**FY2017**

**COMMUNITY MENTAL HEALTH SERVICES**

**BLOCK GRANT IMPLEMENTATION REPORT\***

**ILLINOIS DEPARTMENT OF HUMAN SERVICES**

**DIVISION OF MENTAL HEALTH**

**\*NARRATIVE REPORT OF PROGRESS AND ACHIEVEMENTS IN FY2017 TOWARD THE IMPLEMENTATION OF THE SFY2016-SFY2017** **COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT APPLICATION AND PLAN WHICH WAS SUBMITTED ON SEPTEMBER l, 2015**

Introduction

This implementation report covers the second year of a two-year Mental Health Block Grant plan for FY2016-FY2017 which was submitted to SAMHSA on September 1st, 2015. In general, this report describes our achievements, continuing progress, and documents the challenges encountered during FY2017 in working on 14 strategies related to the DMH priorities and goals that were supported by performance measures and includes the Ten Percent Set–Aside Revision to the plan that was introduced and added in FY2016.

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 FY2017, and other pertinent data are provided.

FY2017 IMPLEMENTATION REPORT

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**Plan Table 1.1 Array of Services**

|  |  |
| --- | --- |
| 1. Priority Area:  **Facilitation of an effective array of clinical and support services for adults and children.** | 2. Priority Type MENTAL HEALTH SERVICES |
| 3. Population(s) SMI, SED:  |
| 4. Goal of the priority area: *Facilitate the array of community-based services available to adults and youth in need of mental health services* |
| 5. Strategies to attain the goal: Actively enhance and support the provision of the following core services available through Medicaid: * Mental health assessment
* Psychological evaluation, if recommended,
* Treatment plan development, review and modification:
* Crisis intervention,
* Psychotropic medication administration, monitoring, and training;
* Therapy/counseling services
* Community support (includes Community Support services for individuals, groups, and families; Community Support residential services and services of Community support teams,)
* Assertive community treatment,
* Psychosocial rehabilitation
* Mental health intensive outpatient,
* Case management (includes Mental health case management, Client-centered consultation, and Transition linkage and aftercare)

Work with system partners to provide supportive services including: * Educational services,
* Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA),
* Substance abuse services (through DASA),
* Services for co-occurring mental health and substance abuse disorders,
* Medical and dental (through DHFS for Medicaid eligible individuals), and
* Community Integrated Living Arrangements (CILA) for Adults, and,
* Wraparound services (for Children and Adolescents)
 |
| 6. Annual Performance Indicators to measure goal success: **Indicator: Number of individuals who receive mental health services.** |
| a) Baseline measurement (Initial data collected prior to and during SFY 2015): **125,791** |
| b) First-year target/outcome measurement (Progress to end of SFY 2016): **115,000** |
| c) Second-year target/outcome measurement (Final to end of SFY 2017): **72,500 (Modified from 105,000 in December 2016)**  |
| 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:** 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 the majority of the URS tables. |
| f) **Data issues/caveats that affect outcome measures**: None |
| **7. Report of Progress toward goal attainment** **Second year target: \_\_\_\_\_ Achieved \_\_\_X\_\_ Not Achieved (If not achieved, explain why)**The goal of facilitating the array of community-based services available to adults and youth in need of mental health services was met as the services listed above were provided to 64,403 individuals in FY2017.  However, there was an 11.1% shortfall in attaining the numerical target of 72,500.    Illinois was without a budget since FY2015 and reductions were sustained in General Revenue Funds. State funding has generally declined in the past several years which prompted setting decreasing targets. Persons enrolled in Medicaid received the full array of services available through Medicaid in FY2017.  It is estimated that 66% of mental health clients are receiving services through the managed care programs administered through the state Medicaid agency- the Illinois Department of Healthcare and Family Services (DHFS), which are not under the purview of the SMHA, and hence, not reported through our data system. In addition, due to the nature of the DHFS contracts with the Illinois managed care organizations it is not even clear if DHFS is receiving this information, as the MCO organizations may be viewing this data as confidential and un-sharable.    |

***DMH met this goal in FY2017. Services were provided to 64,403 individuals in FY2017. These individuals received the services available in the array of community-based services provided to adults and youth in need of mental health services as listed above.***

***However, the numerical target of a total of 72,500 individuals served was not attained. The shortfall of 11% is not surprising in view of the budget impasse which continued well into FY2017. Additionally, MCO data continues to be unavailable.***

***It is noteworthy that for almost 98% of everyone served in FY2016, services were either fully or partly paid through Medicaid during the course of the year. This has continued in FY2017. See Table below.***

**Medicaid Status of Persons Served in FY2016 and FY2017**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Medicaid Status** | **Number Served in FY2016** | **Percent of** **Total Served** | **Number** **Served in** **FY2017** | **Percent of** **Total Served** | **Change in Number (%)****FY16-FY17** | **Percentage Change (%)****FY16-FY17** |
| **Medicaid (Only Medicaid)** | **69,758** | **95.5%** | **62,100** | **96.42%** | **-11.0%** | **0.9%** |
| **Non-Medicaid Sources (only)** | **1,251** | **1.7%** | **1,012** | **1.57%** | **-19.1%** | **-0.1%** |
| **People Served by Both** | **1,775** | **2.4%** | **1,291** | **2.00%** | **-27.3%** | **-0.4%** |
| **Medicaid Status Not Available** | **42** | **0.05%** | **0** | **0** | **0** | **0** |
| **Total Served** | **72,826** | **100.00%** | **64,403** | **100.00%** |  |  |

***The Array of Core Mental Health Services***

The array of core mental health services listed in Table 1.1 (above) are purchased on behalf of Medicaid Eligible Illinois citizens with mental illnesses. The services are described in the DMH Provider Handbook that is maintained by the Mental Health Collaborative and is posted on the DHS/DMH Website.

##### Support Services for Adults

##### Educational services in the form of stipends and scholarships for college, trade school, and vocational training are available through the DHS Division of Rehabilitation Services (DRS) and facilitated by mental health providers. Consumers also receive support in pursuing the completion of basic educational requirements (e.g., GED) and other available educational programs through local public school systems. Under the Individuals with Disabilities Education Act (IDEA), local school systems provide special education and a range of related support services to students with disabilities over the age of 18, including career and technical education, competitive and supportive employment, interagency linkages for social services, and supports for transition to post-secondary (college) education. A continuum of Substance Abuse Services is funded through the DHS Division of Alcoholism and Substance Abuse (DASA) including outpatient and residential programs for persons addicted to alcohol and other drugs. DMH and DASA have consistently worked together to meet the needs of the dually diagnosed consumer and have implemented specialized treatment programs, training, and support programs when funding has been available. DASA has funded the Illinois Co-Occurring Center for Excellence (ICOCE) to provide training, technical assistance, and consultation and has collaborated with DMH in providing trainings on trauma informed prevention, treatment and recovery as well as adolescent and family co-occurring disorders and their treatment. Adults with serious mental illnesses can access the medical and dental care services available to the general population through the service coordination functions provided in case management and therapeutic services. Most individuals enrolled in Medicaid Managed Care programs under the Department of Health and Family Services (DHFS) are able to access these services. As adults with mental illnesses often have neither the insurance nor the financial means to cover their healthcare costs, they require navigation and assistance in accessing health care and are receiving support in applying for Medicaid, or accessing affordable insurance programs through the Illinois Marketplace. Those who are Medicaid eligible benefit from the medical services and programs provided through the Department of Healthcare and Family Services (DHFS).

***Support Services for Children & Adolescents***

The array of core services provided to children and adolescents are aimed at providing acute care services during a crisis and longer term mental health treatment services intended to reduce psychiatric symptoms and promote adaptive functioning. The overwhelming majority of children served by DMH-funded providers are enrolled in Medicaid. Youth with serious emotional disturbances and their families may also receive Screening, Assessment and Support Services (SASS) and Child and Adolescent Wraparound Services.

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Screening, Assessment and Support Services (SASS) programs have been in operation for 25 years. Since FY2005, the DMH has participated in a significant effort to deliver SASS services collaboratively with the Department of Children & Family Services (DCFS) and the Department of Healthcare & Family Services (DHFS). The primary objectives of SASS are to develop community-based screening and assessment capability, intensive home-based services, and crisis intervention services. The philosophy of service is short-term intervention that is child-centered, family-focused and community-based. Parents are involved in service provision and evaluation.

Wraparound ServicesThe Wraparound approach has strengthened the collaboration needed to serve youth with SED and has promoted an important shared agenda for community mental health providers and schools.DMH has defined the way these services are to be provided to families, offering both traditional and non-traditional supports by using the local network of community providers and associations. In this approach, there is a definable planning process involving the child and family which results in an individualized plan for that child and family that focuses on strengths and needs across multiple settings**.**

Essential **medical and dental services** are available to children and youth with SED regardless of income and are accessed through case management or referral. Children enrolled in Managed Care programs receive these services as part of their service package. Mental health providers actively assist families to process their medical bills through Medicaid and to obtain health insurance coverage for their children through the DHFS **All Kids** program. Mental health providers may facilitate access to subsidized health care clinics that provide medical and dental services at minimal cost. Funded by the Illinois Legislature since 2006, the State of Illinois provides access to comprehensive health care and affordable health insurance for children and adolescents. Every uninsured child may be eligible regardless of income, current health condition or citizenship. Information is available on the All Kids Website at: <http://www.allkids.com>

**All Kids** also has two programs for pregnant women: Medicaid Presumptive Eligibility (MPE) that offers immediate, temporary coverage for outpatient healthcare for pregnant women and Moms & Babies which covers healthcare for women while they are pregnant and for 60 days after the baby is born. Moms & Babies covers both outpatient healthcare and inpatient hospital care including delivery. See: [http://www.**allkids.com**/pregnant.html](http://www.allkids.com/pregnant.html)

Family Care extends healthcare coverage to parents living with their children 18 years old or younger and also covers relatives who are caring for their children in place of their parents. See: <http://www.familycareillinois.com>

**Table 1.2-1 Individual Placement and Support- Evidence Based Supportive Employment**

|  |  |
| --- | --- |
| 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. Strategies to attain the goal: **(1) During FY2016 and FY2017, maintain the implementation of Evidence Based Supportive Employment.** (2) During FY2016 and FY2017, continue provision of Assertive Community Treatment that meets national fidelity model requirements. (3)By the end of FY 2017, through the provision of rental subsidies, implement a statewide permanent supportive housing initiative which targets an additional 400 consumers acquiring decent, safe, and affordable housing and support services in a manner consistent with the national standards for this evidence based practice. This evidence based strategy will be discussed under Priority # 7 –Advancement of Community Integration. (See Plan Table 1.7 below) |
| 6. Annual Performance Indicators to measure goal success: **Indicator #1: Number of consumers receiving supported employment in FY2016 and FY2017. (National Outcome Measure)** |
| a) Baseline measurement (Initial data collected prior to and during SFY 2015):  |
| b) First-year target/outcome measurement (Progress to end of SFY 2016): **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.**  |
| c) Second-year target/outcome measurement (Final to end of SFY 2017): **Target:**  **2,700****- 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.** |
| 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. |
| **7. Report of Progress toward goal attainment** **Second year target: \_\_X\_\_ Achieved \_\_\_\_ Not Achieved (If not achieved, explain why)**  |

##### This strategic objective has been successfully achieved. The target of 2,700 was significantly exceeded by more than 21%! In FY2017, a total of 56 IPS sites with fidelity to the model served 3,003 unduplicated consumers. An additional 6 sites that were working toward fidelity but had not yet met fidelity standards served 183 consumers. In all, 3,275 consumers received supported employment services.

