | **243** |

**Use of Set-Aside Funding**

From the outset, the intent of DMH was to introduce emerging evidence-based practices for FEP as a component of the services and activities that reflected the values, goals, and objectives inherent in the Vision and Mission of the Division of Mental Health and the SAMHSA requirements for the use of the dollars.

Set-Asidedollars are paid for:

1. The time and costs of assigning a clinician to become the designated agency staff person with expertise in clinical content and service delivery of ESMI services. Each agency was required to designate or hire at least a 0.5 FTE staff person with requisite clinical credentials to coordinate required service components for clients, to be able to reach out and engage clients in the community, and to provide therapeutic clinical services.

2. The time and costs of assigning a senior level agency staff member to a leadership role in ensuring that functions and operational integrity of the ESMI program are carried out at the agency and in collaboration with the Division of Mental Health.

3. Training, technical assistance, consultation events and sessions to develop expertise in evidence-based clinical approaches most helpful to individuals with ESMI.

4. Development of marketing materials and tools to be used for outreach and engagement of persons with ESMI and their families.

Building upon the training, infrastructure, and service delivery established through the 2015 funding, the dollars from the Ten Percent Set-Aside have been used to promote:

* Expansion of programming (using the model described above) to agencies in Region 5 (southernmost in Illinois) and generally increasing the number of agencies in the State that will have ESMI programs.
* Providing additional funding to agencies to facilitate improved implementation of program components as needed.
* Providing for DMH staff person to furnish guidance and expertise in developing, monitoring, coordinating, and providing technical assistance to agencies in carrying out programming. In short to become the DMH experts for the provision of evidence-based services to individuals (and families as appropriate) who experience first and early episodes of a serious mental illness
* Increasing agency participation in: (1) ongoing focused training in ESMI approaches and in related evidence-based components. (2) structuring technical assistance and consultation to meet emerging needs in the areas of program development, service delivery, outreach and engagement approaches, financial supports for treatment, and program sustainability.
* Purchasing special services that are not Medicaid reimbursable.

Non-billable costs are covered by the Illinois Mental Health Block Grant Set-Aside funds. Illinois pays agencies actual costs for those expenses related to training and non-billable time per their submitted invoices up to the maximum of their contract.

The DMH contractual process for this initiative included specified goals, performance measures and performance standards for each participating provider. This combination of data and measures is being utilized to determine the impact of the FIRST.IL initiative.

Several perceived challenges that are being addressed in training and consultation include:

* Working with participating providers to modify the treatment paradigm from a singular focus on agency services for persons with serious and continuous mental illness to include the engagement of persons in acute distress and encountering mental illness for the first time in their lives. The continuing clinical engagement of clients with ESMI has been problematic at times and remains a subject of active interest and planning.
* Assuring the financial support required for agencies to be able to sustain their programs and to serve those individuals who should be served but lack the resources to pay for their services.
* The three newest FIRST.IL sites in Illinois are gaining experience in conducting the outreach and engagement activities that are required in the ESMI program. Adaptation and the development of skill in these areas takes significant time and slows down the implementation process. In the past year, these agencies have shown growth through active marketing and outreach and their enrollment numbers have increased.
* Coverage for CSC programming by private insurance has been problematic and only some ESMI services have been paid. Legislation has been passed in Illinois aimed at improving and streamlining coverage by private insurance to allow for billing of team services that include therapy and case management. The Legislation is scheduled to go into effect on January 1, 2020. Planning and implementation are currently under discussion.

**Priority #5: Access Data/Consumer Satisfaction Survey**

|  |  |
| --- | --- |
| 1. Priority Area:  **Use of Data for Planning** | 2. Priority Type:  MENTAL HEALTH SERVICES |
| 3. Population(s)-SMI, SED, | |
| **4. Goal:** *Use Quantitative data to assess access to care and perception of treatment outcomes to provide data for decision support.* | |
| **5. Objective:** Continue to improve and maintain quality data collection and reporting. | |
| **6. Strategy:** Assess access to care by tracking the number of individuals who received treatment partitioned by race, gender and age. | |
| 7. Annual Performance Indicators to measure goal success:  **Indicator:**  **Number of adults and number of children/adolescents receiving services from publicly funded community-based providers.** | |
| a) Baseline measurement (Initial data collected prior to and during SFY 2018): 128,000 | |
| b) First-year target/outcome measurement (Progress to end of SFY 2018): 72,500 | |
| c) Second-year target/outcome measurement (Final to end of SFY 2019): 72,000 | |
| d) Data source:  Public funding streams for mental health care in Illinois are currently appropriated to multiple state agencies, one of which is DMH. Providers by contract must submit demographic, clinical information and claims data for all individuals funded by DMH and receiving services funded using DMH dollars. The DMH provides data specifications to assure consistency of reporting. The public funds appropriated to the State Medicaid Authority, DHFS, are managed separately through MCO contracts. At this point in time, there is not yet one consistent set of data points for comparative use across MCOs that is accessible to DMH. Thus, the data the State Mental Health Authority has access to for planning purposes remains limited. | |
| e) Description of data:  Registration data is submitted directly to the DMH information system which is operated by the DMH’s Administrative Services Organization (ASO). Claims data, which is submitted to the state Medicaid agency Healthcare and Family Services (HFS), is returned to the ASO after processing where it is stored with registration information in the DMH data warehouse. This information is used as a basis for developing reports and for analytic purposes, and is the basis for reporting the data used to populate most of the URS tables | |
| f) Data issues/caveats that affect outcome measures: See section d above. | |
| **8. Report of Progress toward goal attainment**  **Second year target: \_\_X\_\_\_ Achieved \_\_\_\_\_ Not Achieved (If not achieved, explain why)** | |

***The numerical target of 72,000 was achieved in FY2019 and extensively exceeded. The Department of HealthCare and Family Services (DHFS) reported reimbursing Medicaid claims for mental health services for 150,973 individuals in FY2019.***

Previously, targets were developed based solely on SMHA claims data and did not include claims data for individuals treated in the public system whose claims are processed by MCOs. Managed Care has been implemented in Illinois for the past four years, with an increasing number of individuals’ claims for publicly funded mental health care processed through the MCOs each year. As a baseline for reference - in FY 2017, the SMHA processed claims for 64,403 individuals and the MCOs processed claims for an additional 64,066 for a combined total number of individuals served in the publicly funded mental health system of 128,469 in FY 2017.

The SMHA has seen a continuing reduction in the number of consumers served between 2016 through 2019 because of better MCO coverage. Additionally, the lack of coverage for Non-Medicaid services has continued in FY2019. DHFS, the State Medicaid Authority continues to adjust in how MCO claims are processed. Coverage in and enrollment in the ACA continues to affect those served by our providers.

DMH funded community providers are contractually required to register all individuals funded with any DMH dollars in the DMH/ASO Community Reporting Information System. All claims are submitted directly to the Department of Healthcare and Family Services Medicaid Management Information Service (DHFS/MMIS). Processing of claims is subject to business rules established by DMH, thus the linkage between registrations of individuals for services and claims submission is being maintained. DMH reporting standards require full reporting of consumer and service data by community providers. DMH receives claims data on a weekly basis after it is processed and adjudicated by DHFS.

***FY2019 MHSIP SURVEY***

During FY2019 DMH surveyed 3,936 adult consumers and 444 Caregivers of Children who received services at DMH funded community mental health centers during FY2018. Most adult respondents reported being generally satisfied with: services they received, access to services, participation in their own treatment planning, and the quality and appropriateness of the services. However, they were generally less satisfied with the results of their treatment including treatment outcomes, their daily functioning, and social experiences. DMH also conducted a perception of care survey of caregivers of children and adolescents who received DMH funded MH services. The process and results for both are reported below.

