Illinois

UNIFORM APPLICATION
2009

STATE IMPLEMENTATION REPORT
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

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Center for Mental Health Services

Division of State and Community Systems Development

Introduction:

The CMHS Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

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INTRODUCTION

This report provides detailed information regarding the implementation of the Illinois DMH State Block Grant Plan for FY 2009. This first section of the Narrative for Adults summarizes Illinois' progress in addressing areas in need of improvement based upon the outcomes of the stated objectives in the FY 2009 Adult Services Plan. The following narrative description provides a statement of the level of attainment, information on how each objective was attained, and background information to provide context and purpose for each of the objectives. The objectives discussed in this section have been a crucial part of ongoing DMH planning and delivery of mental health service to adult consumers. The next Section provides a description of significant events that have impacted the mental health system in the past year. Information regarding specific allocation of block grant funds is provided in the last section of the Narrative.

CRITERION I:

FY 2009 BLOCK GRANT OBJECTIVES

ADULT PLAN – SECTION III-A

Criterion I:

Consumer Education and Support:

Objective A1.1: Continue enhancement of the statewide system to educate consumers of mental health services in leadership, personal responsibility and self-advocacy through participation in Consumer Conferences, the use of Wellness Recovery Action Plans (WRAP), and through the Consumer Education and Support Initiative.

Indicators:

- **Number of Regional consumer conferences held.**
- **Number of Certified WRAP Facilitators.**
- **Number of participants in the quarterly regional WRAP continuing education/refresher trainings conducted in FY2009.**

This continuing objective was actively and successfully accomplished in FY2009. The statewide system of consumer education was enhanced through participation in

six regional consumer conferences held across the state during FY2009. More than 2,000 consumers, family members, providers, DMH and other state agency staff attended these conferences. Since the inception of the Wellness Recovery Action Plan (WRAP) Initiative well over 200 individuals (including consumers currently receiving services) have received Certificates as WRAP Facilitators through their completion of a 40-hour intensive course. As of the end of October 2009 there are 238 Certified WRAP Facilitators in Illinois. Sixteen (16) quarterly WRAP Refresher/Continuing Education training events were conducted during FY2009, four in each DMH region (Region 3 and Region 4 were combined for this training). By the end of the year, 288 facilitators had participated in these events - an average of 18 facilitators attending each event.

Regional Consumer Conferences.

DMH Recovery Support Specialists work with stakeholders to design, plan and convene annual consumer conferences in each DMH region. These conferences often have a well-known and /or national speaker who delivers the keynote address and sets the tone in an aspect of recovery and resilience for the conference.

WRAP Initiative.

Under the leadership of the DMH Director of the Office of Recovery Support Services, the Wellness Recovery Action Plan (WRAP) model has been adopted by Illinois. A statewide WRAP steering committee meets on a monthly basis to plan and review progress on the WRAP initiative. Through the establishment of 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 emerging best practice in recovery-based services.

In FY2008, a statewide survey of all certified WRAP Facilitators was conducted. The purpose of the survey was to identify the percentage of trained facilitators who were facilitating WRAP classes, and the best means to support them. The findings of the survey were successfully utilized in addressing the stated needs of the facilitators through the ongoing development and delivery of continuing education/refresher courses.

Objective A1.2: In FY2009, the DMH Office of Recovery Support Services will conduct a series of conference calls designed to disseminate important information to consumers across the State.

Indicators:

- **Number of conference calls completed in FY2009.**
- **Number of participants in Consumer Education / Support teleconferences.**
- **Amount of Block Grant funds allocated for this purpose.**

This objective has been fully accomplished. In FY2009, nine pre-arranged statewide calls were held for consumers (see list of topics below), with an average of 438 participants per call. These calls provided a forum for discussion of service

information, performance data, new developments, and emerging issues to promote consumers' awareness and knowledge. The calls are facilitated by the Mental Health Collaborative For Access and Choice and funded through their contract. Block Grant funds were not allocated for this activity.

Consumer Education and Support.

Dissemination of accurate information regarding services for consumers is the primary focus of the Consumer Education and Support Initiative that began in FY2007 as an outgrowth of the DMH System Restructuring Initiative (SRI). 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 goal of this project is to ensure that consumers of mental health services receive current, accurate and balanced information regarding changes in the service delivery system, empowering them to take an active, participatory role in all aspects of service delivery.

The topics of the teleconferences in FY2009 were:
July: Transitioning Into Independent Living
August: The New Consumer & Family Handbook
September: Do You Want to Get a Job?
October: Shared Decision Making
January: Brainstorming Together
February: Systems Advocacy
April: Empower Yourself with Work
May: Empower Yourself with Your Housing
June: Empower Yourself with Your Rights

Recovery Training

Objective A1.3: In FY2009, continue to provide recovery-oriented training to all interested stakeholders and support the role of Certified Recovery Support Specialists (CRSS).
Indicator:

- **Number of recovery oriented training sessions provided to stakeholders.**
- **Number of individuals obtaining the CRSS credential.**

This objective has been fully accomplished. In FY2009, 37 recovery oriented training sessions were held for all interested stakeholders. As of June 2009, 173 individuals had achieved their CRSS certification and are in good standing with the Illinois Certification Board (ICB). In FY2009, the DHS/DMH worked together with the Mental Health Collaborative for Access and Choice to design a study guide for individuals seeking to obtain their certification. The CRSS study guide is being produced by the Collaborative and is expected to be available (print and online copies) by 11/30/09.

Recovery-oriented training

Audiences for these training sessions have included diverse stakeholder groups, educating consumers of mental health services, family members of consumers, mental health and addiction professionals, advocates, college students, occupational therapy professionals, and many others. Topics for these sessions have included the foundational principles of mental health recovery, Wellness Recovery Action Planning (WRAP), mentoring, advocacy, crisis planning, recovery support, spirituality, and others.