**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 expanding and improving implementation of evidence based supportive employment in the past several years have included:

* DMH completed the third year of the five year 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 is focused on: (1) Development of the state infrastructure required to support implementation and sustainability of IPS Supported Employment; (2) Implementation of IPS in two underserved communities [the Edgewater and the Woodlawn communities in Chicago] completed in FY2015 with an expansion of availability to include all persons needing IPS services in those areas; and, (3) Enhancements to the current IPS model including the integration of physical and behavioral health with employment supports, peer support, and financial literacy. DMH continues to work with the UIC Center on Mental Health Services and Research Policy to collect and analyze data.
* The Illinois Employment First Interagency Council which is chaired by Lore Baker from the Department of Human Services continues to meet on a regular basis. The Council developed a mission statement that encompasses the goals of increasing employment opportunities for persons with disabilities in Illinois and supports the sustainability and scalability of IPS. Another major duty of the Council that is a direct goal from our SAMHSA Strategic Plan is to identify what all partnering State of Illinois Departments and Divisions are measuring as employment outcomes, and then align IPS employment outcome measures with other DHS outcome measures that focus on increasing self-sufficiency through employment.
* The Department of Human Services has initiated meetings between the Division of Mental Health [DMH] and the Division of Rehabilitation Services [DRS] to create a Memorandum of Understanding [MOU] between DMH and DRS for the implementation of IPS/Supported Employment to citizens of Illinois with mental illness. A strategic plan for both Divisions to work together to implement IPS in Illinois will be established in the MOU and will include processes to create, monitor, sustain, fund, and provide technical assistance to IPS Programs. The Department of Healthcare and Family Services [HFS] has participated in these meetings in their role of the State’s Medicaid authority to provide guidance with funding using Medicaid. A national context expert, Lisa Mills, has assisted in providing technical assistance in the development of this MOU.
* DMH and the Division of Alcohol and Substance Abuse [DASA] continues to collaborate in integrating IPS and SSI/SSDI Outreach, Access and Recovery [SOAR] to reduce the gap in income support services for homeless individual seeking SSI/SSDI and/or employment. Two IPS provider agencies with IPS and SOAR [Trilogy in Chicago and Cornerstone in Joliet] has partnered with DMH/DASA to serve IPS to their SOAR population. DASA/DMH have started refresher trainings of clinical staff of the SOAR process.
* The Division of Mental Health posted a “Request for Proposals [RFP]” to fund three DMH IPS Trainer Positions to provide IPS technical assistance to IPS Agencies in Regions 1 & 2 for FY2018.
* 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 6,155 hours provided to 1,900 staff [including agency IPS provider staff and support personnel, state employees of DHS, HFS, DCEO, DCFS, and community stakeholders] for IPS across the State in FY2017. IPS Technical Assistance Team activities have included:
	+ Providing face-to-face individual consultation, teleconference/phone, and large group in-person trainings.
	+ Assisting with the development of the web-based IPS Web Portal to further extend training resources.
	+ Development of a CY2017 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 the Recovery Services Development Group (RSDG) to improve integrated Recovery support, IPS/WRAP, and the quality of peer support at IPS Agencies.
	+ 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 to improve their engagement skills n talking to consumers about employment.
	+ Working with the NAMI Illinois IPS Family Project Team to develop knowledge and tools necessary to equip IPS Workers to engage family and/or natural supports in IPS services so that there is implementation of this practice occurring as a standardized practice.
	+ 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.
	+ Working to implement the SAMHSA 8 Dimensions of Wellness to IPS Providers in Region 1.
	+ Helping to develop the role and supervision of Employment Recovery Specialists and CRSS staff attached to IPS Teams.

Accomplishments in FY2017 included:

* IPS technical assistance was provided to 56 IPS Sites and to 18 Drop-In Centers located in the Chicagoland Area, Peoria, and Decatur.
* In FY2017 the Illinois Web Portal, “Pathways to Employment – Putting Illinois to Work” <http://www.illinoisips.org/> has seen great use --
	+ The home page averaged 3,561 views a quarter;
	+ The average number of unique users per week was 122;
	+ The average number of page views per week was 289;

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 this steering committee. 15 CMHCs [11 of them being IPS sites] are currently offering 20 NEW-R groups to consumers.

* Financial literacy training was provided by Dr. Jane Burke-Miller to Illinois SAMHSA Staff in FY2017. Two 1.5 hours trainings [via teleconference] using a financial literacy curriculum that she and the University of Illinois at Chicago [UIC] developed. This training will be helpful to IPS Team members in providing the financial education that IPS participants need to inform them on making better financial decisions with their work earnings.

EBSE has also confronted several challenges:

* Due to the absence of a state budget, three mental health providers discontinued IPS services and some mental health providers merged with others, resulting in extremely long waiting lists with remaining providers to enroll consumers as well as limiting the recruitment of new CMHCs to become IPS providers.
* 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. The SAMHSA Transformation grant is still being used to address these state infrastructure issues and to facilitate sustainability and scalability.
* The IPS braided funding model in which the DRS portion of the model is outcome driven continues to be insufficient to meet the cost of services. Inability to project costs and revenues make it very difficult for IPS providers to maintain and expand IPS staff and enrollment into IPS. A major portion of the funding for IPS is contingent on producing good employment outcomes- providers are paid milestone payments when a person has been working successfully in a job that fits their preferences for 15 days, 45 days, and 90 days. If the person who has been successfully working for 90 days continues to need intensive follow-along support, two additional post-employment milestone payments could be paid to providers at 120 days and 150 days. This additional funding is not enough to cover the cost of the services provided to consumers which cannot be billed to Medicaid [e.g. vocational engagement, job development, job placement, some types of follow-along supports, etc.] There has so far been no significant increase of non-Medicaid-enrolled consumers in IPS. Most IPS programs currently mainly serve persons who are Medicaid-enrolled. Providers who are achieving a high amount of successful employment outcomes cannot receive additional funding after their milestone contract is met. There have been many examples in years past that an IPS Provider who completed their milestone contract did not receive additional funding above their contract amount during that current fiscal year, and had to wait until the following fiscal year to increase their milestone contract. Finally, and outcome-based funding system does not allow new IPS Providers to receive any DRS milestones until consumers are placed and start to obtain milestones. It usually takes a new IPS Provider anywhere from a year to two years to have an established IPS program that starts generating job starts and employment outcomes that can fund and sustain an IPS Staff. This makes it very difficult to CMHCs who do not have the available resources to start an IPS program.
* 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 challenge to program sustainability.
* Current resources to provide IPS technical assistance are 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 needs modernization to keep up with growth and data needs.

Statistics for FY2017 are presented in the Table below:

|  |  |
| --- | --- |
| **Total # of Fidelity Sites:** | **56** |
| **Total unduplicated # of consumers who received IPS at the fidelity sites:** | **3,003** |
| **Total # of Sites not at Fidelity:** | **6** |
| **Total unduplicated # of consumers who received IPS at the non-fidelity sites:** | **183** |
| **Total unduplicated # of consumers who received IPS:** | **3,275** |

 **Plan Table 1.2-2 ACT**

|  |  |
| --- | --- |
| 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. Strategies to attain the goal: (1) During FY2016 and FY2017, maintain the implementation of Evidence Based Supportive Employment. **(2) During FY2016 and FY2017, continue provision of Assertive Community Treatment that meets nationally expected outcomes**. (3)By the end of FY 2017, through the provision of rental subsidies, implement a statewide permanent supportive housing initiative which targets an additional 400 consumers acquiring decent, safe, and affordable housing and support services in a manner consistent with the national standards for this evidence based practice. This evidence based strategy will be discussed under Priority # 7 –Advancement of Community Integration. (See Plan Table 1.7 below) |
| 6. Annual Performance Indicators to measure goal success: **Indicator #2**:  **Number of persons with SMI receiving Assertive Community Treatment in FY2016 and FY2017 (National Outcome Measure).** |
| a) Baseline measurement (Initial data collected prior to and during SFY2015): **1,020** |
| b) First-year target/outcome measurement (Progress to end of SFY 2016): **1,050** |
| c) Second-year target/outcome measurement (Final to end of SFY 2017): **1,050** |
| **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:**. 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 the majority of the URS tables. |
| f) **Data issues/caveats that affect outcome measures:** The State is moving to an outcomes based evaluation of services provided, and this will include ACT services. The State is working on establishing a baseline, with focus on the following with respect to ACT: Number of Emergency Department Visits, Number of Hospitalizations for Psychiatric Treatment, Number of Placements into IMDs. |
| **7. Report of Progress toward goal attainment** **Second year target: \_\_\_\_ Achieved \_\_\_X\_\_\_Not Achieved (If not achieved, explain why)** |

***DMH was successful in maintaining 25 ACT teams in FY2016 and has increased the number of ACT Teams in FY2017 to 32. This evidence-based practice is reported to have been provided to 735 individuals in FY2017 by the end of the fiscal year. The numerical target of 1,050 was not achieved. However, this data is recently reported and DMH has not as yet had an opportunity to evaluate it. It would appear that a 22% increase in the number of teams in the State should result in a greater number of individuals being served. This evidence-based practice was provided to 1,124 individuals in FY2016 as of the year ending October 31, 2016.***

**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. Consistent with national trends, Illinois is moving towards outcome based evaluations of services. DMH is currently working on identifying and gathering baseline data in those areas which have demonstrated positive outcomes - reducing emergency room visits, psychiatric hospitalizations and the need for institutional care. DMH is also considering recovery-based measures such as employment.