Adults

The Adult Consumer Survey is part of the Mental Health Statistics Improvement Program (MHSIP) Quality Report performance measures. The surveys address two goals of the Division: data-based decision-making in a continuous quality improvement environment and to enhance and expand the involvement of consumers, families and caregivers in the review, planning, evaluation and delivery of mental health services.

DMH surveyed over 3900 adult consumers who received services at DMH funded community mental health centers. Participants were chosen at random and the survey was sent to their home address. All surveys were confidential. Consumers were asked to rate their experiences on a scale of 1 to 5 whether they agreed or disagreed with 28 statements. Of 3,936 surveys attempted, 3,928 contacts were made, and 418 were completed and returned. The number of responses at nearly 11% was sufficient for statistical purposes to grade services offered. The table below provides an overview of the responses to the areas surveyed.

|  |  |
| --- | --- |
| ***Areas Surveyed*** | ***% Pos*** |
| **Reporting Positively About General Satisfaction with Services** | **94%** |
| **Reporting Positively about Access** | **93%** |
| **Reporting Positively about Participation in Treatment Planning** | **94%** |
| **Reporting Positively about Quality and Appropriateness** | **95%** |
| **Reporting Positively about Social Connectedness** | **89%** |
| **Reporting Positively about Functioning** | **89%** |
| **Reporting Positively about Outcomes** | **88%** |

Children and Adolescents

The Division adopted the MHSIP: Youth Services Survey for Families to collect feedback from caregivers of children ages 0 – 17 who are receiving community mental health services funded by the DMH. As with Adults, DMH is seeking to maintain the percentage of parents/caregivers reporting positive outcomes through the Youth Services Survey for Families.

The perception of care survey of caregivers of children and adolescents aged 0-17 who received DMH funded MH services was conducted in FY2018. Participants were chosen at random and the survey was sent to their home address. Adolescents aged 12-17 who had fewer than 9 service-days were excluded to protect the privacy of those seeking care before letting their caregiver know. Caregivers who received the survey were asked to rate on a scale of 1 to 5 whether they agreed or disagreed with 28 statements. Of 444 surveys attempted, 442 were contacted, and 34 were completed and returned. This nearly 8% response rate was large enough sample for a statewide evaluation. The characteristics of the children of the respondents were the same as the characteristics of the total population served. The table below provides an overview of the responses to the areas surveyed.

|  |  |
| --- | --- |
| *Domain* | *% Pos* |
| Reporting Positively About Cultural Sensitivity of Providers | 83% |
| Reporting Positively about Participation in Treatment Planning | 72% |
| Reporting Positively about Social Connectedness | 81% |
| Reporting Positively about Access | 68% |
| Reporting Positively about Overall Satisfaction with Care | 67% |
| Reporting Positively about Functioning | 63% |
| Reporting Positively about Outcomes | 62% |

**.**

**Priority #6 Justice: Mental Health Juvenile Justice Program (MHJJ)**

|  |  |
| --- | --- |
| **Priority Area: Maintain effective systems to serve the forensic needs of justice–involved consumers of services.** | 2. Priority Type:  MENTAL HEALTH SERVICES |
| 3. Population(s) SMI, SED, OTHER: | |
| 4. Goal of the priority area:  *Maintain a system of care to address the mental health needs of consumers with criminal justice involvement.* | |
| 5. Objective; Provide an alternative to incarceration for youth with SED and link them to community-based service that addresses their unique needs and strengths. | |
| 6. Strategies to attain the objective:  Maintain the Mental Health Juvenile Justice Initiative. | |
| 7. Annual Performance Indicators to measure goal success:  Indicator 2:  **Number of youths served by the MHJJ Program statewide.** | |
| a) Baseline measurement (Initial data collected prior to and during SFY 2017): **209 enrolled in FY2017** | |
| b) First-year target/outcome measurement (Progress to end of SFY 2018): **200 youth to be enrolled in FY2018** | |
| c) Second-year target/outcome measurement (Final to end of SFY 2019): **200 youth to be enrolled in FY2019 In FY2019 789 youth were referred to the program and 618 were successfully linked to an agency for service.** | |
| d) Data source:  MHJJ Program Data Base maintained internally by DMH oversight staff | |
| e) Description of data:  Aggregate the number of youths receiving services from the Mental Health Juvenile Justice program across the year that will be compared to data from subsequent years. | |
| f) Data issues/caveats that affect outcome measures: None | |
| **8. Report of Progress toward goal attainment**  **Second year target: \_\_\_X\_\_ Achieved \_\_\_\_\_ Not Achieved (If not achieved, explain why)** | |

***This strategy was very successfully accomplished in FY2019. The target of 200 youth to be enrolled was extensively exceeded. By the end of the fiscal year 618 youth were enrolled.***

***Although fiscal and clinical resource limitations and reductions continued to exist in FY2017, the MHJJ Program expanded significantly in FY2018. A key factor in this expansion was that*** ***the MHJJ Program expanded its eligibility criteria in FY2017 to include youth who are “at risk” of contact with the criminal justice system. “At risk” youth have a mental illness or symptoms, may have had ancillary contact with police (e.g., school resource officers, station adjustments), and are not receiving necessary services and/or any type of intervention that could divert them from becoming more involved in the criminal justice system.***

***During FY2019 there were 20 agencies operating the MHJJ program, up from the 14 agencies that had provided services earlier in FY2017. Several new agencies had begun providing MHJJ services and some legacy agencies that had more robust staffing than in previous fiscal years which contributed to the significant increase in MHJJ program activity. By the end of FY2019, of 793 referrals that were screened, 618 were found eligible for the program and received mental health and support services.***

**Number of Youth Served by Fiscal Year**

|  |  |  |
| --- | --- | --- |
| **Fiscal Year** | **Eligible** | **Enrolled** |
| **FY2017 Actual** | **214** | **209** |
| **FY2018 Actual** | **748** | **693** |
| **FY2019**  **Actual** | **789** | **618** |
|  |  |  |

***MHJJ continues to successfully identify youth in the juvenile justice system with serious mental illness, treat the youth in the community, improve the youth’s overall functioning and support the youth from re-arrest.***

**Background**

The Mental Health Juvenile Justice (MHJJ) program was designed to divert youth with serious emotional disturbances out of the juvenile justice system and into community-based care. Initially funded in CY2000 as a pilot project in just seven counties, the MHJJ program expanded to covering 29 Illinois counties, involving 20 community agencies statewide, and services provided by an estimated 60 clinicians in FY2015. The program has always sought to maintain the number of available providers.

The MHJJ program is overseen through the DHS/DMH Forensic Services Program, aims to strengthen the linkages among the courts, probation, detention, schools, mental health, and other community-based services, and recognizes that family engagement at all levels is vital to achieving best outcomes. Whenever any court personnel (Judge, attorney, probation officer, detention center staff) refers a minor who is in detention, a liaison (a masters level clinician from a community agency), with parental consent, will assess that

child. These specially-trained MHJJ liaisons screen the youth for the presence of a serious mental illness such as a major affective disorder or psychosis and a functional assessment is conducted to identify areas of functional impairment as well as areas of strength that can be leveraged in the development of an individualized action plan. Should that child have a major mental illness (with psychotic or affective disorders), the liaison will work with the family to identify appropriate community services (using a wraparound model that includes mental health, medication, substance abuse, special education and public health services). Based on this action plan, youth are linked with appropriate community-based services. MHJJ liaisons continue to monitor the progress of each youth for a period of six months. DHS provides funding for MHJJ to the community agencies from state general revenue funds (GRF). Most agencies receive funding for one liaison. Flexible spending funds may be budgeted to supplement the youth’s ancillary treatment services or family stabilization if no other source of funding is available. Several MHJJ agencies have been able to offer parent to parent support through their Family Resource Developers. MHJJ is a simple model that can be expanded to these and other juvenile justice populations and is applicable in multiple settings (urban, suburban and rural) as it makes use of existing community services at no cost to the courts.