Certified Recovery Support Specialist (CRSS).
In collaboration with the Illinois Certification Board (ICB), the Divisions of Mental Health, Rehabilitation, and Alcoholism and Substance Abuse have developed the Illinois Model for Certified Recovery Support Specialist (CRSS). The CRSS, through collaboration with the ICB, is now competency-based rather than curriculum-based. Individuals are certified as having met specific predetermined criteria for essential competencies and skills. The purpose of certification is to assure that individuals who meet the criteria for CRSS provide quality services. The credentials granted through the certification process will: (1) be instrumental in helping guide employers in their selection of competent CRSS professionals, (2) define the unique role of CRSS professionals as health and human service providers and (3) provide CRSS professionals with validation of, and recognition for their skills and competencies. Access to this new credential became available through the ICB beginning in July of 2007.

As a means of disseminating information regarding this new credential, the DHS/DMH has developed a brochure entitled "Employing Persons with the CRSS Credential." Additionally, the ICB has provided staff presence at each of the regional consumer conferences, to distribute information and respond to questions. 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.

In FY2010, the Office of Recovery Support Services will continue to work with other system partners, including the ICB and the Mental Health Collaborative for Access and Choice (MHCAC), to develop training and study materials for those seeking to obtain their CRSS. Additional information regarding this cutting edge approach in credentialing for mental health peer specialists can be found at
http://www.iaodapca.org/forms/crss/CRSS_Model.pdf

Permanent Supportive Housing

Objective A1.4: By the end of FY2009, through the provision of rental subsidies, implement a statewide permanent supportive housing initiative which targets 150 consumers acquiring decent, safe, and affordable housing and support services in a manner consistent with the national standards for this evidence based practice.
Indicators:

- **Number of consumers who acquire appropriate permanent supportive housing through the DMH Bridge Subsidy Program in FY2009.**
- **Number of DMH selected Bridge Subsidy Administrators established and functioning in the state by the end of the fiscal year.**
- **Number of DMH-funded providers participating in the program.**
- **Amount of money expended for the program in FY2009.**

This objective has been successfully accomplished. The targeted number of consumers to be served was exceeded. At the conclusion of FY2009, DMH had approved over 275 eligible consumers through all rounds (in FY2009) of open access to this initiative. In this process, at the end of FY2009, 168 of these approved eligible consumers had been able to secure housing. DMH has established partnerships with seven (7) service providers for the provision of Subsidy Administration duties. These seven Subsidy Administrators currently cover the entire state of Illinois. The DMH Permanent Supportive Housing (PSH) Bridge Subsidy Initiative is open and available to all DMH service providers currently under IDHS/DMH contract. By the conclusion of the fiscal year, 100 agencies (approximately 60% of DMH contracted agencies) had actively applied to access this initiative on behalf of the consumers they represent. In FY2009 DMH utilized approximately $5 million of newly dedicated funding to new Permanent Supportive Housing expansion.

The Permanent Supportive Housing Initiative has continued to make noteworthy progress since the end of the state fiscal year (June 30,2009). As presented in the table below, 564 individuals have been approved since implementation of the program began. As of November 15, 2009, 290 individuals are residing in PSH housing units, and 274 are in the process of locating PSH housing. DMH is currently targeting a defined population of consumers, including: those in long term care facilities or at risk of being in a nursing facility, long-term patients in state hospitals, young adults aging out of the ICG/MI program or out of DCFS guardianship, residents of DMH funded supported or supervised residential settings, and those who are determined by DMH to be homeless. The number of individuals so far approved in each targeted category is provided below.

Individuals Approved and Eligible for PSH Housing By Priority Population Group (As of November 15, 2009)

Priority Group	Number Approved
Resident of DMH Funded Residential	224
Homeless Individuals	154
Resident of Long Term Care Facilities*	129
At Risk of Placement in Long Term Care	45
Discharge from State Hospital	6
Aging Out ICG Recipient	4
Aging out DCFS Ward	2
Total	**564**

*Included in the "Resident of long term care" category listed above, 50 persons are from the Money Follows the Person (MFP) initiative and 12 are from the Rapid Reintegration Project (RRP).

Background: Illinois has been consistent in its efforts to develop housing options and support services for consumers of mental health services. Community supports range from in-home help for families, to community integrated living arrangements where people share a home with services individually tailored to their needs, or independent apartments with support services. Supported and Supervised Residential programs offer skills training, counseling and other supports to assist consumers in maintaining a stable living arrangement. Since FY2005 the Illinois General Assembly has steadily increased the State's commitment to housing for persons with mental illnesses. In FY2009 the Illinois General Assembly added an additional $3.75 million to expand permanent supportive housing in Illinois for persons with special needs, bringing the total dollars allocated in five years to $18.25 million.

In FY2009 Illinois expanded resources in creating the DMH Permanent Supportive Housing (PSH) policy and model. The goal of this initiative is to promote and stabilize consumer recovery by providing decent, safe, and affordable housing opportunities linked with voluntary DMH-funded community support services. Permanent Supportive Housing (PSH) is a specific Evidence Based program model in which a consumer lives in a house, apartment or similar setting, alone or with others (upon mutual agreement – no more than two consumers within a common unit). The criteria for supportive housing include: housing choice, functional separation of housing from service provision, affordability, integration (with persons who do not have mental illness), and right to tenure, service choice, service individualization and service availability. Housing is integrated and affordable (consumers pay no more than 30 % of their income on rent). Ownership or lease documents are maintained in the name of the consumer, so tenant landlord relationships are maintained.

The Bridge Subsidy Initiative provides funding to subsidize rental costs for a targeted population of eligible consumers approved for PSH. Consumers will be required to commit up to 30% of their income for rent, in accordance with HUD standards. The Bridge Subsidy will pay the remaining rental cost. The Bridge Subsidy Initiative also includes one-time transitional funding to address move expenses. These Transition Assistance Funds pay for items such as application fees, security deposits, utility deposits, and household needs like furniture, small appliances and home making supplies.