**Plan Table 1.3 Access to Services**

|  |  |
| --- | --- |
| 1. Priority Area: **Use of Data for Planning** | 2. Priority Type: MENTAL HEALTH SERVICES |
| 3. Population(s)-SMI, SED,  |
| **Goal:** *Use Quantitative data to assess access to care and perception of treatment outcomes to provide data for decision support.*  |
| **Strategy:** Assess access to care by tracking the number of individuals who received treatment partitioned by race, gender and age.  |
| 6. Annual Performance Indicators to measure goal success: **Indicator:** **Number of adults and number of children/adolescents receiving services from DMH-funded community-based providers.** |
| a) Baseline measurement (Initial data collected prior to and during SFY 2015): **125,797** |
| b) First-year target/outcome measurement (Progress to end of SFY 2016): **115,000** |
| c) Second-year target/outcome measurement (Final to end of SFY 2017): **72,500 (Modified from 105,00 in December 2017 based on FY2016 data.)** |
| 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: 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 the majority of the URS tables |
| f) Data issues/caveats that affect outcome measures: None |
| **7. Report of Progress toward goal attainment** **Second year target: \_\_\_ Achieved X Not Achieved (If not achieved, explain why)** |

***Although the numerical target of 72,500 was not achieved, the strategy was satisfactorily accomplished in FY2017. DMH used quantitative data to evaluate access to care by tracking the number of individuals who received treatment during the fiscal year partitioned by race, gender and age. A total of 47,076 adults and 17.327 children and adolescents were served in FY2017. The decline in population served has continued in FY2017at 10% for adults and 15% for children and adolescents but appears to be leveling off from the steep decline seen in FY2016. Managed Care has been implemented in Illinois in the past three years and a substantial number of individuals are being served by MCOs outside of the SMHA system. It was anticipated that as the number served by MCOs grows, there will be a concomitant decrease in the numbers served in the SMHA public mental health system as was the case in SFY2015 and FY2016. Additionally, Illinois had been without a budget from FY2015 through FY2017 and reductions have been sustained in General Revenue Funds.***

***Although DMH strived to maintain access to care by utilizing service benefit packages and utilization management strategies in recent years, the service benefit packages for non-Medicaid consumers had to be discontinued in FY2016 due to lack of funding.***

**Number of Adults Receiving Services from DMH-funded**

**Community-based Providers**

|  |  |  |  |
| --- | --- | --- | --- |
| (1) | (2)  | (3)  | (4)  |
| **Fiscal Year**  | **FY 2015**  | **FY2016** | **FY2017** |
|  | **Actual**  | **Actual** | **Actual** |
| **Performance Indicator**  | **91,083** | **52,396** | **47,076** |
| **Numerator**  | **N/A** | **N/A** | **N/A** |
| **Denominator**  | **N/A** | **N/A** | **N/A** |

**Number of Children/Adolescents Receiving Services from**

**DMH-funded Community-based Providers**

|  |  |  |  |
| --- | --- | --- | --- |
| (1) | (2)  | (3)  | (4)  |
| **Fiscal Year**  | **FY 2015**  | **FY2016** | **FY2017** |
|  | **Actual**  | **Actual** | **Actual** |
| **Performance Indicator**  | **34,888** | **20,430** | **17,327** |
| **Numerator**  | **N/A** | **N/A** | **N/A** |
| **Denominator**  | **N/A** | **N/A** | **N/A** |

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.

**Plan Table 1.4-1- Illinois Center of Excellence for Behavioral Health and Justice**

|  |  |
| --- | --- |
| **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. Strategies to attain the goal: (a) **Utilize the training and technical assistance provided by the Illinois Center of Excellence for Behavioral Health and Justice to facilitate appropriate responses to the needs of persons with behavioral health disorders who are involved with the criminal justice system.** (b) Maintain the Mental Health Juvenile Justice Initiative. |
| 6. Annual Performance Indicators to measure goal success: Indicator #1:1. **Number of technical assistance and training events provided with number of participants.**
2. **Number of Illinois counties involved and represented by attendees of the events.**
 |
| 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 2016): **See Below** |
| c) Second-year target/outcome measurement (Final to end of SFY 2017): **Target: 30 events, 1200 attendees representing at least 70 counties. Outcome: 59 events, 2613 attendees representing 87 counties.** |
| d) Data source: Quarterly data reports and descriptions of events gathered and reported to BJA and DMH by the Center of Excellence.  |
| e) Description of data: Agendas for training events. Documentation of technical assistance events (e.g. dates, consultant and individuals receiving TA).  |
| f) Data issues/caveats that affect outcome measures: |
| **7. Report of Progress toward goal attainment** **Second year target: \_\_X\_ Achieved \_\_\_\_\_\_Not Achieved (If not achieved, explain why)** |

***This strategy was successfully achieved and all the targets were substantively exceeded!***

***In FY2017, 2,613 representatives from 87 of the 102 Illinois counties (85.3%) attended 59 training, technical assistance, and informational events. FY2016 was a similarly active year with nearly 1,700 representatives from 77 counties (75.5%) attending 37 event*s. *During the first quarter of SFY2018, the Center of Excellence convened 4 training/technical assistance events that were attended by 136 persons representing agencies in 16 of the 102 counties in Illinois. The table below depicts the quarterly activities of the Center of Excellence.***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|

|  |  |  |  |
| --- | --- | --- | --- |
| **Quarter** | **Number of Events** | **Number of Participants** | **Number of Counties (Duplicated)** |
| **July 1-Sept 30, 2016** | **18** | **569** | **20** |
| **Oct-December 2016** | **11** | **846** | **14** |
| **January-March 2017** | **15** | **536** | **39** |
| **April-June 30,2017** | **15** | **662** | **12** |
| **SFY2017 Totals** | **59** | **2,613** |  |
| **July 1,2017 –Sept 30, 2017** | **4** | **136** | **16** |
| **Totals FFY2017****(Oct 1, 2016-Sept30, 2017)** | **45** | **2,180** | **87 (Unduplicated)** |

 |

 |

***Background:***

**The Illinois Center of Excellence for Behavioral Health and Justice (Center of Excellence)** became operational in April of 2012[[1]](#footnote-1). The Illinois Center of Excellence for Behavioral Health and Justice is a statewide entity working to equip communities to appropriately respond to the needs of persons with behavioral health disorders that are involved with the criminal justice system. The Center of Excellence is housed at the University of Illinois College of Medicine Rockford, with training access at other University of Illinois sites in Chicago, Peoria, Springfield, and Urbana/Champaign. This project has been supported by Grant # 2014-DJ-BX-1183, awarded by the [Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice](https://www.bja.gov/), through the [Illinois Criminal Justice Information Authority](http://www.icjia.state.il.us/). The Center of Excellence provides resources and training on over 60 topics. Customized technical assistance is provided to circuit courts, counties, communities and organizations. The most requested training included topics on mental health signs and symptoms, addressing mental illness, psychotropic medications and their side effects, the neurobiology of addiction, suicide prevention, trauma-informed response, legal issues in problem-solving courts, and appropriate responses to persons in a behavioral health crisis. The Center of Excellence conducts an annual survey to identify topics for training for the following year.

A key component of this mission is enhancement and development of Problem-Solving Courts through technical assistance, consultation, training, and information dissemination. The Center of Excellence has determined that there are 107 problem- solving courts across Illinois judicial circuits. These courts include 25 mental health courts, 62 drug courts, 17 veteran’s courts, 2 DUI courts, and 1 youthful offender court. The Illinois Center of Excellence for Behavioral Health and Justice also provides training to a variety of entities on a wide range of topics. For example, the Center of Excellence provides training to problem-solving courts, and to IDOC staff on trauma-informed care. Issues relevant to conditional release and recovery, trauma, and cognitive behavioral approaches (for residential providers), and on mental health treatment models for correctional inmates have also been a focus of training.

Since the opening of the Center of Excellence in April 2012, the Center of Excellence has provided training to persons from 99 of the 102 counties in Illinois (97%) and has “reached” all 102 counties (100%)

**Plan Table 1.4-2 Mental Health Juvenile Justice Program**

|  |  |
| --- | --- |
| **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 at risk of or with juvenile justice involvement.* |
| 5. Strategies to attain the goal: (a) Utilize the training and technical assistance provided by the Illinois Center of Excellence for Behavioral Health and Justice to facilitate appropriate responses to the needs of persons with mental health disorders who are involved with the juvenile justice system or at risk of involvement. **(b) Maintain the Mental Health Juvenile Justice Program.** |
| 6. Annual Performance Indicators to measure goal success: Indicator #2:**Number of youth served by the MHJJ Program statewide.** |
| a) Baseline measurement (Initial data collected prior to and during SFY 2015): **311** |
| b) First-year target/outcome measurement (Progress to end of SFY 2016): **350** |
| c) Second-year target/outcome measurement (Final to end of SFY 2017): **280 (Modified December 2016 from 370 based on FY2016 data.) Actual FY2017: 209** |
| d) Data source: MHJJ Program Data Base maintained internally. |
| e) Description of data:Aggregate the number of youth 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 |
| **7. Report of Progress toward goal attainment** **Second year target: \_\_\_ Achieved \_\_\_X\_\_\_ Not Achieved (If not achieved, explain why)**At the start of CY2016 agencies began to suspend their MHJJ programs. By July 1, 2016, a total of seven agencies suspended their MHJJ programs due to the financial impact of the budget impasse. One agency in Cook County was able to resume the MHJJ program in October 2016. Currently, there are 14 agencies operating in the MHJJ program. The decrease in participating agencies significantly impacted the number of youth served in FY2017.  |

***Although fiscal and clinical resource limitations and reductions continued to exist in FY2017, the MHJJ Program has been maintained although enrollment in the program substantially decreased to 209 from 331 in*** ***FY2016. At the start of Calendar Year 2016 agencies began to suspend their MHJJ program. By July 1, 2016, a total of seven agencies had suspended their MHJJ programs due to the financial impact of the budget impasse. One agency in Cook County was able to resume the MHJJ program in October 2016. During FY2017 there were 14 agencies operating the MHJJ program out of the 21 agencies that had provided services earlier in FY2016. The decrease in participating agencies has significantly impacted the number of youth served in FY2017.***

***It should now be noted that as of SFY2018, six new agencies have initiated MHJJ services and are now in the process of gradually implementing their programs and working towards becoming fully operational.***

***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. The annual evaluation and outcome analysis continues to demonstrate that completion of the MHJJ project is associated with overall clinical improvement, decreased functional impairment, and reduced rates of recidivism for youth.***

***The Table below offers a comparative view of activity in the program since FY2014. Compared to FY2014, the number of youth actually enrolled in the program and receiving treatment services designed to avert re-arrest, reduce the intensity of their emotional disturbance, and improve their functioning and quality of life had increased by 44% in FY2016 and the re-arrest rate dropped by 7% in FY2015[[2]](#footnote-2). The DMH contract with Northwestern University to evaluate the program was discontinued in FY2017 and the data website has been largely non-functional. As a result, more recent information about linkage and re-arrest rate is not currently available.***

|  |  |  |  |
| --- | --- | --- | --- |
| **FY 2014** | Screened | Eligible | Enrolled |
|  | 272 | 252 | 230 |
| **FY 2015** | Screened | Eligible | Enrolled |
| 346 | 311 | 311 |
| **FY 2016** | Screened | Eligible | Enrolled |
| 341 | 346 | 331 |
| **FY 2017****Projected** Based upon 14 (down from 20) agencies operating MHJJ  | 300 | 289 | 280 |
| **FY2017 Actual** | **222** | **214** | **209** |
|  | **FY’14** | **FY’15** | **FY’16** | **FY’17** |
| Linked to services | 91.27% | 97.11% | 79.0% | N/A |
| Re-arrest rate[[3]](#footnote-3) | 22% | 15% | N/A | N/A |

**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 2000 as a pilot project in just seven counties, the MHJJ program covered 29 Illinois counties, involved 20 community agencies and included the efforts of 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. Access to flexible spending funds is available to supplement the youth’s ancillary treatment services or family stabilization if no other source of funding is available. A number of 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 FY2016, the MHJJ Program expanded its eligibility criteria to include youth who are “at risk” of coming into 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 has recently moved into the delivery of Trauma Informed Care as a priority for the youth it serves.