In FY2017, the MHJJ Program expanded its eligibility criteria to include youth who are “at risk” of contact with the criminal justice system. “At risk” youth have a mental illness or symptoms, may have had ancillary contact with police (e.g., school resource officers, station adjustments, and are not receiving necessary services and/or any type of intervention that could divert them from becoming more involved in the criminal justice system. As a result of this expansion, wards of the Illinois Department of Children and Family Services (DCFS) who have become justice involved and need the kind of services and monitoring for the courts that MHJJ provides, youth with mental illnesses who may have had ancillary contact with police (e.g., school resource officers, station adjustments) and would benefit from MHJJ services, and youth with significant trauma histories/symptoms who have come into contact with the justice system are now eligible.

MHJJ continues to emphasize targeted outreach to, and education of, referral sources of minority youth with serious mental illnesses. As research has shown that an estimated 75% of children in the juvenile justice system have experienced traumatic victimization, the MHJJ program continues to guide agencies to be considerate of trauma informed practices in interacting with youth and in linking youth to trauma informed services.

**Priority #7: Recovery/Consumer Services**

|  |  |
| --- | --- |
| 1. Priority Area:  **Expansion of the scope of consumer and family participation through advancement of the recovery vision and family driven care.** | 2. Priority Type:  MENTAL HEALTH SERVICES |
| 3. Population(s) SMI, SED OTHER (Adolescents with SA or MH, Students in College, LBGTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disabilities, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities | |
| 4. Goal of the priority area:  *Establish and enhance the public mental health system of care based upon principles of Recovery and Resilience in which consumers and families are knowledgeable and empowered to participate and provide direction at all levels of the system and peer-run programs are increasingly utilized.* | |

**Certified Recovery Support Specialist Certification**

|  |
| --- |
| **5. Objective #1: Continue work to increase the number of Certified Recovery Support Specialists and to facilitate their deployment statewide.** |
| 6. Strategies to attain the objective:  **Strategy #1:** Support the role of Certified Recovery Support Specialists and their deployment statewide by hosting training for consumers and providers to help increase agencies’ understanding of the role, value, function, and advantages of hiring CRSS professionals and by providing competency training events for individuals interested in the CRSS credential. |
| 7. Annual Performance Indicators to measure goal success:  **Indicator #1:**  **Number of training events held each year to increase stakeholder understanding of the CRSS credential and to increase competency in CRSS domains.** |
| a) Baseline measurement (Initial data collected prior to and during SFY 2017: **15** |
| b) First-year target/outcome measurement (Progress to end of SFY 2018): **9** |
| c) Second-year target/outcome measurement (Final to end of SFY 2019): **9 training events were the target. 15 were completed in SFY2019** |
| d) Data source:  **Document each training event and aggregate by year for comparison across years.** |
| e) Description of data: Training agenda and attendance sheets documenting participation for each training event held. |
| f) Data issues/caveats that affect outcome measures: |
| **8. Report of Progress toward goal attainment**  **Second year target: \_\_X\_\_\_ Achieved \_\_\_\_\_ Not Achieved (If not achieved, explain why)** |

***The continuing expansion of the Certified Recovery Support Specialist (CRSS) certification was effectively addressed and the number of training events was significantly exceeded in SFY2019. A total of 15 training events were held in SFY19. Six competency training events based on a two-day curriculum were held at three locations in the State, with a total of 325 participants and three CRSS Ethics Workshops were held at the same locations in August 2019 with 325 registered participants. An additional three training events were held in March 2019 offering CRSS Fundamentals Training, with statewide registration exceeding 400 totals.***

***As of November 2019, 242 individuals with CRSS certification were active in the State, an increase of nine more individuals since June 2018, and all were in good standing with the Illinois Certification Board (ICB). An additional 22 individuals are in the application process. This reflects a 39.9% increase in the number of CRSS certified individuals since July 2015, when 173 individuals with CRSS certification were active in the State.***

***On October 17, 2019 Governor Pritzker recognized the contribution and accomplishments of Recovery Support Specialists in Illinois by proclaiming October 2019 as RECOVERY SUPPORT CELEBRATION MONTH in Illinois, “celebrating Recovery Support Specialists as they are increasingly integrated into the fabric of our workforce and the landscape of our lives.”***

The Certified Recovery Support Specialist (CRSS) is a credential for those persons with lived experience who provide mental health or co-occurring mental illness and substance abuse peer support to others using unique insights gained through their personal recovery experience. The CRSS credential assures competence in advocacy, professional responsibility, mentoring, and recovery support. Certified Recovery Support Specialists can infuse the mental health system with hope and empowerment, and improve opportunities for others to:

* Develop hope for recovery
* Increase problem-solving skills
* Develop natural networks
* Participate fully in the life of the community.

The Illinois Model for Certified Recovery Support Specialist (CRSS) was developed through the collaboration of the Illinois Certification Board (ICB), the DHS Divisions of Mental Health (DMH), Rehabilitation (DRS), and Alcoholism and Substance Abuse (DASA). The credential has been accessed through the ICB since July 2007. Individuals are certified as having met specific predetermined criteria for essential competencies and skills. Individuals attending consumer conferences, statewide consumer education and support teleconferences, and regional WRAP Refresher trainings, receive CEU’s toward achieving or maintaining their credential through the ICB.

The DMH Office of Recovery Support Services continues to work with other system partners, including the ICB and the Mental Health Collaborative for Access and Choice (MHCAC), to:

* Disseminate public information about the credential;
* Develop training curricula, and study materials for those seeking to obtain their CRSS credential;
* Plan and conduct Webinars and other training events for provider agencies to help increase agencies’ understanding of the role, value, function, and advantages of hiring CRSS professionals.

These efforts have proven to be fruitful. The number of individuals in the State possessing the credential, active in the State, and in good standing with the Illinois Certification Board (ICB) has steadily increased since October 2013. The aim of DMH is to continue to increase the number certified Recovery Support Specialists in Illinois.