DMH has been allocated funding from an Illinois Hospital Tax Initiative to provide PSH to a targeted estimated 600 consumers of mental health services over a three-year period. Additionally, DMH funds have been utilized for the development of a web-based housing stock database to identify available housing stock in Illinois. This real time web-based housing search website (Ilhousingsearch.org) became active as of 6/15/09 and is open to everyone in Illinois to search for housing opportunities.

Medication Algorithms

Objective A1.5: (a) Continue and increase training and implementation of medication algorithms as an evidence-based practice. (b): Continue and increase the training of State Operated Hospitals and affiliated Community Mental Health Centers.

Indicators:

- **Number of training sessions and agencies completing training at each level.**
- **Number of training sessions and number of State Operated Hospitals and affiliated Community Mental Health Centers who complete training at each level.**

This continuing objective has been accomplished in FY2009.

The program uses a three-stage training model:

Level 1-Education: Introduces and informs potentially interested service providers about the role of CIMA and how agencies can participate in the project.

Level 2-Planning: This second stage of engagement involves meetings with specific, interested agencies. An assessment is made to determine what changes are required to convert the agency's existing service delivery system to one that supports algorithm use.

Level 3-Training: The third step in training involves clinical training of agency personnel in the use of the algorithms, outcomes, educational materials, and documentation practices that support algorithm use.

Agencies engaging in CIMA, Community Mental Health Centers (CMHCs) and State Operated Hospitals (SOHs), have done so to varying degrees, with some completing all three levels of training and others opting out after the first or second levels. Of participating agencies, some have implemented all three algorithms while others have chosen fewer. In FY2009, 43 agencies were trained at Level 1, 24 agencies at Level 2, and 20 agencies were trained at Level 3. This represents a comparative increase over FY2008 when 37 agencies were trained at Level 1, 21 agencies at Level 2, and 18 agencies were trained at Level 3. The cumulative number of sessions trained is always slightly higher than the "Agencies Trained" metric in part because some agencies are trained in more than one algorithm and some "Training Levels" require more than one training session to accomplish. The cumulative numbers of trainings in FY2009 increased as well in all three levels. In FY2009 the numbers were: Level 1: 54 sessions; Level 2: 29 sessions; and Level 3: 25 sessions. (In FY2008 the number of sessions for each level were: Level 1: 45; Level 2: 26, and Level 3: 23).

A major focus of CIMA during this past fiscal year has been to engage CMHCs and SOHs, particularly those that would work together. Although most algorithmic treatment takes place in the CMHC setting, training hospitals affiliated with CMHCs helps optimize the continuity if inpatient care may be needed. Accordingly, CIMA has made specific efforts to identify and engage affiliated SOHs and CMHCs, when one or the other expresses interest in participating. To date, five of the seven eligible SOHs have received CIMA training in at least one algorithm, with three

receiving training in more than one. Of the CMHCs affiliated with three of the five trained state hospitals, seven have completed Level 3 training and one has completed Level 2. For the other two state hospitals, each has an affiliated CMHC that so far has completed Level 1 training. Several other CMHCs have been trained that are associated either with the two state hospitals that have yet to participate, or with community hospitals that have declined to participate.

In addition, there are two state hospitals with forensic programs that have received Level 3 training in the schizophrenia and depression algorithms. Because lengths of stay are typically much longer in forensic state hospitals relative to civil hospitals, the continuity of care issue is less pertinent. The two nonparticipating SOHs were approached again this past year. One indicated that it was not ready to participate. The other scheduled initial training, but then delayed it. In both cases changes in medical leadership, resource limitations, and high clinical workloads were cited as reason for delays. Accordingly, these hospitals will be revisited in FY2010 to engage their participation.

Background: The Center for the Implementation of Medication Algorithms (CIMA) is an initiative designed to disseminate empirically informed medication algorithms, patient and family education, and outcomes assessment systems that support the psychopharmacotherapeutic treatment of schizophrenia, major depression, and bipolar disorder, consistent with recommendations of the 2003 report of the President's New Freedom Commission on Mental Health. Since its inception in July 2004, CIMA has provided education, implementation planning, and clinical training to personnel in mental health treatment agencies across the State using the three-stage training model. Delivery of Level 1-Education takes multiple forms, including, for example, the dissemination of educational materials, meetings with leadership, or presentations to individuals, an agency or agencies, or several constituencies representing multiple agencies. Levels 2 and 3 are interventions that are aimed specifically to interested agencies. To facilitate its dissemination efforts, CIMA has developed a website that offers materials and other resources related to the algorithms trained. The Website address is: http://www2.uicomp.uic.edu/Dept/Psychiatry/CIMA/index.shtml). Professional personnel at CIMA provide consultation to agencies and agency providers ranging from systemic issues related to implementation to individual patient consultations. CIMA personnel also stay current with research in clinical psychopharmacology and outcomes assessment and update the algorithms as needed.

To engage non-participating agencies, several efforts were made this past year to do Level 1-Education with CMHCs, including meetings with individual leadership and presentations to single or multi-constituency groups. From these efforts, two major CMHCs completed Levels 1-3 training in the Depression algorithm during the year. A third, multi-site CMHC has completed Levels 1 and 2 training, expressed interest in completing Level 3 training in the schizophrenia algorithm, but has put that on hold citing cuts in funding. Other CMHCs opting not to participate at this time have cited the lack of a financial incentive for changing their current practice/documentation patterns to ones aligned with algorithm use as reason for delays. Accordingly, continued efforts to

engage CMHCs is an objective for the next fiscal year, again with coordinated efforts to create incentives. In FY2010 to date, there has been an increase in the number of agencies who cite "cuts in funding" as the primary reason for non-participation.