**Plan Table 1.5-1 Recovery**

|  |  |
| --- | --- |
| 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:  |
| 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.* |
| 5. Strategies to attain the goal: **Strategy #1: Conduct a series of statewide teleconferences designed to disseminate important information to adult consumers and parent/caregivers across the State.****Strategy #2:** Support the role of Certified Recovery Support Specialists and their deployment statewide by hosting webinars for 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.**Strategy #3:** Enhance competency and encourage WRAPtrained and certified facilitators to provide an increasing number of WRAP® classes in the State.**Strategy #4:** In FY2016 and FY2017, continue to advance Family Driven Care in Illinois by certification of parent providers as Family Partner Professionals. |
| 6. Annual Performance Indicators to measure goal success: Indicator #1: **Number of statewide teleconferences held each year.** |
| a) Baseline measurement (Initial data collected prior to and during SFY 2015): **20** |
| b) First-year target/outcome measurement (Progress to end of SFY 2016): **21** |
| c) Second-year target/outcome measurement (Final to end of SFY 2017): **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 |
| **7. Report of Progress toward goal attainment** **Second year target: X Achieved \_\_\_\_\_\_Not Achieved (If not achieved, explain why)** |

***This strategy was successfully achieved in FY2017 and will continue for adult consumers in FY2018. Ten teleconferences were conducted in FY2017 with an aggregate attendance, for nine out of the ten, of 3,854. The dates, topics, and number of participants of each teleconference are detailed in the table below. In FY2016, ten teleconferences were conducted for an audience of adult consumers with an aggregate attendance of 5,211 (duplicated) reflecting a 6.5% increase in participation over FY2015 when it was 4889 .***

**Adult Consumer Education Teleconferences in FY2017**

|  |  |  |
| --- | --- | --- |
| **Date of Call** | **Topic** | **Number****of Participants** |
| July 28, 2016 | Exploring the Possibilities of Steering Our Thoughts in the Right Direction | 460 |
| August 25, 2016 | Exploring the Possibilities of Stretching Our Money | 443 |
| September 22, 2016 | Possibilities through Creative Expression | 507 |
| October 27, 2016 | Exploring the Possibilities in Our Communities | 462 |
| January 26, 2017 | Enrich Your Life through Work and All That! | Unknown |
| February 23, 2017  | Discover Your Strength To Heal! | 447 |
| March 23, 2017 | Spark Your Power of Knowledge and Creativity! | 298 |
| April 27, 2017 | Nurture Your Emotional Self! | 509 |
| May 25, 2017 | Create Comfort In Your Environment! | 338 |
| June 22, 2017 | Spirituality, Community & You! | 390 |

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 provided a forum for discussion of information about a range of services and approaches that have 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.

**Plan Table 1.5-2 Certified Recovery Support Specialists**

|  |  |
| --- | --- |
| 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:  |
| 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.* |
| 5. Strategies to attain the goal: **Strategy #1:** Conduct a series of statewide teleconferences designed to disseminate important information to adult consumers and parent/caregivers across the State.**Strategy #2: Support the role of Certified Recovery Support Specialists and their deployment statewide by hosting webinars for 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.****Strategy #3:** Enhance competency and encourage WRAPtrained and certified facilitators to provide an increasing number of WRAP® classes in the State.**Strategy #4:** In FY2016 and FY2017, continue to advance Family Driven Care in Illinois by certification of parent providers as Family Partner Professionals. |
| 6. Annual Performance Indicators to measure goal success: Indicator #2: **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 2015:  |
| b) First-year target/outcome measurement (Progress to end of SFY 2016): **15** |
| c) Second-year target/outcome measurement (Final to end of SFY 2017):  **15** |
| d) Data source: Document each training event and aggregate by year for comparison across years. |
| e) Description of data: Agenda for each training event held |
| f) Data issues/caveats that affect outcome measures: |
| **7. Report of Progress toward goal attainment** **Second year target: \_X\_\_ Achieved \_\_\_\_\_\_Not Achieved (If not achieved, explain why)** |

***This objective was substantively accomplished early in FY2017. Six competency training events based on a two day curriculum were held at three locations in the State with a total of 520 participants. Additionally, three CRSS Ethics Workshops were held at the same locations in August, 2016 with 260 registered participants. (See Table Below for detailed information)***

**CRSS Training Events in FY2016-2017**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Location** | **Number of** **Attendees** | **Competency Event** |
| June 14, 2016 | Mt. Vernon | 35 | Day One |
| June 21, 2016 | Springfield | 75 | Day One |
| June 28, 2016 | Chicago | 150 | Day One |
| **Total Day One** |  | **260** |  |
|  |  |  |  |
| July 12, 2016 | Mt. Vernon | 35 | Day Two |
| July 19, 2016 | Springfield | 75 | Day Two |
| July 26, 2016 | Chicago | 150 | Day Two |
| **Total Day Two** |  | **260** |  |
|  |  |  |  |
| August 16, 2016 | Mt. Vernon | 35 | Day Three: Ethics |
| August 23, 2016 | Springfield | 75 | Day Three: Ethics |
| August 30, 2016 | Chicago | 150 | Day Three: Ethics |
| **Total CRSS Ethics** |  | **260** |  |

***As of June 2017, 208 individuals with CRSS certification were active in the State, and all were in good standing with the Illinois Certification Board (ICB***). ***An additional six individuals have chosen to be placed on inactive status.*** ***This reflects a 23.7% increase in the number of CRSS certified individuals since July, 2015 when 173 individuals with CRSS certification were active in the State and a 41% increase since July 2014, when 152 individuals with CRSS certification were active in the State.***

**Background:**

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 have the ability to 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 doubled since October, 2013. The aim of DMH is to steadily increase the number of agencies that hire CRSS professionals.

 **Plan Table 1.5-3 WRAP**

|  |  |
| --- | --- |
| 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:  |
| 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.* |
| 5. Strategies to attain the goal: **Strategy #1:** Conduct a series of statewide teleconferences designed to disseminate important information to adult consumers and parent/caregivers across the State.**Strategy #2:** Support the role of Certified Recovery Support Specialists and their deployment statewide by hosting webinars for 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.**Strategy #3: Enhance competency and encourage WRAP trained and certified facilitators to provide an increasing number of WRAP® classes in the State.****Strategy #4:** In FY2016 and FY2017, continue to advance Family Driven Care in Illinois by certification of parent providers as Family Partner Professionals. |
| 6. Annual Performance Indicators to measure goal success: Indicator #3:1. **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 2015: N/A |
| b) First-year target/outcome measurement (Progress to end of SFY 2016):  |
| c) Second-year target/outcome measurement (Final to end of SFY 2017): 15 |
| d) Data source: Training Agendas and attendance sheets documenting participation.  |
| e) Description of data: WRAP Refresher training agendas for each event; Attendance Sheet  |
| f) Data issues/caveats that affect outcome measures: None |
| **7. Report of Progress toward goal attainment** **Second year target: \_X\_\_ Achieved \_\_\_\_\_\_Not Achieved (If not achieved, explain why)** |

***As of June 2017, 419 individuals have been trained and certified as WRAP Facilitators in Illinois. Of those, 174 (42%) are actively participating in Refresher Training.***

***WRAP Refresher Training was successfully accomplished in FY2017. Fifteen refresher courses were conducted at 6 sites in the State. The total number of participants was 373, an 8% increase over the number of participants in FY2016. Detail is provided in the tables below.***

|  |  |  |
| --- | --- | --- |
| **Dates in FY2017** | **Location** | **Avg. Attendance** |
| 3/16, 6/15, 9/14, 12/14 | Chicago | 20 |
| 3/10, 6/9, 9/8,12/8 | Elgin | 20 |
| 3/30, 6/6, 8/31 | Springfield, Pekin | 30 |
| 1/11, 6/27,8/30,11/14 | Belleville, Mt. Vernon | 15 |
| **15 Refresher Classes** | **6 Sites** |  |

|  |  |  |
| --- | --- | --- |
| **Fiscal Year** | **Refreshers Offered** | **Total Number** **of Participants** |
| FY2016 | 12 | 345 |
| FY2017 | 15 | 373 |

**WRAP (New strategy in FY2016):**

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, the majority of 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.

**Plan Table 1.5-4 Certified Family Partnership Professional**

|  |  |
| --- | --- |
| 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:  |
| 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.* |
| 5. Strategies to attain the goal: **Strategy #1:** Conduct a series of statewide teleconferences designed to disseminate important information to adult consumers and parent/caregivers across the State.**Strategy #2:** Support the role of Certified Recovery Support Specialists and their deployment statewide by hosting webinars for 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.**Strategy #3:** Enhance competency and encourage WRAPtrained and certified facilitators to provide an increasing number of WRAP® classes in the State.**Strategy #4: In FY2016 and FY2017, continue to advance Family Driven Care in Illinois by certification of parent providers as Family Partner Professionals.** |
| 6. Annual Performance Indicators to measure goal success: Indicator #4: **The number of individuals who are credentialed as CFPPs by the end of each fiscal year.** |
| a) Baseline measurement (Initial data collected prior to and during SFY 2015):  |
| b) First-year target/outcome measurement (Progress to end of SFY 2016): **18** |
| c) Second-year target/outcome measurement (Final to end of SFY 2017):  |
| d) Data source: The number of parents certified as Family Partner Professionals will be aggregated across the year for comparison with data collected for subsequent years. |
| e) Description of data: Reports showing the number of parents certified as FPPs |
| f) Data issues/caveats that affect outcome measures: None |
| **7. Report of Progress toward goal attainment** **Second year target: \_\_\_ Achieved \_\_\_X\_\_\_ Not Achieved (If not achieved, explain why)**At the end of FY2016, the Illinois Certification Board (ICB) reported 18 CFPPs in good standing in the State, just two individuals short of the targeted 20. Funding for the oversight staff was discontinued in June, 2016. As a result, education and training toward applying for the credential has ended and the certification of parents with lived experience as Family Partner Professionals is no longer being tracked. |

***This strategy was substantively addressed in FY2015 and continued in FY2016. The CFPP credential continues to exist in FY2017. The Illinois Certification Board (ICB) has previously reported 18 CFPPs in good standing in the State. However, during FY2016 it was decided that family voice should reside at the local/regional level and be tied directly to a Statewide Family Run Organization and funding for the Family Consumer Specialists was discontinued in June, 2016. As a result, education and training toward applying for the credential has ended and the certification of parents with lived experience as Family Partner Professionals is no longer being tracked. The Division of Mental Health is currently working closely with Youth and Family Peer Support Alliance (YFPSA) in planning and providing the family voice statewide. As a result of this paradigm shift, parents with lived experience who could support families of children and youth with SED in Illinois are being encouraged to seek national certification to be a Certified Parent Support Provider (CPSP) which is provided through the National Federation of Families for Children’s Mental Health. The CPSP credential has been in existence since 2012 and is universally recognized.***