**Wrap Training**

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| --- |
| 5. **Objective #2: Increase the use and efficacy of the WRAP model** |
| 6. **Strategy #2:** Enhance competency and encourage WRAPtrained and certified facilitators to provide an increasing number of WRAP® classes in the State. |
| 7. Annual Performance Indicators to measure goal success:  **Indicator #2:**   1. **Number of WRAP Refresher trainings offered statewide each year** 2. **Number of WRAP participants each year** |
| a) Baseline measurement (Initial data collected prior to and during SFY 2017: **15** |
| b) First-year target/outcome measurement (Progress to end of SFY 2018): **20** |
| c) Second-year target/outcome measurement (Final to end of SFY 2019): **20** |
| d) Data source: Document each training event and aggregate by year for comparison across years. |
| e) Description of data: Training agenda and attendance sheets documenting participation for each training event held. |
| f) Data issues/caveats that affect outcome measures: None |
| **8. Report of Progress toward goal attainment**  **Second year target: \_\_\_X\_\_ Achieved \_\_\_\_\_ Not Achieved (If not achieved, explain why)** |

***WRAP Refresher Training was successfully accomplished in FY2019. Sixteen refresher courses were conducted at 6 sites in the State. The total number of participants for FY2019 was over 400. Detail is provided in the table below.***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Region** | **1st Quarter** | **2nd Quarter** | **3rd Quarter** | **4th Quarter** |
| 1 | 19 | 11 | 26 | 11 |
| 2 | 23 | 36 | 28 | 33 |
| 3 | Data  misplaced | 15 | 18 | 21 |
| 4 | 21 | 24 | 21 |
| 5 | 24 | 24 | 21 | 28 |
| **Total # participants:** | **66+** | **107** | **117** | **114** |

***As of June 2019, 558 individuals have been trained and certified as WRAP Facilitators in Illinois. Of those, 233 (41.8%) are actively participating in Refresher Training.***

**Background**

The Wellness Recovery Action Plan (WRAP) model is well established in Illinois. DMH Recovery Support Services provides annual WRAP® Facilitator Training and has trained over 400 people how to deliver WRAP® statewide since 2002. Through WRAP classes in community agencies and the introduction of the principles of WRAP at consumer forums and conferences, thousands of consumers throughout the state have benefited from receiving orientation and education in the principles and components of this evidence-based practice in recovery-oriented services. A recently recognized evidence-based practice, WRAP® is a multi-week program led by certified facilitators. WRAP® teaches people living with mental illnesses how to identify and use illness self-management resources and skills that help them stay well and promote their recovery. Studies show that WRAP® improves participants’ quality of life and reduces their psychiatric symptoms. The community support services WRAP® facilitators provide are Medicaid-reimbursable, making WRAP® an affordable program for many agencies. However, many individuals who have completed WRAP® Facilitator Training have not gone on to provide WRAP® classes. DMH Recovery Support Services (RSS) continues to work on increasing the number of trained facilitators who are providing WRAP® classes and increase access to WRAP® Facilitator Training in Illinois.

**Peer Respite Programs**

|  |
| --- |
| **5. Objective # 3: Develop and establish infrastructure for the introduction and implementation of Peer Respite (Wellness) programs in Illinois.** |
| **6. Strategy #3: Provide educational events and technical assistance to encourage consumer participation and advocacy and public education to promote this model.** |
| 7. Annual Performance Indicators to measure goal success:  **Indicator #3:**  **(a) Number of educational events and/or technical assistance appointments regarding Peer Respite (Wellness) held each year.**  **(b) Number of programs opened during the year.** |
| a) Baseline measurement (Initial data collected prior to and during SFY 2017: **Not Applicable -** New **Objective for FY2018-FY2019** |
| b) First-year target/outcome measurement (Progress to end of SFY 2018): **5** |
| c) Second-year target/outcome measurement (Final to end of SFY 2019): **5** |
| d) Data source: Training Agendas and attendance sheets documenting participation. |
| e) Description of data: Agendas for each event and Attendance Sheets |
| f) Data issues/caveats that affect outcome measures: None |
| **8. Report of Progress toward goal attainment**  **Second year target: \_\_\_\_ Achieved \_\_\_X\_\_ Not Achieved (If not achieved, explain why)** |

***Although this objective was successfully accomplished in FY2018, the loss of three staff persons in the DMH Bureau of Wellness & Recovery Services in FY2019 seriously damaged efforts toward establishing infrastructure for the introduction and implementation of peer respite services. The initiative has been temporarily placed on the back burner. It was decided to discontinue this objective for FY2020 in favor of continuing efforts in other important areas.***

***During FY2018, educational events were held in three sites (north, central, south) to introduce the model to the recovery community. A total of 400 individuals participated in these events statewide. Additionally, a standardized training was developed to provide technical assistance and support for organizations seeking to develop a Peer Respite, and DMH Recovery Support Services provided training for five organizations.***

Peer Respites are one option in the continuum of care for individuals experiencing mental health crises. Peer Respites stand out from other options on this continuum in large part because individuals access them by choice. One of the standards of practice for Peer Respites across the nation relates to the voluntary nature of their services: individuals are “self-referred”.

To gain a greater understanding of the commonalities among these programs across the states, as well as their uniquenesses, DMH Recovery Support Services began researching the Peer Respite model in 2017.

The Peer Respite model continues to be considered a valuable potential addition to the continuum of care for individuals experiencing mental health crises in Illinois. DMH as staff resources allow, Recovery Support Services will continue to offer education and technical assistance to any organization seeking to establish a Peer Respite in Illinois.

**Consumer Education Teleconferences**

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| 5. **Objective #4:** **Continue to inform and empower consumers and families.** |
| 6. **Strategy #4:** Conduct a series of statewide teleconferences designed to disseminate important information to adult consumers and families across the State. |
| 7. Annual Performance Indicators to measure goal success:  **Indicator #4:**  **Number of statewide teleconferences held each year. Number of participants per teleconference.** |
| a) Baseline measurement (Initial data collected prior to and during SFY 2017): **10** |
| b) First-year target/outcome measurement (Progress to end of SFY 2018): **10** |
| c) Second-year target/outcome measurement (Final to end of SFY 2019): **10** |
| d) Data source:  Document each teleconference event and aggregate by year for comparison across years. |
| e) Description of data: Teleconference agendas |
| f) Data issues/caveats that affect outcome measures: None |
| **8. Report of Progress toward goal attainment**  **Second year target: \_\_X\_\_\_ Achieved \_\_\_\_\_ Not Achieved (If not achieved, explain why)** |

***This strategy was successfully achieved in FY2019. Ten teleconferences were conducted in SFY2019 with an attendance ranging from 303 to 411 persons per call and an aggregate attendance of 3,609. The dates, topics, and number of participants of each teleconference are detailed in the table below.***

**Adult Consumer Education Teleconferences in FY2019**

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| **Date of Call** | **Topic** | **Number**  **of Participants** |
| 07/26/18 | Opening Up to Who We Are | 346 |
| 08/23/18 | Communicating Effectively About Things That Matter to Us | 353 |
| 09/27/18 | Finding Hope Within | 319 |
| 10/25/18 | Exploring Our Spirituality | 393 |
| 01/24/19 | Caring for Our Whole Health | 342 |
| 02/28/19 | Unlocking Our Hidden Talents | 379 |
| 03/28/19 | Springing Forward to Hope | 368 |
| 04/25/19 | Growing Beyond the Pain of the Past | 411 |
| 05/23/19 | Standing Tall in the Face of Bullying | 303 |
| 06/27/19 | Growing Through Grief and Loss | 395 |
| **First Quarter of** | **FY2020 \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*** |  |
| 07/25/19 | Building Meaningful Connections | 374 |
| 08/22/19 | Giving Ourselves a Break | 353 |
| 09/26/19 | Regaining Power through Change | 347 |
| 10/24/19 | Living Well on a Shoestring Budget | 314 |

For many years, DMH has recognized the need for providing consumers with the tools they need to cogently and effectively participate in the development and evaluation of the service system. The primary focus has been to ensure that consumers of mental health services receive current, accurate, and balanced information regarding changes in the service delivery system that empowers them to take an active, participatory role in all aspects of service delivery. These calls provide a forum for discussion of information about a range of services and approaches that has included integrated health care, crisis planning, and personal wellness; new developments such as changes in service policies and procedures; and emerging issues such as thriving in challenging economic times, using presentations that are designed to advance consumers’ awareness and knowledge.