In the current fiscal year, CIMA is continuing its efforts to engage CMHCs and is attempting to address the incentive issue. CIMA has been working on proposals to motivate agency participation and on the development of a mechanism that allows reviewers from funding agencies to assess accurately and efficiently whether an agency is actually delivering algorithmic treatment. CIMA is also exploring avenues this year through which to offer Continuing Medical Education (CME) credit to physicians who participate, in support of their licensing requirements. The past few years have witnessed advances in pharmacotherapy research sufficient to warrant an evaluation of whether any of the algorithms trained through CIMA are eligible to be updated. Accordingly, this determination and any warranted updates are currently another objective of the project. Lastly, CIMA has begun the process of updating its website and plans to continue and complete the process this year. One of the aims of this update is to expand Non-English versions of the educational and other resource documentation offered on the site.

Evidence Based Supported Employment (EBSE)

Objective A1.6: Continue to expand the implementation of Evidence Based Supportive Employment.

Indicators:

- **Number of consumers receiving supported employment who are employed in competitive jobs in FY2009.**
- **Number of technical assistance sessions provided to the 13 pilot sites to increase fidelity to the SE model.**

This objective was excellently accomplished. Evidence Based Supported Employment has significantly expanded in the past year. The number of mental health agencies working to implement EBSE increased from 13 to 17. Twelve of these agencies have reached fidelity to standards of EBSE based upon the Individual Placement and Support (IPS) model. One agency provides the service at 8 sites and another at 2 sites. Thus, the total number of locations where fidelity EBSE services can be accessed is 20. Four additional locations were working to reach fidelity at the end of the fiscal year. In the last quarter of FY2009 1,144 consumers were receiving supported employment services. Of these, 320 were employed in competitive jobs. During FY2009, a total of 1,916 individuals received IPS services and 987 were competitively employed through EBSE programs. Individuals enrolled in IPS worked a total of 91,396 days in FY2009. (This number only includes persons who were open in the IPS programs and does not include days worked by people who transitioned off the caseload once they were successfully employed.) Most people work part time.

Extensive Technical Assistance was provided in the past year. Over 200 technical assistance sessions were conducted onsite, and one all-day IPS Leadership meeting

was held for all DRS and MH IPS Supervisors. Additionally, a total of 74 tele-conferences were conducted. These included employment specialists on job development issues (50); supervisors on their role (12), and IPS providers on various implementation issues, with recent emphasis on planning and implementing job retention supports (12). Assessments of fidelity were done for 25 sites.

The EBSE initiative reports the following important accomplishments in FY2009:

- Four new pilot sites were established after consensus was reached within the agencies to implement EBSE.
- An EBSE (IPS) Section to the DHS/Division of Rehabilitative Services (DRS) Procedure Manual was developed to better align DRS procedures with the evidence-based practice.
- The statewide EBSE steering committee, with large consumer and family member representation as well as a range of other stakeholders, continues to meet regularly once every two months.
- A technical assistance model for EBSE was developed and work is continuing on refining the model. Learning is ongoing in identifying technical assistance needs and strategies to guide mental health agencies and their local DRS offices on how to implement EBSE. Varying levels of technical assistance are being provided to the 17 agencies.
- One fourth of the members of the technical assistance/fidelity team are persons who have lived with the experience of serious mental illness.
- Illinois partnered with the Dartmouth Psychiatric Research Center to develop a Vocational Rehabilitation Fidelity Scale for EBSE in order to clarify the Vocational Rehabilitation role in implementing the model and increase accountability.
- Despite the poor economic conditions, outcomes have not had a major decline. However, programs have begun to reduce the number of employment specialist positions.

Illinois was awarded a Johnson & Johnson/Dartmouth Community Mental Health Program Grant to develop an IPS Family Project affiliated with NAMI-Illinois. Four local NAMI affiliates are educating membership about IPS, the role of employment in recovery, and how to access the Work Incentives Planning and Assistance Program (benefits planning). An Illinois Family Project Team which includes a Benefits Specialist has been established with the purpose of educating families of individuals with mental illnesses to advocate for, create, and expand high quality supported employment (IPS) programs that result in an increased number of people in sustained competitive employment.

The Illinois Family Project team has adopted the following goals to be implemented over the next two years:

1. Pilot a model of engaging families around IPS by building on existing educational forums.
2. Develop-train-the-trainer capacity that can be spread to other local NAMI chapters at Supported Employment locations.

3. Engage families in the development and support of a recovery vision that includes employment.
4. Expand knowledge and use of benefits counseling.
5. Expand NAMI supports (affordable housing, collaboration with employers, employment wardrobe, job seeking skills, mentoring and coaching, soft skills, support after employment)to families receiving services at local IPS sites.
6. Assess the model for adaptation to other family organizations and family populations not typically engaged in formally structured support organizations (e.g. immigrants, refugees).

At least three of the NAMI affiliates are now regularly including a section on the role of employment in recovery in Week 11 of their family-to-family courses. Illinois is the first state to receive permission from the developer of NAMI's Family-to-Family program to do this. There are at least two other states who are now looking into following Illinois' lead in doing this.

Background: Supported Employment is an evidence-based practice that has been shown to improve employment rates of persons with serious mental illness by as much as 60%. Two grants have assisted in implementing this model in Illinois: a NIH/SAMHSA Planning grant to address state infrastructure issues (which ended in September, 2007) and a Johnson & Johnson/Dartmouth Community Mental Health Program Grant to support implementation at four pilot sites ended in June 2009. The DMH and the DHS/Division of Rehabilitation Services (DRS) are actively collaborating to implement this evidence-based practice initiative.

Review of data from July 1, 2008 through June 30, 2009 (fidelity agencies only) has yielded the following statistics:

	Jul 1 – Sept 30, 2008	Oct 1– Dec 31, 2008	Jan 1 – March 31, 2009	Apr 1- June 30 2009
Number of agencies at fidelity	11	11	12	12
Number of locations at fidelity	18	19	20	20
Number of consumers receiving supported employment	1209	1218	1182	1144
Number employed in competitive jobs	322	343	328	320
Number of days persons enrolled in EBSE held competitive jobs	22,082	24,933	22,182	22,199
Number of hours worked per week by persons currently enrolled	7,396	8,533	7,363	7,526
Number of working people transitioned off the IPS Caseload	216	241	210	57
Number of new enrollees	239	239	258	210

In the first quarter of FY2010, there was a 15% decrease from the last quarter of FY2009 in the number of consumers receiving supported employment (to 970) and in the number of new enrollees (to 177) as a result of layoffs that occurred during the beginning of this fiscal year when the non-Medicaid funds were reduced in the agency contracts. However, the number employed in competitive jobs declined by only 6% (to 301) and the other indicators remained essentially at the same levels.