**The Division of Mental Health continues to collaborate with the Youth and Family Peer Support Alliance, the Illinois Statewide Family Run Organization, on the advancement of Family Driven Care in Illinois.  During FY2017 work was done on the development of a state-wide youth network with the aims of (a) expanding the platform for youth sharing their perspectives on mental health and the services they receive, and (b) on expanding the platform for caregivers to share their perspectives on mental health and the services their youth receive.  The objective is to build a dynamic/active community of support for families of children and youth with serious mental health challenges to engage in the development of community and state policies, practices, and programs that meet their mental health needs.**

***Youth Network Activities***

**1. Work to develop training, coaching, and technical assistance opportunities to support the positive growth and development of individuals who have lived experience in various child-serving systems**

**2. Enhance the organizational purpose of a statewide youth movement, ensure authentic youth representation at all levels of the project and in the development and writing of the comprehensive strategic plans now in development in Illinois.**

**3. Establish a strong youth and family partnership/connection to support and be involved in expansion of the SOC approach**

**4.      Coordinate and support the organization of self-sufficient youth networks in each region of the state of Illinois;**

**5.      Provide support and technical assistance to the State of Illinois as it develops its family run approach and larger Systems of Care infrastructure and seeks assistance with convening stakeholders, family and youth voice and peer support.**

***Family/Caregiver Activities***

**1. Provide support, training and technical assistance to grassroots family/youth organizations throughout the state, on an as-needed basis, focused on collaboration and infrastructure development including: leadership, advocacy, best practices, and recovery programming**

**2.   Create, maintain and support an interactive website (i.e. online community) for youth, families, youth advocates, parent peer supporters and stakeholders to obtain resources, educational information and support**

The Certified Family Partnership Professional (CFPP) credential certifies a minimum-level of competency for parents providing peer support to other families of a child with an emotional/behavioral disorder. CFPPs were trained to incorporate their unique life experiences gained through parenting a child with emotional and/or behavioral challenges that required them to personally access resources, services, and supports from multiple child-serving systems to achieve their family goals.

**Table 1.6 Statewide System of Care**

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| 1. Priority Area: **Lead in the development and implementation of a statewide, unified, state –of –the-art System of Care 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, Other:  |
| 4. Goal of the priority area: ***Create a State of the Art Behavioral Health System in Illinois that ensures the highest level of fidelity and service delivery based on Systems of Care Values and Principles, family driven, and emphasizes services that are evidence-based.*** |
| 5. Strategies to attain the goal: (1) Establish and maintain a System of Care Technical Assistance Center for Illinois (STACI). (2) Focus on developing and providing training relative to SOC principles, High Fidelity Wraparound, care coordination, evidence based practices, promising approaches and frameworks, family and youth leadership as well as other topics that support the expansion of the SOC framework statewide. (3) Focus on the development of the SOC Social Marketing Campaign designed to develop educational materials and the forums necessary to inform the statewide service infrastructure and the public about SOC such as an annual SOC conference, SOC education and awareness plans, and ensuring that cross-agency committees and initiatives have the necessary supports to incorporate SOC values and principles into their planning processes. |
| **6. Annual Performance Indicators to measure goal success:** **Indicator #1: A Systems of Care Technical Assistance Center for Illinois (STACI), dedicated to ongoing development and implementation of Systems of Care values and coordination of statewide planning, preparation, and education surrounding Systems of Care, is established and operational as evidenced by the number of FTE staff actively employed and the number of technical assistance events during the fiscal year.**  |
| 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 2016): TBD |
| c) Second-year target/outcome measurement (Final to end of SFY 2017): TBD |
| d) Data source: Organization and budget documents; calendar of events-dates, times, and attendance.  |
| e) Description of data: Number of staff hired and training/TA agendas for events held. |
| f) Data issues/caveats that affect outcome measures: Ability to hire staff in a timely way. |
| **7. Report of Progress toward goal attainment** **Second year target: \_\_\_ Achieved \_\_\_X\_ Not Achieved (If not achieved, explain why)****A Systems of Care Technical Assistance Center for Illinois (STACI) was established in FY2016 by an Inter-government Agreement but is still in the planning and developmental stage. It is not operational and staff positions have not been filled. State funding in support of STACI was not available due to the budget impasse. Currently, progress in actualizing STACI is tied directly to extensive reform planning efforts that are occurring in Illinois, including the roll-out of the Health and Human Service Transformation, Governor’s Children’s Cabinet, and the EPSDT lawsuit settlement. These initiatives, especially the settlement of lawsuit will be impacting the development of a new service array and assessment process for children, adolescents and their families.** |

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| **Indicator #2 (FY2017): a. A Director of Training is hired****b. The number of training events held in FY2016 and FY2017 relative to SOC principles, High Fidelity Wraparound, care coordination, evidence based practices, promising approaches and frameworks, family and youth leadership as well as other topics that support the expansion of the SOC framework statewide** |
| 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 2016): TBD |
| c) Second-year target/outcome measurement (Final to end of SFY 2017): TBD |
| d) Data source: Director of Personnel; Documentation to support training, e.g. agendas  |
| e) Description of data: Number of events on Training Calendar and attendance |
| f) Data issues/caveats that affect outcome measures: Ability to hire staff in a timely way. |
| **7. Report of Progress toward goal attainment** **Second year target: \_\_\_ Achieved \_\_X\_\_\_ Not Achieved (If not achieved, explain why)****Employment of Director of Training continues to be on hold pending the outcome of EPSDT Litigation and the statewide reform of child and adolescent services.**  |

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| **Indicator #3 (FY2017) a. A Director of Communication is hired.****b. The number of meetings convened by this office in FY2016 and FY2017 dedicated to the development of a SOC Social Marketing Campaign designed to develop educational materials and forums necessary to inform the statewide service infrastructure and the public about SOC, an annual SOC conference, SOC education and awareness plans, and ensuring that cross-agency committees and initiatives have the necessary supports to incorporate SOC values and principles into their planning processes.**  |
| 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 2016): N/A |
| c) Second-year target/outcome measurement (Final to end of SFY 2017): TBD |
| d) Data source: Director of Personnel; Educational material developed |
| e) Description of data: Staff hired and working; Material developed |
| f) Data issues/caveats that affect outcome measures: Ability to hire staff in a timely way. |
| **7. Report of Progress toward goal attainment** **Second year target: \_\_\_ Achieved \_\_X\_\_\_ Not Achieved (If not achieved, explain why)****As with the indicators above, current circumstances preempt a communication office that would carry out the activities listed in the indicator. This remains an outcome that has yet to be achieved. However, the functions of the position are being addressed in other venues such as the successful social marketing for Children’s Mental Health Awareness by the IUY Facilitation Team in the State. See Background section below.** |

***In FY2017 there has continued to be substantial progress towards realizing the development and implementation of a statewide, unified, state –of –the-art System of Care to promote optimal social and emotional development for all children, adolescents, and young adults with behavioral health needs.***

***Due to the extensive reform efforts that were initiated in FY2016-FY2017 in Illinois, the progress of STACI is tied directly to the roll-out of the Health and Human Service Transformation Initiative, Governor’s Children’s Cabinet, and the EPSDT Litigation settlement, all of which will impact the development of a new service array and assessment process. Throughout all of these change efforts the Division of Mental Health (DMH) has taken a leadership role to ensure Systems of Care values and principles are the foundation for the strategic planning and implementation process. DMH C&A Services is working strategically in Illinois to ensure that Systems of Care values and principles are the foundation for the strategic planning and implementation process. Members of the SOC facilitation team continue to collaborate on the development of the STACI in Illinois.***

***The delay in the litigation, waiver approval, and state plan amendments has impacted the ability of DMH to implement the milestone achievements planned in the System of Care Grant. In addition Illinois went from July 1, 2015 until July 2017 without a state budget. The lack of a state budget has also considerably hampered implementation efforts.***

**Background: Accomplishments in FY2016-2017:**

Fiscal Years 2016 and 2017 were difficult years in Illinois to try to implement new initiatives as the state went the entire fiscal year without a budget, and entered FY2017 without a proposed budget. At the end of FY2016 an interim six month budget was passed which paid community providers for six months of services. Despite the absence of a state budget, DMH, in partnership with other child-serving state agencies, has continued to accomplish tasks and move the message of System of Care forward.

On February 18, 2016 Governor Bruce Rauner signed an Executive Order creating the Governor’s Cabinet on Children and Youth (aka Children’s Cabinet). This Cabinet was charged with the creation of a strategic vision for education, health, and human services to reduce the fragmented system that currently exists, while working to effectively identify and address any barriers to agency collaboration. This Cabinet provides funding and policy recommendations while promoting awareness of important issues facing children, adolescents and their families.

Illinois has been engaged in Health and Human Services Transformation that is designed to place a unique focus on prevention and public health; on paying for value and outcomes rather than volume; developing services that are evidence-based and data-driven; and moving the individual from institutional care to community care. This Transformation process is designed to develop a primer Health and Human Service System in Illinois which functions across the life span. Many members of the facilitation team are involved in the process and have been working to ensure systems of care values and principles are embedded into the work. To support this transformation, the Department of Healthcare and Family Services collaborating with 11 other state agencies developed an 1115 Medicaid demonstration waiver that was released for public comment on August 26, 2016. The 1115 Medicaid demonstration waiver was successfully submitted and Illinois continues to wait for information regarding its approval. The submission of this waiver resulted in State Plan Amendments that we are also waiting for approval on.

Throughout FY2016, a core team of individuals representing the Departments of Children and Family Services, Healthcare and Family Services, and Human Services, worked collaboratively with John Lyons on the development of a Universal Assessment to be implemented in Illinois and utilized with all publicly funded children and adolescents regardless of payee. The initial roll-out included training with four “early adopter sites” that agreed to work with the State Departments on resolving the initial training and implementation glitches before the statewide training plan will be implemented. This Universal Assessment is titled the IM-CANS (Illinois Medicaid Child and Adolescent Needs and Strengths Assessment) and will replace the mental health assessment completed as part of Illinois Medicaid Rule 132. The tool includes a physical health risk assessment so that physical health and mental health can both be addressed.

In April 2016, the six child serving systems in Illinois signed an Intergovernmental Agreement to address the mental health needs of Children and Adolescents that are at risk for psychiatric lock-out. This action is in support of Public Act 098-0808, and consistent with the unique population of focus that Illinois identified in our Systems of Care Expansion Implementation Cooperative Agreement. Two work groups were convened to meet the requirements under this Act. The first consists of content experts from the six child serving state agencies to put together the program plan and the second is a group of lawyers also representing the six child serving systems who are ensuring that the program plan is in line with current rules, so that any necessary changes can be initiated immediately. Their first accomplishment was to develop the Specialized Family Support Program Consent that allows the family to sign a single consent to share information across the Departments. This “Universal Consent” is the first of its kind in Illinois and meets not only HIPPPA, but also FERPA and the Illinois Mental Health Confidentiality requirements. To date, the program group has experienced many accomplishments including the identification of the population of focus and the “front door” for entering the program. The draft program plan is reaching its final stage and will shortly be ready for approval of the Department Directors.