**Priority #8:** C&A Services

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| 1. Priority Area:  **Lead in the development and implementation of statewide, unified, state –of –the-art Child and Adolescent Services to promote optimal social and emotional development for all children, adolescents, and young adults with behavioral health needs.** | 2. Priority Type:  MENTAL HEALTH SERVICES |
| 3. Population(s) SED, ESMI, Other: (Adolescents with SA or MH, Students in College, LBGTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disabilities, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities) | |
| 4. Goal of the priority area:  ***Integrate a State-of-the-Art Behavioral Health System in Illinois that ensures service delivery based on Systems of Care Values and Principles, family driven, and emphasizes services that are evidence-based.*** | |
| 5. Objective #1: Identify and establish the most appropriate and best criteria for diagnostic assessment of children from birth through age five that should be consistently used by community child and adolescent mental health providers. | |
| 5. Strategies to attain the objective:   1. Review options and determine if a manual will be adopted for use across Illinois. 2. Develop/adopt a DSM 5-ICD 10 crosswalk for the diagnosis and billing codes. 3. Identify and implement changes to the DMH reporting system. 4. Collaborate with other systems that will be impacted by these changes. 5. Determine any training and technical assistance needed to implement the goals and objectives.   I | |
| **Annual Performance Indicators:**  **Indicator #1: Diagnostic criteria for the assessment of children from Birth to age 5 is adopted and implemented by community providers by the end of SFY2019.** | |
| a) Baseline measurement (Initial data collected prior to and during SFY 2017): N/A | |
| b) First-year target/outcome measurement (Progress to end of SFY 2018): **A DSM 5-ICD 10 crosswalk for the diagnosis and billing codes is drafted and adopted. (Contingent on the ICD-10 being adopted)** | |
| c) Second-year target/outcome measurement (Final to end of SFY 2019): **The set of diagnostic criteria has been piloted and is utilized by community providers.** | |
| d) Data source: | |
| e) Description of data: | |
| f) Data issues/caveats that affect outcome measures: | |
| **8. Report of Progress toward goal attainment**  **Second year target: \_\_\_X\_\_ Achieved \_\_\_\_\_ Not Achieved (If not achieved, explain why)** | |

***In FY2018, the Department of HealthCare and Family Services (DHFS) did not accept the recommendations for using a DSM-5/ICD-10 crosswalk for the diagnosis and billing codes for children Birth to Age 5 as part of the revision of their services rule (Rule 140).  DMH was able to include language that assessment and treatment must be provided in a developmentally appropriate manner in our Administrative Rule 132, the Rule for Certified Community Mental Health Centers. At that point in time, we reported the target as “Not Achieved”.***

***In FY2019 After a prolonged process due to unanticipated delays over many months, the Medicaid Rule (Rule 132) which contained the certification requirements and process for Community Mental Health Centers and defines the Medicaid Services they provide was fully revised in conjunction with DHFS into two Rules that separated the service definitions from the certification process. The new 59Ill Adm. Code 132 containing revised certification requirements and processes became effective on January 1, 2019. HFS has filed a corresponding amendment- 89Ill. Admin. Code 140 - which now includes the service definitions.***

***Rule 132 requires Certified Community Mental Health Centers to provide access to appropriate services to persons of all ages across the life span. It defines Emotional Disturbance in Children and the treatment approach required as follows (Section 132.25):***

*“Emotional Disturbance – For clients under age 21, symptoms of an emotional disorder contained in the DSM-5 and ICD-10-CM that is the condition that will be the main focus of treatment. For clients under age 6, DC 0-5 may be utilized to develop an age appropriate diagnosis, then the crosswalk between the DSM 5/ICD-10/DC 0-5 shall be used to identify which DSM-5/ICD-10 condition will be the main focus of treatment. Emotional disturbance does not include organic disorders such as dementia and those associated with known or unknown physical conditions such as hallucinations, amnestic disorder and delirium; psychoactive substance induced organic mental disorders; and intellectual disabilities, autism spectrum disorders or psychoactive substance use disorders.”*

*With the adoption of Rule 132 which became effective January 1, 2019, the DSM5/ICD-10/DC0-5 crosswalk is now a valuable diagnostic tool in the treatment of Serious Emotional Disturbance. Ongoing usage and study are now required to increase its operational reliability, validity, and effectiveness. The success of its implementation will depend on the collaborative effort and process with the Department of Healthcare and Family Services.*

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| 5. Objective #2: Identify policies and resources necessary to assist Child and Adolescent mental health providers in moving towards a value-based purchasing system. |
| 6. Strategies to attain the objective:   1. Review clinical outcomes tools that need to be added to the DatStat System to assist providers in measuring improved clinical outcomes for children, adolescents, and families. 2. Initiate and make the necessary changes to the DatStat System to incorporate the new tools. 3. Determine any training and technical assistance needed to assist providers in the utilization of the tools and understanding how to measure outcomes. |
| **7. Indicator #2: By the end of FY2019, the DATSTAT System will incorporate tools for measuring clinical outcomes that will enable C&A providers to be successful in a value-based purchasing system** |
| a) Baseline measurement (Initial data collected prior to and during SFY2017): N/A |
| b) First-year target/outcome measurement (Progress to end of SFY 2018): **A set of clinical outcomes tools that need to be added to the DatStat System to assist providers in measuring improved clinical outcomes for children, adolescents, and families is drafted and reviewed.** |
| c) Second-year target/outcome measurement (Final to end of SFY 2019): **Providers receive training and technical assistance in the utilization of the tools in measuring outcomes.** |
| d) Data source: Changes to DATSTAT System include operational outcome measure tools. Provider attendance in training sessions |
| e) Description of data: Attendance records of training and technical assistance sessions that support providers reporting usage of the outcome measures. |
| f) Data issues/caveats that affect outcome measures: |
| **8. Report of Progress toward goal attainment**  **Second year target: \_\_X\_\_\_ Achieved \_\_\_\_\_ Not Achieved (If not achieved, explain why)** |

***This objective has been substantively addressed in FY2018 and FY2019.***

***This target which called for the drafting and review of a set of clinical tools that would be implemented and included in the Child and Adolescent Data System within two years by the end of FY2019 has been superseded and already largely achieved through the adoption of the IM-CANS as the statewide comprehensive assessment tool. The IM-CANS is a standardized assessment and service planning tool that will identify an individual’s integrated healthcare needs and strengths across all life domains and recommend the service needs required to achieve the amelioration of a client’s condition and improvement in well-being.* *In FY2019, DHFS has conducted training and provided administrative assistance to providers in the use if the IM CANS in measuring outcomes.***

***DHFS, the State Medicaid Authority, is now requiring the use of the IM-CANS as the tool to communicate the comprehensive assessment results of the global needs and strengths of individuals who require mental health treatment funded through Medicaid in Illinois.  Given the considerable resources required to implement this mandate, it was determined that the roll out of additional mandatory clinical measures at this time would be administratively burdensome to providers.***