Assertive Community Treatment

Objective A1.7. Continue provision of Assertive Community Treatment that meets national fidelity model requirements.
Indicators:

- **Number of ACT teams meeting National fidelity standards by the end of FY 2009.**

This objective has been met. The provision of Assertive Community Treatment that meets national fidelity standards is continuing in Illinois. As of July 2009 all ten ACT teams in the state continue to meet the standards. More than 650 individuals received ACT services in FY2009.

During FY 2009, DMH provided additional technical assistance to agencies that elected to provide ACT services to help them in meeting the National ACT fidelity requirements. This has included statewide calls with ACT team leaders, as well as break out sessions focused on ACT during the annual Evidence Based Practices Conference held in May 2009. Technical assistance, including statewide calls, will continue in FY2010 as well.

Background: Illinois was an early adopter of the ACT model beginning implementation in 1992. ACT is the most intensive specialized model of case management in which a team of mental health professionals takes responsibility for a small group of program participants' day-to-day living and treatment needs. These individuals typically require assertive outreach and support to remain connected with the necessary mental health services to maintain their stability in the community. Often these consumers have a history of repeated admission to psychiatric inpatient or excessive use of emergency services. Previous efforts to provide linkage to necessary services have failed and the need for multiple services requires extensive coordination. The active participation of nurses, psychiatrists, and specialists trained in substance abuse is crucial to the success of the ACT model.

During FY 2007, the Illinois ACT model was modified as part of the State Medicaid Plan amendment to bring it into line with the National ACT Model and a plan was developed to monitor the fidelity of ACT services. Subsequently, several agencies determined that they did not have the capacity to deliver the evidence-based ACT model, and chose to adopt the step-down model of the Community Support Team (CST) instead. A description of CST is provided in the Available Services section of the 2010 Adult Plan.

Family Psychoeducation

Objective A1.8. Assess the planning and implementation capacity of DMH to assist providers to consistently implement Family Psychoeducation as an evidence-based practice.

Indicators

- **A report on the implementation efforts, status and capacity including progress toward the establishment of a specific billing code for Family Psychoeducation as an Evidence Based Practice in FY 2009**
- **Number of provider agencies in Region I taking significant steps to involve families of consumers and reduce existing barriers to family involvement by the end of FY 2009.**

This continuing objective was addressed in FY2009. Efforts in implementation by agencies have continued in one DMH Region. Assessment and planning for statewide implementation of Family Psycho-education is continuing. A report on implementation efforts was presented to the Clinical Systems Bureau in October 2009. A specific billing code for Family Psychoeducation has not yet been established although guidelines for such a code were submitted in the past. DMH is planning to review the possibilities for integration of Fee For Service structures for Evidence Based Practices in the near future.
Seven provider agencies in Region I have reported, through the vehicle of the Region One Implementation Group, that significant steps have been taken in their agencies to involve families of consumers and reduce existing barriers to family involvement. This is thought to be a conservative figure, based on the likelihood of similar efforts in other agencies that have been unable to send representatives to this meeting.

Background: DMH Region I Family Psychoeducation implementation efforts have continued. This committee has evolved into a public/private Family Psychoeducation (FP) implementation group, with active participation from state personnel, clinician, consumer, provider, and advocacy groups. The activities of this group have resulted in the formation of a number of family psychoeducation programs and have served to encourage change among those provider agencies whose treatment philosophies did not include the assumption that family participation (when desired by the consumer) can be enormously important. Currently, three agencies in the region are implementing varying models of family psychoeducation. Two agencies are formulating plans to deliver family psychoeducation services as close as possible to fidelity. Several other agencies have developed programs in conjunction with these implementation teams. All of them have reported it as a positive experience and have cited the benefits to consumers as a result of family involvement.

Staff members from community agencies, along with DMH Region I and DMH Central Office staff members, continue to meet and provide mutual consultation on clinical, financial, and implementation issues, and to report on progress in individual program

growth. Collaborative efforts to implement Family Psychoeducation in Illinois have resulted in an increased number of providers who have adjusted their treatment focus to extend services to more families when doing so would clearly benefit the consumer. Agencies that have been involved but have not yet implemented an EBP model of family psychoeducation have made decisions to become more family focused, and to try to rectify some of the barriers that have existed in mental health systems to involvement of families. Similarly, productive relationships between agencies and advocacy groups such as NAMI, who has long been a participant in this project, have emerged.

While the Illinois Medicaid Rule (132) now allows agencies to bill for family psychoeducation services in a variety of ways, a specific billing code allowing an enhanced rate has been discussed, but not as yet established. DMH's Bureau of Clinical Systems is currently involved in a project that has, as one of its goals, the development of structural, systemic changes designed to make the implementation of treatments based on scientific evidence an easier task at all levels of the public mental health system. It is not clear at this time if establishing separate billing codes for each of the EBPs will be a productive part of that structure but the Division is invested in identifying and examining the types of changes and systemic interventions that can encourage closure of the gap from science to service. DMH is committed to implementing evidence-based practices and is attempting to develop the resources for training, technical assistance, fidelity monitoring, and other essential ingredients to major implementation efforts. The work on Family Psychoeducation is continuing in the current fiscal year with special attention to reducing the perceived barriers to family involvement in agencies and increasing family participation in treatment.

DMH Public Awareness Campaign

Objective A1.9: Continue to advance the public awareness campaign to reduce negative portrayals associated with mental illnesses. Expand the focus to greater access to mental health services and the interaction of mental health, the experience of violence, and applicable prevention/intervention efforts.