On April 3, 2017 pursuant to PA 98-0808 the Custody Relinquishment Prevention Act, the six child serving systems in Illinois began accepting referrals into the Specialized Family Support Program. This program is designed to deflect eligible youth from entering DCFS care solely to obtain behavioral health treatment; provides crisis stabilization services to children at risk of custody relinquishment and their families; determines the most appropriate treatment services for the eligible population through a comprehensive, standardized assessment process; and links eligible youth and their families to services at the right intensity and level of care in a timely manner. Since the beginning of the program, there has been 44 children and adolescents referred to the program. The average age of referred youth is 15, and no children under the age of 10 have been referred.

This year (FY2017) the IUY Facilitation team took a proactive role in social marketing for Children’s Mental Health Awareness, in the absence of a Director of Communication. There were many events that occurred across the State. The activities included a 2 day conference on “Empowering Families in Illinois”; a dinner dance, release of balloons, walk around the block, the screening of “Resilience” by filmmaker James Redford followed by a round table discussion facilitated by Dr. Colleen Cicchetti of Lurie Children’s hospital and included the Director of Mental Health, Diana Knaebe, Pastor Chris Harris, Noah Baker, a youth with lived experience, and James Redford. Throughout the state, Private Psychiatric Hospitals that serve the child and adolescent population showed their support in various ways to help eradicate the stigma of children’s mental health. Information was disseminated in the form of posters, flyers, and brochures that were displayed in public areas of the hospitals such as the cafeteria, elevators, clinic offices, waiting rooms and even a few community mental health centers got involved. With the many changes currently occurring in Illinois, and the reluctance to move forward with the development of STACI until after influencing decisions are made, supporting the social marketing campaign for Children’s Mental Health Awareness Day was a great success.

**Barriers to accomplishment in FY2017:** The delay in the litigation, waiver approval, and state plan amendments has impacted the ability of DMH to implement the System of Care Grant. In addition Illinois went from July 1, 2015 until July 2017 without a state budget. The lack of a state budget hampered our ability to implement the grant.

Illinois is a Managed Care state, for the past two years about 50% of the geographic state and about 60% of Medicaid eligible individuals have been covered by managed care. In the summer of 2017, HFS rebid the Managed Care contracts with the expectation that 100% of the state will be covered by Managed Care. In addition, one Managed Care company was chosen to cover the DCFS youth in care, so that population will also be covered by Managed Care. The DMH will be working collaboratively with our system partners to ensure that the Community Mental Health providers in the new Managed Care areas are prepared to contract with and become part of the Managed Care Company’s provider network.

The Illinois Children’s Healthcare Foundation (ICHF) has recently announced their Children’s Mental Health Initiative 2.0. This ten million dollar investment will begin with the funding community level collaborative to develop a formal implementation strategy, coordinated governance and a sustainable financial model over one year based on a System of Care philosophy. Once the communities have completed their plans, the ICHF will initiate phase two, where it will be determined which plans will receive financial support for an additional 6 years of implementation. The DMH will collaborate with these sites and ICHF to provide the necessary technical assistance and supports to expand the work to additional communities.

There are two local community SAMHSA Systems of Care grants in Illinois and the DMH will be working collaboratively with those sites and also the ICHF sites to develop learning collaboration, so the sites can learn from each other.

**The System of Care Planning Grants:** Initial steps in the implementation of a statewide System of Care (SOC) were successfully achieved in FY2015 when DMH was awarded the System of Care Expansion Implementation Cooperative Agreement that became effective as of October 1st 2014 and provided a total of $3,915,844 in federal funding over four years to implement a strategic plan that develops and establishes a statewide system of care approach.

The DMH C&A Office had been awarded a Substance Abuse Mental Health Services Administration (SAMHSA) Statewide SOC Expansion Planning Grant to bring agencies together to plan a statewide system of care approach. Illinois United for Youth (IUY) is the System of Care (SOC) planning initiative that resulted from the Grant. In February and March of 2014, IUY successfully completed an application for SAMHSA funding titled, “Implementation of Cooperative Agreements for Expansion of the Comprehensive Community Mental Health Services for Children and their Families Program (System of Care (SOC) Expansion Implementation Cooperative Agreements) grant. IUY formulated a comprehensive strategic plan to improve and expand the service delivery system for Illinois youth with a focus on community-based interventions that are fully rooted in the Systems of Care Philosophy. IUY is leveraging the commitment of youth, their families, the child-serving state Departments, a myriad of stakeholders, and the collective experience gained from SAMHSA-funded local Systems of Care to work towards the adoption and integration of Systems of Care Principles across the service delivery systems for youth. A set of multiple strategies was identified and submitted to SAMHSA as “Pathways: Illinois Strategic Plan for Children’s Mental Health” Pathways established a framework grounded in System of Care principles and practices while assuring the flexibility that allows funders and operating agencies to implement change in manageable increments. Successful implementation relies on applying strategic planning efforts to multiple locations within the State, each with varying degrees of need, resources, infrastructure, funding and other supports. A central feature of the IUY Pathways approach is the establishment and availability of training, technical support, and an infrastructure designed to inform stakeholders, persons in leadership positions, and the public about the benefits of the System of Care framework.

**Plan Table 1.7 Community Integration – Williams Consent Decree**

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| 1. Priority Area: **Advancement of Community Integration** | 2. Priority Type: MENTAL HEALTH SERVICES |
| 3. Population(s) SMI, SED, OTHER: SMI  |
| 4. Goal of the priority area: ***Complete the successful transition of individuals with diagnosed SMI who are residents of long term nursing homes, from this level of care to the less restrictive settings, ideally, independent living in the communities with appropriate and necessary support services.*** |
| 5. Strategies to attain the goal: By the end of FY 2017, through the provision of rental subsidies, implement the transition of residents from 24 designated nursing homes (statewide) categorized as IMDs to permanent supportive housing - , safe and affordable housing and support services in communities of preference in a manner consistent with the national standards for this evidence based supportive housing practice. |
| 6. Annual Performance Indicators to measure goal success: **Indicator: Number of consumers transitioning from long term institutional settings who access appropriate permanent supportive housing. (National Outcome Measure)** |
| a) Baseline measurement (Initial data collected prior to and during SFY 2015): 1,306 consumers (cumulative) will be transitioned by the end of SFY2015. Note: Accomplished |
| b) First-year target/outcome measurement (Progress to end of SFY 2016): 1,706 consumers/Class Members (cumulative) will be transitioned by the end of SFY2016. **Note: 1,676 actualized** |
| c) Second-year target/outcome measurement (Final to end of SFY 2017): Target: 400 consumers to be transitioned in FY2017. 2,106 consumers/Class Members (cumulative) will be transitioned by the end of SFY2017. **Note: projection increase of 400** |
| d) Data source: Individuals receiving permanent supported housing have not been required to be registered for mental health treatment services. Therefore, it was necessary to create a special database to track access to and receipt of permanent supportive housing.  |
| e) Description of data: The data for this indicator will be generated from permanent supportive housing applications of individuals in longer term institutional settings which are stored in the special database, as well as a special PSH outcomes database. |
| f) Data issues/caveats that affect outcome measures:  **The Consent Decree is now in its 6th year of operation and currently projected for a 7th year**. The outcome of this action may continue depending on negotiations between the parties and the court decision. |
| **7. Report of Progress toward goal attainment** **Second year target: \_\_X\_\_ Achieved \_\_\_\_Not Achieved (If not achieved, explain why)** |

***This strategy continued to be successfully accomplished in FY2017 with the transition of 380 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 95% attained.***

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

The *Williams* vs. Quinn Class Action lawsuit was filed in 2005 and settled in 2010. The suit targeted 4,500 residents of nursing facilities designated as Institutes for Mental Disease (IMD) defined as having more than 50% of their 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 its seventh year of the original five year settlement. Since implementation, 1,990 former residents of IMDs have been transitioned to the community. The majority were afforded an opportunity to move into affordable apartments (signed leases) made possible by the Permanent Supportive Housing model with a bridge subsidy and some were moved into other housing options appropriate to their needs. In SFY2016, the state invested $23 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. Final Spending for FY2017 was $36 million and included $26 million in grant funded services as well as $6.7 million for Medicaid services to Class Members. Additional Medicaid services were provided through the Managed Care Organizations. Administrative and operational expenditures totaled $3.3 million.

The FY2018 Governor’s Introduced Budget includes $44.7 million in General Revenue funds dedicated to expanding home and community based services and other transitional costs associated with the consent decree implementation. Expenditures through October, 2017, include $1.3 million for administrative and operational expenses as well as $10.6 million in grant funded services. In addition, $1.7 million has been expended for Medicaid services to Class Members. By the end of SFY2018 it is estimated that spending will total approximately $44.7 million.

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

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.

## Plan Table 1.8 Service Members, Veterans, and their Families (SMVF)

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| 1. Priority Area: **Coordination and facilitation of mental health services for Illinois Service Members, Veterans, and their Families (SMVF).** | 2. Priority Type: MENTAL HEALTH SERVICES |
| 3. Population(s) OTHERService members , Veterans, and their Families (SMVF) requiring mental health services:  |
| 4. Goal of the priority area: ***Collaborate with U. S. Department of Defense, Department of Veterans Affairs (DVA), Illinois Departments of Military Affairs and Veterans’ Affairs, and other state agencies and partners to improve access to community-based mental health services for SMVF.*** |
| 5. Strategies to attain the goal: a). Develop and maintain partnerships with the Federal 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.d). Educate and train community providers in military and veteran clinical cultural competence..  |
| 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 for SMVF.**  |
| a) Baseline measurement (Initial data collected prior to and during SFY 2015): **14** By the end of FY2015 the number of collaborative meetings attended by DMH representatives that have agendas aimed at completing the behavioral health inventory and coordination of existing services. |
| b) First-year target/outcome measurement (Progress to end of SFY 2016): **15 meetings (12 were targeted)**By the end of FY2016, the number of formal partnerships, IJF BHWG members, and 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 2017): **Target:** **12 were targeted. Actual in FY2017: 28 meetings** (**Included six working groups plus the IJF Board meeting at least quarterly (7x4=28) meetings.)**1. By the end of FY2017, the number of formal partnerships, IJF BHWG members, and 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. |
| **7. Report of Progress toward goal attainment** **Second Year Target: \_\_X\_\_ Achieved \_\_\_\_\_\_ Not Achieved (If not achieved, explain why)** |

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| **Indicator #2.****The number of Military and Veteran 101 Clinical Cultural Competency Workshops completed during the fiscal year and the number of participants each year.**  |
| 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 2016): **Four (4) Workshops completed. Target was a minimum of two.** |
| c) Second-year target/outcome measurement (Final to end of SFY 2017): **Due to funding and resource limitations of the Illinois Joining Forces Foundation, Military and Veteran 101 Workshops were not conducted in FY2017.**  |
| 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. |
| **7. Report of Progress toward goal attainment** **Second Year Target: \_\_ Achieved \_\_\_\_X\_\_ Not Achieved (If not achieved, explain why)** |