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| **5. Objective #3:** Develop a trauma informed credential for C&A mental health providers similar to the trauma credential that has been developed by the Department of Children and Family Services (DCFS). |
| 6. Strategies to attain the objective:  a. Review the current DCFS trauma credential and determine if it is consistent with the needs of the larger community-based system.  b. Review what other states have adopted related to trauma informed credentials for providers.  c. Develop an Illinois specific trauma informed credential.  d. Determine any training and technical assistance needed to implement the credentialing process.  e. Develop an implementation plan.  f. Implement the plan. |
| **Indicator #3: By the end of FY2019, specified curriculum-based or evidence-based trauma-informed credentialing will be available in Illinois.** |
| a) Baseline measurement (Initial data collected prior to and during SFY 2017): N/A |
| b) First-year target/outcome measurement (Progress to end of SFY 2018): **The written set of requirements, privileges, and applications of a trauma –informed credential is developed, drafted and adopted.** |
| c) Second-year target/outcome measurement (Final to end of SFY 2019): **The credentialing process is implemented as evidenced by the number of providers applying for the credential or having been successful in obtaining the certification.** |
| d) Data source: The implementation plan for initializing the use of the credential. |
| e) Description of data: Documentation of completion of steps necessary to implement the new credential. |
| f) Data issues/caveats that affect outcome measures: |
| **8. Report of Progress toward goal attainment**  **Second year target: \_\_X\_\_\_ Achieved \_\_\_\_\_ Not Achieved (If not achieved, explain why)** |

***The constructive collaborative work undertaken by DCFS and DMH to enhance focus and promote specialization in trauma-informed clinical work over the past two years has achieved some positive and sustaining outcomes for children, youth and families at risk in Illinois and the professionals serving them.*** ***Unfortunately, due to the recent initiation of NTI and its national centeredness, the number of individuals who have successfully completed the training in Illinois is not currently known.***

***The Division of Mental Health collaborated with DCFS on rolling-out the National Adoption Competency Mental Health Training Initiative for Mental Health Professionals (NTI). Illinois was one of the ten states that piloted this training initiative and provided constructive input for utilization of this training nationally. The training, which results in 25 Continuing Education Credits and a competency certificate, consists of 10 modules focused on enhancing the competency for mental health professionals providing therapeutic or clinical services to at risk children youth and families who experience adoption, guardianship, or family disruption issues.  Imbedded in this training is a Module entitled Trauma and the Impact of Adverse Experience on Brain Development and Mental Health.***

***Mental Health and Child welfare professionals are both pre-tested and post-tested on each of the 10 modules and must show increased awareness, sensitivity, and clinical responsiveness to the impact of trauma upon their clients. Certification upon completion of the training is supporting increasing professional competence and expansion of the availability of trauma-informed approaches in meeting the needs of children and youth.***

**Priority #9: Community Integration**

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| **1. Priority Area:**  **Advancement of Community Integration** | **2. Priority Type:**  **MENTAL HEALTH SERVICES** |
| **3. Population(s) SMI, OTHER:** | |
| **4. Goal of the priority area:**  ***Complete the successful transition of residents of long-term nursing homes with diagnosed SMI from this level of care to less restrictive settings, ideally, independent living in their communities with appropriate and necessary support services.*** | |
| **5. Objective: Transition up to 400 additional Williams Class Members each year before the sunset of the Consent Decree.** | |
| **6. Strategies to attain the objective:**  **Through FY 2018, and perhaps beyond, through the provision of open market units rent subsidies Permanent Supportive Housing (PSH), Cluster Housing PSH models, 24 hour supervised residential settings and Community Integrated Living Arrangements (CILA), implement the transition of residents (Williams Class Members) from 24 designated Nursing Facilities (NF) (statewide) categorized as Institutes for Mental Disease (IMD) to permanent supportive housing or other housing alternatives that are safe, affordable housing and provide support services in communities of preference in a manner consistent with the national standards for this evidence based supportive housing practice.** | |
| **7. Annual Performance Indicators to measure goal success:**  **Indicator: Number of consumers who transition from long term institutional settings/IMDs who access appropriate permanent supportive housing or other housing options. (National Outcome Measure)** | |
| **a) Baseline measurement (Initial data collected prior to and during SFY 2017): The number of consumers transitioned by the end of SFY2017: 380 Class Members were transitioned as of June 30, 2017.** | |
| **b) First-year target/outcome measurement (Progress to end of SFY 2018): 400 additional consumers were targeted by the end of SFY2018. 315 Class Members were transitioned to the community.** | |
| **c) Second-year target/outcome measurement (Final to end of SFY 2019): 400 Class Members projected to be transitioned at the end of SFY2019.**  **NOTE: The Williams vs. Pritzker Consent Decree was originally slated to sunset in 2016. The activities of this Consent Decree continued through FY2019 and are anticipated to be budgeted for FY2020. Continuation after the FY2020 will be dependent on negotiations between the Court Monitors, Plaintiffs’ attorneys, and the court decision.** | |
| **d) Data source: Number of Williams Class Members receiving PSH Bridge Subsidies. Note: PSH Bridge Subsidies are only available to Williams Class Members and Front Door Diversion participants.** | |
| **e) Description of data: The data for this indicator is generated from permanent supportive housing applications and subsidies paid for rental units** | |
| **f) Data issues/caveats that affect outcome measures: Continuation after the FY2020 fiscal year will be dependent on negotiations between parties and the court decision.** | |
| **8. Report of Progress toward goal attainment**  **Second year target: \_\_\_\_\_ Achieved \_\_\_X\_\_ Not Achieved (If not achieved, explain why)** | |

***During FY2019 250 individuals were successfully transitioned to independent living in the community supported by clinical services. The numerical target of 400 set to be following the Court implementation plan was attained by 63% but not achieved. The extensive planning and work required to effectively carry this process forward is continuing at a consistent pace. As of the end of the first quarter of SFY2020***

***(October 1,2019) 52 new transitions had been completed.***

***In FY2019, $32,908,200 in General Revenue funds were dedicated and spent to expand home and community-based services and other transitional costs associated with the consent decree implementation.***

***This strategy was also substantively addressed and accomplished in FY2018 with the transition of 315 class members from IMDs to permanent supportive housing (safe and affordable housing and support services) in communities of their preference in a manner consistent with the national standards for supportive housing practice. The numerical target of 400 for the year was 79% attained.***

***As of October 30, 2018, an additional 59 Class Members had been transitioned to the community, either to PSH units or to residential type settings. The target for FY2019 was set to follow the Consent Decree by meeting the projected two-year cumulative transition total of an additional 800 Class Members.***

***Achievement of the targeted 400 individuals is largely dependent on the size of the current pool of class members available for transition. Several factors serve to limit the number in the transition pool and increase delay. Class members may decline participation by disregarding outreach efforts and /or refusing to be evaluated. To be transitioned, an individual must have a source of funding i.e.: social security benefits, etc. Finally, a class member may be evaluated and found to not be clinically appropriate or ready for independent or supported community residence. Housing resources to meet the specific needs of transitioning individuals may be limited temporarily.***

###### Background: The Williams Consent Decree

The *Williams* vs. Quinn (Williams vs. Pritzker) Class Action lawsuit was filed in 2005 and settled in 2010. The suit targeted an estimated 4,500 residents of former skilled nursing facilities (SNF) designated as Institutes for Mental Disease (IMDs), now classified as Specialized Mental Health Rehabilitation Facilities (SMHRFs), defined as having more than 50% of the residents with a diagnosed mental illness. The suit contended that the State violated the rights of residents by not affording them opportunities to move from these settings to the community, specifically to their own leased held apartments. The Williams Implementation Plan may be accessed at: <http://www.dhs.state.il.us/page.aspx?item=56446>

The state is now entering into the ninth year of the original five-year settlement. Since implementation, 2,324 residents of SMHRFs/IMDs have been transitioned to the community. The majority of Class Members were afforded an opportunity to move into lease-held apartments made possible by the Permanent Supportive Housing model with a bridge subsidy. Others were transitioned to other housing options as appropriate to their needs. In SFY2018, the governor’s introduced budget identified $44.7 million dollars to build the infrastructure for transitioning Williams Class Members and to support the development of permanent supportive housing units with an array of service supports necessary for successful transitions. The final spending for FY2018 was approximately $37.6 million dollars.