Indicators:

- **Number of focus groups or expert panels conducted by contractor to obtain information to evaluate and expand the campaign.**
- **Materials developed for dissemination that address resource and access issues.**
- **Materials developed for dissemination addressing the interaction of mental health, mental illness, and violence.**
- **A report of the key achievements of the campaign and the significant public venues utilized to bring the message to all the citizens of Illinois.**

This objective was largely accomplished. The campaign has been targeted to a broad cross section of 'experts' or 'influencers' (providers) who are in a position to assist consumers and families. In FY2009, the campaign expanded the targeted "audiences of influencers" to: Employers, Clergy, Pediatricians, Educators, in addition to the broader 1st and 2nd year audiences of MH providers and the general

public. This expansion was largely based on the planning with focus groups and expert panels conducted by the contractor in FY2008 and follow-up meetings with DMH administrative staff focusing on implementation issues in FY2009. Advertisements, event promotions and printed materials were developed and distributed for each of these segments. Authentic 'first person stories' were solicited for each of the target audiences with photo, story and promotional materials developed for each for inclusion on all subsequent distribution, media, venues, or marketing. Information was provided about up-to-date treatment regimens; screening mechanisms for early identification of persons at risk of developing mental illnesses, and listings of available resources with instructions for making referrals to mental health service providers.

As part of the overall campaign and in order to review the effects of the campaign on the public, DMH developed a comprehensive outcome survey and engaged an independent vendor to complete the survey with a pool of Internet users. Initial survey data indicates that the campaign's strategy and messaging were effective in motivating changes in the knowledge and awareness about mental health issues and in the perceptions of persons with mental illnesses and their families. In addition, individuals who saw and heard the campaign's ads were more likely to express an intention to engage in behaviors consistent with the campaign's explicit calls to action. A report on the initial evaluation of this outcome survey which reflects the success of the campaign is currently being completed.

Background: The Report of the President's New Freedom Commission on Mental Health noted that the "stigma that surrounds mental illnesses is one of three major obstacles preventing Americans with mental illnesses from getting the excellent care that they deserve". One way in which to address this issue is to implement strategies geared toward reducing the stigma associated with mental illness. From FY2007 through FY2009, the Division of Mental Health allocated $200,000 every year to implement a public awareness campaign targeting adults. After extensive planning and deliberation, the "Say It Out Loud" Campaign was officially launched on May 1, 2008 at Navy Pier, one of Chicago's premier venues. The Launch ceremony was attended by over 400 persons and received broad media coverage. Similar events followed in Springfield, Illinois' capital, and other larger population centers in the State.

The DMH developed public service brochures, and T-shirts, buttons, and a variety of other items that carry the anti-stigma message and DMH phone and web contact information to access services. The Division has also distributed materials developed and supported by SAMHSA for the national "What a Difference a Friend Makes" anti-stigma campaign. DMH contracted with a public relations firm to assist in the ongoing development of the campaign, oversee public service announcements and utilize opportunities to distribute public awareness information at large public entertainment events and through mass media outlets. The Department of Human Services has also expanded exposure of the public awareness message by insuring that the materials are distributed at the conferences and other public activities that are sponsored by other DHS Divisions. Due to severe fiscal constraints in FY2010, funding for the Campaign will be

very limited. However, direct coordination by DMH staff and a Web-based approach will be utilized to maintain the Campaign through this fiscal year.

The Transformation Transfer Initiative:

Objective A1.10: Complete a statewide needs assessment and system mapping initiative for individuals with mental illness or co-occurring mental health and substance abuse disorders who are involved with the criminal justice system.
Indicators:

- **Number of cross-system planning meetings convened with key stakeholders at regional and state levels.**
- **A final statewide report and regional reports with recommendations for enhancement and transformation of the system of care to better serve consumers with a combination of mental health, substance abuse, and criminal justice issues is drafted and disseminated.**

This objective was successfully accomplished. A statewide needs assessment and system-mapping initiative for individuals with mental illness or co-occurring mental health and substance abuse disorders who are involved with the criminal justice system was successfully completed. Seven cross-system planning meetings were conducted from April through October 2008. A final statewide report was disseminated in Fall 2008.

The Division of Mental Health contracted with Policy Research Associates (PRA) of Delmar, NY, to provide technical assistance. PRA's technical assistance initiative entitled *ACTION: Transforming Systems and Services,* is meant to serve as a catalyst for change to improve mental health and criminal justice collaboration for justice-involved persons with co-occurring disorders and to help transform fragmented systems. ACTION uses the Sequential Intercept Model to map the local criminal justice system; it identifies local resources, assesses gaps in services, and helps communities develop priorities for change. The process in Illinois included planning telephone calls, an initial meeting of representatives from each of the five DMH regions to introduce the initiative (a one-day Kick-Off Meeting), strategic planning workshops (two days) in each of the regions, and a Wrap-Up meeting (one day) to relate PRA's findings and recommendations to the range of representatives from the State and the regions who participated in the process. In all, seven cross-system planning meetings were conducted from April through October, 2008. Results from the mapping and planning efforts included regional workshop summaries and an overall statewide report entitled, Strategic Planning Illinois: Mental Health Substance Abuse and Criminal Justice. Structured according to the Sequential Intercept Model of identifying points for service delivery, these reports provided information on the following areas: 1) Gaps in service delivery for justice involved individuals within the regions based on each intercept point, 2) Cross intercept gaps in service, 3) Quick fixes for problems in service delivery within regions/counties, 4) Analysis of where the Judiciary can impact positive change, and 5) Lists of issues that require state level

intervention or legislative change. Policy Research Associates completed an overall statewide report in Fall 2008.