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| **Indicator #3: An Annual Report describing progress of: (1) Partnering with the U.S. Department of Veterans Affairs (DVA), the Illinois Departments of Veterans’ Affairs (IDVA), and Military Affairs (IDMA), and increasing the number of other agencies and organizations statewide to address a coordinated system of care. (2) Increasing and expanding the membership of the Illinois Joining Forces (IJF) Behavioral Health Working Group (BHWG). (3) Creating and maintaining a coordinated Crisis Service Intervention System that addresses SMVF needs.**  |
| 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 2016): By the end of FY2016, a report on the number of formal partnerships, IJF BHWG members, and collaborative meetings attended by DMH representatives that have agendas aimed at completing the behavioral health inventory and coordination of services and on the status of the system of care for SMVF individuals citing collaborative accomplishments during the fiscal year.  |
| c) Second-year target/outcome measurement (Final to end of SFY 2017): **A report on SFY 2017 is pending.**By the end of FY2017, a report on continued progress which documents increases in the number of formal partnerships, IJF BHWG membership, describes collaborative meetings attended by DMH representatives that have agendas aimed at completing the behavioral health inventory and coordination of existing services, and reports on improvements in the status of the system of care for SMVF individuals citing 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. |
| **7. Report of Progress toward goal attainment** **Second Year Target: \_\_X\_\_ Achieved \_\_\_\_\_\_ Not Achieved (If not achieved, explain why)** |

***Two of the three strategies were achieved and expectations were exceeded in one.***

***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. During FY2017, in coordination with collaboration partners an inventory of existing behavioral health system providers and services was developed and is being maintained. Work continued on evaluating the adequacy of the existing service network to ensure SMVF have access to needed services and facilitating a coordinated crisis service intervention system between the VA and community providers, with special emphasis on suicide prevention. Unfortunately, due to funding and resource limitations Community provider capacity to serve SMVF was NOT enhanced through Military and Veteran 101 Cultural Competency Training. No workshops were planned, organized and convened which constitutes a labor intensive major achievement for the collaborating agencies. A Veterans’ Care Management Referral System and a Veterans’ Warm Line are being created to help ensure veteran referrals are properly accommodated. Additionally, DMH worked to establish veteran contacts within each DMH regional office to facilitate coordination of SMVF services and continued relationships with the SAMHSA Service Members, Veterans, and their Families Technical Assistance Center and with SAMHSA SMVF Policy Academy and Implementation Academy alumnae.***

**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.

During FY2013, FY2014, and FY2015, DMH participated in planning and built relationships through the SAMHSA SMVF Technical Assistance Center and the SAMHSA SMVF Policy Academy. DMH participated with other Illinois SMVF service agencies in four policy academies, of which two were Implementation Academies, Workforce and Suicide Prevention, designed to evaluate and strengthen the state plan. Relationships continue with these national resources and with the SAMHSA SMVF Policy and Implementation Academy alumnae.

**Illinois Joining Forces**

DMH has 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.

The IJF is characterized by:

* A focus on collaboration, as well as streamlining of duplicative services through partnerships to better support veterans, service members, and their families.
* A network of organizations with improved capability awareness and intra-network referrals.
* Increased effectiveness of the many resources provided by veteran- and military-related organizations in Illinois through transparency and navigability.
* Production of practical, impactful policy recommendations to be included in the annual report of the Illinois Discharged Service Member Task Force.

Three key principles underline the IJF initiative:

(1) No Wrong Door for access;

(2) No Wrong Person for eligibility; (While VA has some delimiting criteria, the IJF initiative declines no one regardless of dishonorable discharge, length of service etc.) and,

(3) Universal assessment –Have you or your family member ever served in the Armed Forces?

IJF serves as the focal point for organizations across Illinois by employing an online referral network and collaboration tools. There are nine working groups in IJF including: healthcare, behavioral health, homelessness, disability benefits, legal, deployment support, education, and employment & training. The workgroups meet quarterly to stay aware of the ongoing work of participating organizations and to address targeted military and veterans’ issues. The IJF workgroups use the military and veteran expertise of their members to educate organizations that assist service members and veterans but do not have military/veteran-specific programs.

DMH continues to chair the Behavioral Health Workgroup, one of the nine working groups in the IJF initiative. The Behavioral Health Workgroup is:

* Facilitating a coordinated crisis service intervention system between the VA facilities and community providers through the use of emergency response teams across the State.
* Working to enhance community provider capacity to serve SMVF through planning and holding workshops in Military and Veteran 101 Cultural Competency Training.
* The workgroup has been responsible for education sessions that have trained well over 1500 providers across the State.

While this training was primarily in Behavioral Health, specialized events have included services for service members, veterans and families with behavioral health issues in the Justice System; events for general health providers; and events for providers from areas such as education and social services. Training content has included issues in military culture, the social/emotional issues faced by service members and their families facing deployment; the problems confronting returning service members seeking reintegration and return to normal civilian life; special interventions for families; the assessment and treatment of Post-Traumatic Stress Disorder (PTSD); and, Traumatic Brain Injury (TBI)

**Activity in FY2017**

Through October 2017, IJF referred a total of 328 clients for mental health crisis, and other appropriate support services. Of these referrals, 86% were either a veteran or services member, and 14% family member or other. [[4]](#footnote-4)

Of 366 requests for services, the call center fielded 38%, 30% originated through the IJF website and 32% through IJF partner relationships.

Website Users, Call Volume, Facebook Reach, and Twitter Impressions are all treading up. Further, all measurable trend lines since the inception of IJF are also on a continual upward trend.

Classes are offered to interested civilian providers including mental health care providers, interested civilian primary school educators, business organizations, etc. This educational approach has helped increase the collective capability of Illinois-based organizations to serve military and veteran communities. As a result of Illinois Joining Forces and the collaboration it enables, the entire “system of support” is becoming more navigable for service providers and for the service members, veterans, and families.

**Plan Table 1.9:**

|  |  |
| --- | --- |
| 1. Priority Area: **Advancement of the use of interactive communication technology.** | 2. Priority Type:MENTAL HEALTH SERVICES |
| 3. Population(s) SMI, SED, OTHER:  |
| 4. Goal of the priority area: ***Develop the infrastructure to advance the use of interactive communication technology for clinical work in areas of Illinois where critical behavioral health professional shortages exist.***  |
| 5. Strategies to attain the goal: Through FY2017, continue to track Tele-psychiatry services at rural sites in Illinois and, contingent upon funding opportunities, plan for further expansion of the program.  |
| 6. Annual Performance Indicators to measure goal success: **Indicator #1: Number of youth living in rural areas receiving services through Tele-psychiatry.** |
| a) Baseline measurement (Initial data collected prior to and during SFY 2015):  |
| b) First-year target/outcome measurement (Progress to end of SFY 2016):  |
| c) Second-year target/outcome measurement (Final to end of SFY 2017):  |
| d) Data source: The DMH contractor that maintains and services the system also tracks the number of Tele Psychiatry events, hours, and the number of individuals served. |
| e) Description of data: Aggregate data on the number of youth receiving Tele-psychiatry services in rural areas across each year for comparison with subsequent years of data. |
| f) Data issues/caveats that affect outcome measures: Continued funding |
| **7. Report of Progress toward goal attainment** **Second year target: \_\_\_\_\_ Achieved \_\_\_X\_\_\_Not Achieved (If not achieved, explain why)**This strategy continued to be fully addressed in FY2016 until funding for it was discontinued at the end of the fiscal year. This pilot project in rural Illinois was instrumental towards bringing about the changes and procedures needed for Tele psychiatry to become a Medicaid reimbursable service in Illinois .The contractor agency managing the pilot became increasingly efficient at submitting Medicaid claims. Given the fiscal limitations in FY2016 due to the absence of a state budget, and that payment for these services became available from another source, DMH decided to discontinue funding this project at the end of FY2016.  |

***This strategy continued to be fully addressed in FY2016 until funding for it was discontinued at the end of the fiscal year. However, this pilot project in rural Illinois was instrumental towards bringing about the changes and procedures needed for tele psychiatry to become a Medicaid reimbursable service in Illinois .The contractor agency managing the pilot became increasingly efficient at submitting Medicaid claims. Given the severe fiscal limitations in FY2016 due to the absence of a state budget, and the fact that payment for these services became available from another source, DMH decided to discontinue funding this project in FY2017.***

##### Background:

There is a well-documented shortage of child and adolescent psychiatrists in the United States. Up to 20% of children suffer a mental health condition. There are less than 300 Child and adolescent psychiatrists in Illinois with at least 90% concentrated in or around the Chicago metropolitan area leaving the rural areas with only 10% of certified child and adolescent psychiatrists to cover the great need of services in these communities. The DMH Tele-psychiatry Project provided psychiatric services to children and adolescents in the areas of the state where communities don’t have access to board certified child psychiatrists. The most common diagnoses of children served were: Bipolar Disorder, Attention-Deficit/Hyperactivity Disorder (ADHD), and Post-Traumatic Stress Disorder.

**Plan Table 1.10: FEP SET-ASIDE**

|  |  |
| --- | --- |
| 1. Priority Area: **FEP Set-Aside: Implementation of Specialized Programming and Evidence – Based Services for persons experiencing First Episode Psychosis.**  | 2. Priority Type:MENTAL HEALTH SERVICES |
| 3. Population(s) SMI, SED, OTHER:  |
| 4. Goal of the priority area: ***Develop the infrastructure to initiate and sustain evidence-based clinical programs for persons with FEP.*** |
| 5. Strategies to attain the goal: (a) By the end of FFY2016, introduce and establish outreach, engagement, treatment, and coordination of support services for persons having experienced an initial psychotic episode at 11 agencies in the State.(b) At each participating agency site, employ a staff person (at least 0.5 FTE) with the credentials and clinical expertise to initiate specialized services and to facilitate a team approach that draws from services existing in the agency which have been shown to be Evidence-based and successful in the treatment and support of persons encountering FEP. (c) Utilizing consultation and ongoing technical assistance from the Best Center, 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 have 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.
* Family and Individual Psychoeducation
* Counseling and Case Management
 |
| 6. Annual Performance Indicators to measure goal success: **Indicator #1: (a) Number of sites in the State with funded FEP Programs.** **(b) The total FEP set-aside expenditure by the State for the sites.** |
| 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 2016):  **11 Funded Sites** |
| c) Second-year target/outcome measurement (Final to end of SFY 2017): **11 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 FEP sites on an ongoing basis by statewide coordinators of the program using the Strengths Barriers and Outcomes Form (SBO) which documents the program strengths, the barriers encountered, and the outcomes in terms of number of referrals and number of clients enrolled at each participating site.  |
| e) Description of data: The SBO format lists all active sites in the State. Records of contracts and funding awards for each agency are maintained by the DMH Fiscal Office.  |
| f) Data issues/caveats that affect outcome measures:  |
| **7. Report of Progress toward goal attainment N/A****Second year target: \_\_\_X\_\_ Achieved \_\_\_\_\_\_Not Achieved (If not achieved, explain why)** |