In FY2019, $32,908,200 in General Revenue funds were dedicated and spent to expand home and community-based services and other transitional costs associated with the consent decree implementation.

Eight community mental health centers provide a full array of services and supports, including Assertive Community Treatment (ACT) and/or Community Support Teams (CST) An additional seven agencies provide transition coordination services and case management only.

The Illinois Housing Development Authority (IHDA), the Corporation for Supportive (CSH) Housing and Governor’s Housing Coordinators, in partnership with DHS, have worked with developers, real estate companies and landlords to increase housing stock. In the process of transitioning interested Class Members to community housing, it is expected that the chosen community service providers will assure the provision of coordination services during transition that include: assistance with the housing search; developing a comprehensive individualized service plan that includes a risk mitigation plan and a 24 hour emergency back-up plan; assuring that entitlements are transferred and in effect; assistance with purchasing furniture and supplies; and, most importantly, assuring that linkages are completed for requisite services, especially needed mental health services as well as medical and other necessary services and supports.

IHDA currently manages the HUD 811 project-based vouchers. There are 195 HUD 811 units available for Class Members across the Consent Decrees, as well as individuals through the Front Door Diversion Project (diverting from admission to Long Term Care).

## Priority #10: Mental Health and the Military

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| 1. Priority Area:  **Coordination and facilitation of mental health services for Illinois Servicemembers, Veterans, and their Families (SMVF).** | 2. Priority Type:  MENTAL HEALTH SERVICES |
| 3. Population(s) OTHER  Service Members, Veterans, and their Families (SMVF) requiring mental health services: | |
| 4. Goal of the priority area:  ***Collaborate with military and state agency partners to improve access to home and community-based mental health services for service members, veterans, and their families.*** | |
| 5. Objective #1: Sustain a coordinated system of care | |
| 6. Strategies to attain the objective:  a). Develop and maintain partnerships with the Department of Veterans Administration, the Illinois Departments of Veterans’ Affairs (IDVA), and Military Affairs (IDMA), and other agencies and organizations meeting regularly to develop, establish and maintain a coordinated system of care.  b). Develop an inventory of existing behavioral health system providers and services to provide a referral system.  c). Build a coordinated crisis service intervention system between the VA and community providers, with special emphasis on suicide prevention. | |
| 6. Annual Performance Indicators to measure goal success:  **Indicator #1: The number of collaborative meetings attended by DMH staff representatives that have agendas aimed at completing the strategies and coordination of services.** | |
| a) Baseline measurement (Initial data collected prior to and during SFY 2017):  12 were targeted in FY2017 but DMH staff participated in 28 meetings. The DMH manager originally assigned the responsibility for this priority retired in December 2017 and two DMH staff who are both veterans are now assigned joint responsibility for this priority. | |
| b) First-year target/outcome measurement (Progress to end of SFY 2018):  **By the end of FY2018, twelve collaborative meetings attended by DMH representatives that have agendas aimed at completing the behavioral health inventory and coordination of services.** | |
| c) Second-year target/outcome measurement (Final to end of SFY 2019):  **By the end of FY2019, twelve collaborative meetings attended by DMH representatives that have agendas aimed at completing the behavioral health inventory and coordination of existing services.** | |
| d) Data source:  Meeting Minutes and records of DMH staff members assigned to this collaborative task. | |
| e) Description of data: See Above. | |
| f) Data issues/caveats that affect outcome measures: None. | |
| **8. Report of Progress toward goal attainment**  **Second year target: \_\_\_X\_\_ Achieved \_\_\_\_\_ Not Achieved (If not achieved, explain why)** | |

***This objective was achieved. By the end of FY2019, twelve collaborative meetings had been attended by DMH representatives that had agendas aimed at completing the behavioral health inventory and coordination of services. Twelve (12) meetings were previously attended in FY2018.***

***During FY2018 and FY2019, efforts to build and maintain an effective system of care to meet the needs of service men and women, veterans, and their families has been ongoing. Additionally, Illinois has approved the Certified Veterans Support Specialist (CVSS) credential. – A conversation is ongoing regarding the creation of a bridge for current CRSS credential holders who are veterans to be able to obtain the CVSS with minimal additional training and how to ensure that holders of the credential can receive compensation thru Medicaid which will require an amendment to the state spending/ appropriations plan.***

***During FY2018-FY2019, DMH participated in collaborative meetings that had agendas aimed at maintaining partnerships with the Department of Veterans Administration, the Illinois Departments of Veterans’ Affairs (IDVA), and Military Affairs (IDMA), and other agencies and organizations; work toward completing the behavioral health inventory of existing providers; monitoring the ongoing coordination of services; and facilitating a coordinated system of care. Emphasis was placed upon coordination of a crisis intervention system with a focus on suicide prevention. There is an ever-growing network of community providers in a collaborative system of care.***

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| **Objective #2: Improve quality of community mental health services to servicemen, veterans, and their families** |
| **Strategy to obtain the objective:** Educate and train community providers in military and veteran clinical cultural competence. |
| **Indicator #2.**  **The number of Military and Veteran 101 Clinical Cultural Competency Workshops completed during the fiscal year and the total number of participants each year.** |
| a) Baseline measurement (Initial data collected prior to and during SFY 2017): Although four Workshops were conducted in SFY2016, due to funding and resource limitations of the Illinois Joining Forces Foundation, Military and Veterans 101 Workshops were not conducted in SFY2017. |
| b) First-year target/outcome measurement (Progress to end of SFY 2018): **A plan for the resumption of Military and Veteran Clinical Cultural Competency Workshops in FY2019 under DMH sponsorship and in collaboration with IJF will be developed and finalized by the end of the fiscal year**. |
| c) Second-year target/outcome measurement (Final to end of SFY 2019): **Utilizing the Military and Veterans Clinical Competency curriculum, three Workshops will be conducted by the end of FY2019.** |
| d) Data source:  Calendar dates of these events and attendance records of each. |
| e) Description of data: See Above. |
| f) Data issues/caveats that affect outcome measures: None. |
| **8. Report of Progress toward goal attainment**  **Second year target: \_\_X\_\_\_ Achieved \_\_\_\_\_ Not Achieved (If not achieved, explain why)** |

***Although the numerical target of three workshops was not achieved during State Fiscal Year 2019(July 1 to June 30), substantial planning and persistent collaborative activity resulted in the production of two workshops in the beginning months of state fiscal year 2020. Smart Policy Works and a host committee of Thresholds, Illinois Joining Forces, and the Illinois Department of Veteran Affairs on (IDVA) brought the She Served Conference into Springfield, IL on September 17, 2019. The theme of the Conference was: Reducing Barriers to Women Veterans’ Health Care and it included free registration to panels with information regarding healthcare for Women veterans, a keynote panel, and continuing education credits. The event was attended by more than 50 people. A Veterans Benefits and Services Informational will be a Region I Central Provider Network Meeting Agenda and is scheduled on December 3, 2019.***

***This objective has been a moving target that is ongoing and has been substantially addressed. DMH is currently working with staff from the IDVA, Smart Policy Works, as well as Illinois Joining Forces, to coordinate training throughout the State of Illinois. Military and Veteran 101 Clinical Cultural Competency Workshops were discontinued by Illinois Joining Forces in FY2017 due to its limited resources. DMH has been working on a plan for the resumption of Military and Veteran Clinical Cultural Competency Workshops in FY2019 under DMH sponsorship in collaboration with IJF. An initial step in that planning has been completed. DMH conducted a survey that indicated a growing interest in the mental health provider network in veteran services and trainings to address questions regarding treatment for veterans as well as the availability of benefits. The survey was presented to the statewide network of community mental health providers that have a standing relationship with DMH. As respondents preferred actual attendance at these workshops, plans are underway for workshops in the Chicago area to be completed with face to face attendance. In southern more rural parts of Illinois, where distances are a factor there is interest in Webinars using the same curriculum, so that the training will be available across the State.***