Background: In FY2008 DMH was awarded a SAMHSA Transformation Transfer Initiative grant for $105,000. The grant funded a statewide mental health/criminal justice needs assessment and system mapping initiative to help inform the system transformation process in Illinois. The overriding goal of this initiative was to support the efforts of the Criminal Justice Transformation Workgroup led by DMH that was convened to recommend enhancements in the system of care for individuals with mental illness or co-occurring mental health and substance abuse disorders who are involved with the criminal justice system. The Kick-Off meeting, facilitated by the DMH Deputy Director of Forensic Services and consultants from Policy Research Associates (TAPA Center) was held with an advisory group of stakeholders from across Illinois in April of 2008. Noteworthy was the involvement of judiciary from across the state in the planning start-up. The regional strategic planning workshops attempted to convene a diversified group, representing all systems and especially Mental Health, Substance Abuse, Criminal Justice, Diversion programs, the Courts, Support Services (housing, peer support etc), and Consumers with mental illness and co-occurring disorders with lived experiences in the criminal justice system, their family members, and advocacy services. In each of the five DMH regions, information was provided about points within the criminal justice system where individuals might be intercepted with services and interventions as well as information about best practices and promising initiatives which address the needs of this group. PRA assisted each region to establish a set of priorities for change and to develop an initial action plan based upon the processes in each region for service delivery to support recovery, identification of gaps in service and barriers to service delivery, and information about local resources and opportunities for change. These regional planning meetings were completed in September 2008.

The statewide report disseminated by Policy Research Associates included the following list of conclusions and recommendations for Mental Health and Justice in Illinois:

- Expand Police Crisis Intervention Teams (CIT)
- Improve coordination with law enforcement and expand crisis stabilization bed capacity if needed.
- Expand Intercept 2 (initial detention/initial court hearings)diversion options and Data Link.
- Improve screening and basic jail mental health services.
- Improve the Unfit to Stand Trail (UST) and the Not Guilty by Reason of Insanity (NGRI) process to reduce jail waiting lists for hospital admission and develop outpatient capacity for examination and competency restoration.
- Improve jail transition planning.
- Improve prison discharge planning.
- Involve field parole staff with community mental health planning and improve parole coordination with mental health service providers.
- Consider multiple funding strategies.

- Continue to develop and expand integration of consumers with histories of justice system involvement into planning and service delivery activities.
- Continue to expand on innovative housing initiatives.
- Expand capacity for integrated dual disorder treatment services.
- Develop trauma-informed systems and implement trauma-specific services.
- The Mental Health and Justice Steering Committee should review the accumulating "legal disabilities" faced by consumers with mental illness.
- Continue to improve collaboration between the mental health systems, Veterans Administration, veterans groups and the criminal justice system.
- Develop a Coordinating Center of Excellence.

Recommendations to the Judiciary**:**

- Consider a broader range of diversion alternatives.
- Consider a survey of mental health training needs for the judiciary.
- Share current expertise.

Community Monitoring of Conditionally Released NGRI Consumers

Objective A1.11. Maintain the tracking system for persons adjudicated Not Guilty by Reason of Insanity (NGRI) who have been released to the community.
Indicator:

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

This objective was accomplished inFY2009. DMH Forensic Services has maintained the tracking system and ensured the provision of services for persons adjudicated as NGRI who have been conditionally released from DHS facilities to the community by court order. A total of 120 individuals adjudicated as NGRI were maintained in the community on Conditional Release (CR) status in FY2009.

During FY2009, 27 individuals received an initial placement on Conditional Release by jurisdictional courts and 19 individuals who had NGRI status were removed from the monitoring system due to changes in their legal status by the jurisdictional courts. As of the end of the fiscal year a total of 91 "active files" were maintained in this tracking system**.** Agency compliance with court reporting and service delivery requirements for this population was 98% for FY2009. This objective is continuing in FY2010.

Forensic Services is mandated by law to monitor the community-based treatment services and status of individuals who have been court-ordered into treatment due to a finding of Not Guilty by Reason of Insanity (NGRI). Beginning in FY2010 two tracking systems are being maintained for this group. One follows those NGRI consumers who have been conditionally released from DHS facilities by court order. The second tracking system will monitor those NGRI consumers who are ordered directly into outpatient treatment by the Court. Initial tracking of this group in FY2009, yielded a total of 48 individuals court–ordered directly into outpatient treatment who were monitored in the community. Of these, eight (8) individuals received an initial placement as Outpatient NGRI by jurisdictional courts during FY2009 and eleven (11) were removed from the monitoring

system due to changes in legal status. At the end of FY2009, 37 "active files" were being maintained in this tracking system**.** Agency compliance with timely court reporting and service delivery requirements for this population was 78% for FY2009. Monitoring and reporting the results for this separate tracking system to improve the provision of services for this group will be a new objective in FY2010.

Jail Linkage Evaluation

Objective A1.12: Evaluate linkage services for individuals with serious mental illness released from Illinois jails and the outcome goals of the implementation stage of the CRC grant initiative.

Indicators:

- **Complete an evaluation of the performance and outcome goals of the Data-Link Phase II initiative.**
- **Assess the success of efforts to sustain mental health linkage and jail diversion initiatives in Illinois.**
- **Assess the outcome goals of the third year of the CRC grant initiative**.

This objective has been accomplished. The final evaluation of the Data Link Phase II initiative, funded by the Illinois Criminal Justice Information Authority and performed by the University of Illinois (Southern) has been completed and posted on the ICJIA Website (www.icjia.state.il.us**). The findings recommend the expansion of this project throughout the State of Illinois. Although not reducing recidivism as anticipated, the Division of Mental Health is working on preliminary data reflecting the reduction of inpatient hospital bed days for the individuals served by this project. Cook County Jail linkage continues to need dedicated case managers. Will, Peoria, Jefferson, Marion County, and Cook-Proviso are continuing to link individuals into community services. Three new counties have been added to data-link and will begin technology aided linkage activities in FY2010.**

The final progress report for Cook County Community Re-Integration Initiative (CRC) was completed in February of 2009. The CRC met its major goals and service projections. This included expanding jail diversion contacts through the Cook County Mental Health Court (CCMHC) and CIT street deflections to emergency rooms and outpatient providers. Over three years, 256 clients were diverted or participating in mental health court. CRC also met its goals of involving CCMHC participants in evidence based practices including trauma related services, ACT, and IDDT, training 242 new CIT officers, and providing training to project staff and partners on best practices including trauma related services, ACT, and IDDT.