|  |
| --- |
| **Indicator #2: Number of training events held each year to increase knowledge and clinical competence in the delivery of FEP services in community agencies statewide.** |
| 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 2016): **2 major consultative events**. **Additionally, the Roll-Out in first quarter of SFY2017 has included one 3-Day Training event and 56 consultative teleconferences between 9-18-16 and 11-28-16.** |
| c) Second-year target/outcome measurement (Final to end of SFY 2017): **Target:** **200** **Achieved: In addition to 3 full days of Initial Training, 307 documented technical assistance and consultation teleconferences occurred during the fiscal year beginning in July, 2016 through June 2017.**  |
| d) Data source: **Records of teleconference calls and attendance are maintained by statewide coordinators and BeST Center consultants.** |
| e) Description of data: See Above |
| f) Data issues/caveats that affect outcome measures:  |
| **7. Report of Progress toward goal attainment N/A****Second year target: \_\_\_X\_\_ Achieved \_\_\_\_\_\_Not Achieved (If not achieved, explain why)** |

|  |
| --- |
| **Indicator #3: Number of clients meeting criteria for FEP enrolled in team services statewide.**  |
| 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 2016): **N/A (Sites report 23 clients enrolled during the 1st Quarter of SFY2017.)**  |
| c) Second-year target/outcome measurement (Final to end of SFY 2017): **Target:** **60**  **Achieved: 123 (as of 11-28-2017)** |
| d) Data source: **Enrollment data from each participating site aggregated by statewide coordinator on SBO Form.** |
| **e) Description of data: Number of persons meeting eligibility criteria for FEP program enrolled at each site.** |
| f) Data issues/caveats that affect outcome measures:  |
| **7. Report of Progress toward goal attainment N/A****Second year target: \_\_\_X\_\_ Achieved \_\_\_\_\_\_Not Achieved (If not achieved, explain why)** |

***The goal and strategies listed above have been achieved and the targets have been significantly surpassed!***

***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. In agencies that provide supported employment services, IPS Specialists are also on the team. 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 this first year of operation, technical assistance, consultation, and formal trainings were both intensive and extensive. During the course of the fiscal year (July 2016 through June 2017), there were a total of 223 Technical Assistance and Consultative meetings between DMH, the BeST Center, and the 11 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. 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. This work has continued vigorously past the first quarter of FY2018 with 97 teleconference calls and two one-day training sessions in CBT-p, (one in Chicago and one in Springfield) during October, 2017.***

***As of 11/28/2017, after a full year of outreach to and active engagement of clients reporting an experience of a first episode of Psychosis, the 11 agencies reported having a cumulative enrollment of 123 clients who meet criteria for eligibility for these services. The participating mental health agencies and the number of referrals and of persons enrolled reported by each of them are described in the table below:***

|  |  |  |
| --- | --- | --- |
| **Agency** | **Number of****Referrals****As of 11/28/2017** | **Number of** **Clients Enrolled****As of 11/28/2017**  |
| Advocate Illinois Masonic Behavioral Health Services, Chicago | 36 | 13 |
| Bridgeway MHC,  | 17 | 4 |
| Centerstone  | 30 | 17 |
| Chestnut | 37 | 17 |
| Grand Prairie | 50 | 12 |
| Human Resources Development Institute | 33 | 13 |
| LifeLinks | 22 | 4 |
| Memorial Behavioral Health | 31 | 4 |
| Robert Young Mental Health Center | 28 | 7 |
| Trilogy | 99 | 14 |
| Thresholds | 114 | 18 |
| **TOTAL** | **497** | **123** |

***In addition to the 123 persons enrolled and receiving services as of November 28th , agencies reported enrolling and providing services to 56 individuals who have been discharged [[5]](#footnote-5)from their programs, bringing the total number served by FIRST IL in the first fifteen months of operation, to 179 persons.***

**Background:**

The DMH First Episode Program Planning Workgroup began meeting on a weekly basis in May, 2015 to discuss and finalize an approach to implement evidenced based early intervention for persons who present with First Episode Psychosis. DMH engaged the Best Practices in Schizophrenia Treatment (BeST) Center, Department of Psychiatry, at Northeast Ohio Medical University (NEOMED) to provide technical assistance and consultation to the DMH First Episode Program Planning Workgroup on program design considerations and the feasibility of implementing the model in a practical manner that could meet the needs of individuals with FEP and result in successful outcomes. The Workgroup also had two consultative conference calls with the Portland State University EASA Center for Excellence in Oregon.

An initial two day BeST Center consultation at the state and provider community levels was planned and subsequently held on September 29th and 30th, 2015 in Chicago. It included a day of technical assistance exclusively with Workgroup members, a half day with representatives of DMH contracted agencies which were selected based on criteria for probable success in carrying out initial programming for clients with First Episode Psychosis (FEP), and a half day for steps for continued planning and implementation. Key issues that were addressed in consultation sessions included: discussing and finalizing the diagnostic categories associated with FEP; reviewing the pros and cons of planning for the integrated use of IPS and ACT with a team approach for persons with FEP versus embedding individuals with expertise working with the FEP population on existing teams; sustainability, outreach and education, and site selection for implementation. DMH providers provided consultation with regard to how they could participate in the initiative, including agency resources and agency/staff strengths.

The Illinois vision has been based on FEP programs generally starting slowly because it takes time to identify and engage individuals who experience FEP in the treatment setting. Initially, most FEP programs do not require full-time staffing, and team members may have responsibilities in addition to the FEP program for a significant phase-up period. Pulling together diverse services that may be available in the community, but that are not able to be offered in an integrated way by a FEP treatment team is a very helpful and cost-effective way to start a FEP program. Agencies without a needed service may contract with other providers for specific treatment services and/or share personnel or other resources with other providers.

The actual roll-out of the FEP program in Illinois began in February 2016 when an Application for Funding was sent to agencies that attended the September consultation event as well as agencies selected by the FEP Planning Workgroup as having the most potential for success in organizing and providing FEP services. By May, eleven agencies had responded positively to the Application for Funding and had become listed sites. Final planning and decision-making for the roll-out was carried out in a 2-day consultation event with the BeST Center that included the eleven providers on June 7-8, 2016. In August, the two state coordinators of the program attended the BeST Center Site Observation/Training in Ohio. The BesT Center consultant team returned to Chicago at the end of August and provided FIRST Overview Training to all 11 agencies in Downtown Chicago on August 30, Family Psychoeducation Training (FPE) to all the agencies August 31, and Sept. 1st, all the providers were trained in Individual Resiliency Therapy (IRT), Supported Employment/ Education (SEE) and Case Management Training (CM). Prescriber- only training was provided by calls with the BeST Center psychiatrist on September 26 & 29, and Oct. 3 & 7, 2016. By the end of September, Weekly Team Meetings and Monthly Team Leader Calls had started. Client outreach began internally at the agencies first and some agencies initiated contacts with local colleges.

**Use of Set-Aside Funding**

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 FEP services. Each agency was required to designate or hire at least a 0.5FTE staff person with requisite clinical credentials to coordinate required service components for FTE 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 FEP 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 FEP clinical approaches most helpful to individuals with FEP.

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

Building upon the training, infrastructure, and service delivery established through the 2015 funding, the dollars from the Ten Percent Set-Aside in FY2016 have been used to promote:

* Expansion of FEP programming using the model described above to agencies in Region 5 (southernmost in Illinois) and increasing the number of agencies in the State that will have FEP programs.
* Providing additional funding to agencies to facilitate improved implementation of program components as needed.
* Providing for DMH staff persons to develop, monitor, coordinate, and provide technical assistance to agencies in carrying out FEP programming. In short to become the DMH expert for the provision of evidence-based services to individuals (and their families as appropriate) experiencing an FEP.
* Increasing agency participation in ongoing focused training in the FEP approach and in related evidence-based components as well as structuring technical assistance and consultation to meet emerging needs related to program development and service delivery such as 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 1/12th monthly payments for those expenses related to training and non-billable time.

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 FEP initiative.

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

* Working with participating providers to shift the treatment paradigm from agency services for persons with serious and continuous mental illness to the engagement of persons in acute distress and encountering mental illness for the first time in their lives.
* 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.
* Agencies in Illinois have had very little experience in conducting the outreach and engagement activities that are required in the FEP program. Adaptation and the development of skill in these areas take significant time and slow down the implementation process.
1. In April 2010, the Illinois Supreme Court named a Special Judicial Advisory Committee for Justice and Mental Health Planning. The committee was charged with determining how to maximize court and community resources to aid in the rehabilitation and treatment of alleged offenders with mental health and substance use issues. In December 2010, a multidisciplinary group of stakeholders were convened to oversee planning and program development, to discuss the purpose and feasibility of a Center of Excellence in Illinois. Together they determined the mission, structure, and purpose of the Illinois Center of Excellence for Behavioral Health and Justice. [↑](#footnote-ref-1)
2. [↑](#footnote-ref-2)
3. To examine rates of re-arrest, we examined the number of cases that were closed because of youth re-arrest and also examined whether Monthly Service Reports indicated re-arrest while participating in the program. Among youth with closing reports in FY 2014 and FY 2015, there were no youth with re-arrest as the reason for case closure. According to data from the Monthly Service Reports a relatively small proportion of youth were re-arrested while participating in MHJJ. Approximately 22% of youth who entered the MHJJ program in FY 2014 were re-arrested during their stay in the program. Re-arrest in FY 2015 was lower at 15%. In sum, the majority of youth who participate in MHJJ appear to be successfully diverted from re-arrest, at least while in the program. These findings speak positively of the program and may be related to the positive outcomes showing that youth’s mental health and overall functioning significantly improve while in MHJJ. These findings also provide support for the cost-effectiveness of the program, in that the State of Illinois is spending less money on arrests and legal processing of youth who complete the MHJJ program. Re-arrest data for FY2016 is not yet available. [↑](#footnote-ref-3)
4. The distribution of the referrals fairly matches the veteran distribution throughout Illinois.

Gender:

74% Male

26% Female

 The age distribution was:

=<25 8%

26-34 19%

35-44 16%

45-54 22%

55-64 22%

65+ 13%

The top 5 locations by Illinois County were:

Cook: 43%

Lake: 8%

DuPage: 7%

Will: 4%

Madison: 2%

McHenry: 2%

The Service Era of these clients ranged from Post 9/11:(40%), through Post Vietnam and Persian Gulf: 27%; Vietnam: 16%; to Korea: 22% WWII:1% and Other: 2% [↑](#footnote-ref-4)
5. Of the 56 individuals discharged after being served in FIRST IL, five individuals successfully completed treatment, 28 individuals refused to continue FEP services and dropped-out; 13 individuals moved out of the agency area, including two individuals who moved out of state; one individual transferred to another FEP site, and nine individuals were evaluated by the program’s prescriber after services had been initiated and were found not to meet criteria for FEP. [↑](#footnote-ref-5)