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| **Objective #3:** Build Veteran Service Communities (VSC) throughout the state that can ensure access to Behavioral Health Services. |
| Strategy #3: Partner with the Department of Veterans Administration My VA Communities initiative. This initiative is a relationship building effort to ensure Veterans Administration facilities are connected and engaged with their local communities and is an ongoing effort of The Illinois Division of Mental Health coordinating through Illinois Joining Forces Behavioral Health Working Group to ensure SMVF have access to Behavioral Health Services. |
| **Indicator #3: (a) Number of Veterans Service Communities in the State with active Behavioral Health services at end of each fiscal year. (2) An Annual Report that describes progress related to expanding the membership of the Illinois Joining Forces (IJF) Behavioral Health Working Group (BHWG), maintaining a coordinated Crisis Service Intervention System that addresses SMVF needs, and focusing on increasing the number of Veteran Service Communities (VSC) throughout the state.** |
| a) Baseline measurement (Initial data collected prior to and during SFY 2015): N/A |
| b) First-year target/outcome measurement (Progress to end of SFY 2018): **By the end of FY2018, at least 10 Veterans Service Communities statewide with active behavioral health services and a report on the status of completing the behavioral health inventory, coordination of services, and the system of care for SMVF individuals that cites collaborative accomplishments during the fiscal year.** |
| c) Second-year target/outcome measurement (Final to end of SFY 2019):  **By the end of FY2019, 25 Veterans Service Communities statewide with active behavioral health services and a report on the status of completing the behavioral health inventory, coordination of services, and the system of care for SMVF individuals that cites collaborative accomplishments during the fiscal year.** |
| d) Data source: Meeting Minutes and records of DMH staff members assigned to this collaborative task. |
| e) Description of data: See Above. |
| f) Data issues/caveats that affect outcome measures: None. |
| **8. Report of Progress toward goal attainment**  **Second year target: \_\_\_\_\_ Achieved \_\_\_X\_\_ Not Achieved (If not achieved, explain why)** |

***Building Veteran Support Communities (VSC) throughout the state that can ensure access to Behavioral Health Services has not been achieved. Illinois Joining forces is the lead in addressing this initiative. DMH has been limited to providing subject expertise and support. Illinois Joining Forces, IDVA, IDHS/DMH and other community partners are working to get the VSC’s up and running but the process has been slower than anticipated, especially in Greater Illinois and efforts have been inconsistent. Further information about the Illinois Joining Forces VSC initiative is provided in the summary below. So far one fully functional Veterans Support Community has been established in the state-Lake County, Illinois There are at least 15 others at various stages of development.***

**Background**:

DMH collaborates with the Illinois Departments of Veterans Affairs’ and Military Affairs (National Guard and Air Guard), to coordinate and improve services for service members, veterans, and their families throughout the state. Military personnel returning from the wars in Iraq and Afghanistan are at increased risk of traumatic brain injury, post-traumatic stress disorder, depression, anxiety and other mental health symptoms as well as new-onset heavy drinking, binge drinking and other alcohol-related problems. Anxiety, depression and engagement in high risk behaviors, such as substance abuse, are more likely among adolescents in families with a deployed parent than among similar adolescents in non-deployed families (Chandra et al., 2009) Given the increasing recovery needs among returning military personnel and their families, DMH and DASA have partnered with the Illinois National Guard and Illinois Department of Veterans Affairs in order to improve access to mental health services, alcohol and other drug treatment, and recovery support services among military personnel returning from deployment and their families.

**Illinois Joining Forces**

DMH actively participated in the formation and implementation of the Illinois Joining Forces Initiative and was active in the legislative process that created the Illinois Joining Forces Foundation. Public Act 098-0986, which became effective on August18, 2014, created the Illinois Joining Forces Foundation, a not-for-profit foundation. Provisions in the law for incorporation, the appointment of a Board of Directors, and the collection of funds ensures the long-term sustainability of Illinois Joining Forces, now considered to be critically important for the support of the state’s military and veteran communities.

The Illinois Joining Forces(IJF) is a joint Department of Veterans’ Affairs (DVA) and Department of Military Affairs (DMA) effort to better serve veterans, service members, and their families throughout the state. IJF brings together, under a common umbrella; public, non-profit, and volunteer organizations to foster increased awareness of available resources and to better partner and collaborate with participating organizations. It has been estimated that Illinois alone has as many as 500 veteran- and military-related organizations but the lack of collaboration and coherence between them has resulted in veterans and service members being frustrated and unaware of the many resources available to them.

Illinois Joining Forces (IJF) is working on establishing Veteran Support Communities (VSC’s) statewide to support formal and informal networks of services and supports in communities and regions for service members, veterans, and families (SMVF). The intent is to align and connect service providers, resources, programs, and services and supports along two general operational and core program lines – **Growth** related functional services and support resources generate independence; and **Wellness** related functional services and support resources that resolve crisis in the short term and in the long term develop self-support and personal development.

At a minimum, VSC partners must have the capacity to service veterans in at least these six core functions:

Housing,

Employment

Financial Assistance

Education

Integrated Primary and Behavioral Healthcare

Women Veterans.

For additional information about Illinois Joining Forces see their Website at illinoisjoiningforces.org

**Priority #11: Integrated Health Homes**

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| --- | --- |
| **1. Priority Area:**  **Contingent upon CMS approval of the Illinois Application for a Section 1115 Demonstration Waiver, enhance and improve service coordination through the establishment of Integrated Health Homes.** | 2. Priority Type:  MENTAL HEALTH SERVICES |
| 3. Population(s)-SMI, SED, | |
| **4. Goal:**  *Through the implementation of the plan cited in the DHFS application for the 1115 Waiver, develop and maintain care coordination in community mental health service agencies ensuring that persons with serious mental illness and their families can receive fully integrated and seamless services in their community.* | |
| **5. Objective: Assist community mental health providers to successfully meet integrated Health Home certification requirements.** | |
| **6. Strategy: Provide education, focus, technical assistance, and consistent ongoing support for community mental health centers to become integrated health homes.** | |
| 7. Annual Performance Indicators to measure goal success:  **Indicator: Number of community mental health providers meeting the requirements for certification as Integrated Health Homes.** | |
| a) Baseline measurement (Initial data collected prior to and during SFY 2018): N/A | |
| b) First-year target/outcome measurement (Progress to end of SFY 2018): **Not Applicable** | |
| c) Second-year target/outcome measurement (Final to end of SFY 2019): TBD | |
| d) Data source: TBD | |
| e) Description of data: TBD | |
| f) Data issues/caveats that affect outcome measures: No access to DHFS or MCO service data | |
| **8. Report of Progress toward goal attainment**  **First year target: \_\_\_\_\_ Achieved \_\_\_X\_\_ Not Achieved (If not achieved, explain why)** | |

***After administrative changes (because of the November 2018 election) in the Governor’s Office and in the leadership of the Department of Healthcare and Family Services (IDHFS), the State Medicare/Medicaid Authority, plans for the implementation of Integrated Health Homes are currently undergoing review and consideration by IDHFS.***