Jail Data Link Project: The Division of Mental Health Jail Data Link Project began in 1999 and the first phase of the project was limited to Cook County and 14 pilot mental health community providers. The project blends technological advancements with clinical systems integration and provides information to any County Jail and their respective community mental health providers as to which detainees have a history of mental illness,

both inpatient and outpatient as documented by the Division of Mental Health. This cross-match is provided on an automated technology basis and is performed on a daily basis, based on the jail's current census. With the implementation of Data-Link Phase II, through grant awards provided by the Illinois Criminal Justice Information Authority, the system graduated both technologically (now an SSL Internet based platform) and expanded to the Illinois counties of Will, Jefferson, Peoria and Marion. An additional three (3) community mental health providers were participatory.

Data-Link Phase III has just been implemented (July 1, 2009), with the addition of Winnebago, St Clair and Rock Island counties and four (4) new participating mental health community providers. The Illinois Criminal Justice Information Authority has provided the funding this phase. Specialized case managers hired by participating community mental health providers ensure continuity of care while a detainee is being held by beginning the immediate discharge aftercare planning process which includes, linkage back to their home community agency for mental health services, linkage services for substance abuse, housing initiatives, and, in Phase 3, the expansion of Supportive Employment and Community Support services. Eight case managers are covering Cook County (Proviso), Will, Peoria, Jefferson, Rock Island, Winnebago, St. Clair, and Marion Counties.

Monitoring of Persons with UST Status Returning to the Community

Objective A1.13: Provide continuity of care for individuals found unfit to stand trial (UST) that are restored to fitness in state operated inpatient forensic programs.
Indicators:

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

This continuing objective was accomplished in FY2009. Continuity of care arrangements were made for 373 discharged UST patients who received linkage referrals in FY2009. Of these, 200 discharged UST patients (54%) followed through with appointments as confirmed by providers.

Forensic services tracks individuals discharged from DMH hospitals after inpatient fitness restoration services. A total of 373 discharged UST patients were linked to community services in FY 2009. The documented number of discharged UST patients that followed through with appointments as reported by community agencies within thirty days of release from jail custody was 54% (200). In FY2009, 42% (155),of the documented number of discharged UST patients continued with follow up services as confirmed by community providers. In FY2010 Forensic Services will continue to follow up on discharged UST consumers and work collaboratively to improve the flow of information between DHS, courts, corrections, law enforcement and local providers in order to increase the number of discharged UST consumers who follow up on continuity of care referrals.

Monitoring Length of Stay

Objective A1.14. Reduce the length of stay from the time that court orders are received to the discharge of patients referred to DHS/DMH under UST statutes.
Indicators:

- **The period of time between DHS receipt of court orders to placement of patients in forensic inpatient programs.**
- **The period of time from inpatient admission to recommendation for a court hearing based on resolution of fitness issues.**
- **The period of time between recommendation for a court hearing and discharge from the inpatient program.**

This objective has been partially accomplished and is continuing in FY2010. This objective is being actively pursued. However, the performance measures required to effectively monitor service improvement in this area have required extended deliberation. Forensic performance measures have now been completed. Benchmarking was undertaken in FY2008 to establish a baseline and collect data with which to monitor length of stay. The performance measurements to address this objective were developed in FY2009 with input from staff from all hospital forensic programs and central office quality management staff. Data collection will be initiated in FY2010.

Background: Monitoring the length of stay for inpatient restoration services in DHS facilities is required in order to maintain an adequate number of inpatient beds specialized to this service and to reduce the amount of time that a consumer with a UST finding needs to remain in this more restrictive level of care. Benchmarking data was obtained in August 2008 and showed variation among the forensic inpatient facilities. The variation is being addressed as part of the quality improvement process in FY2010.

Outpatient Fitness Restoration Service Monitoring and Expansion.

Objective A1.15. Develop and maintain a tracking system for persons receiving outpatient fitness restoration services.
Indicators:

- **Number of adult persons receiving outpatient fitness restoration services in FY2009.**
- **Number of juveniles receiving outpatient fitness restoration services in FY2009.**
- **Number of new cases referred for outpatient fitness restoration inFY2009.**
- **Agency compliance with court reporting in FY2009.**
- **Agency compliance with providing fitness restoration services for UST patients in FY2009.**

This objective has been successfully accomplished in FY2009. DMH Forensic Services has developed and maintained an effective tracking system for persons receiving outpatient fitness restoration services. In FY2009, 85 adult consumers and

64 juveniles received outpatient fitness restoration services. There were 48 new referrals during the year and a total of 53 individuals receiving outpatient fitness restoration were removed from the monitoring system due to changes in legal status by the jurisdictional courts. Agency compliance with timely court reporting and service delivery requirements for this population was 96% for FY 2009 and agency compliance with providing fitness restoration services was 100%. As of the end of the fiscal year, there were a total of 110 "active files" maintained in the tracking system.

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

This objective is continuing in FY 2010. Forensic services will **c**ontinue to follow up on Outpatient UST and improve the flow of information between DHS, courts, corrections, law enforcement and local providers.

Services for Individuals with Co-occurring Mental Illnesses and Substance Abuse Disorders

Objective A1.16. Jointly with the DHS Division of Alcoholism and Substance Abuse (DASA), continue to collaborate on planning services delivered to individuals with co-occurring disorders.

Indicators:

- **Number of meetings between DMH and DASA staff**

This objective is no longer applicable. While both DMH and DASA continue to independently fund providers to treat persons with co-occurring disorders and discuss mutual concerns in this regard, there has been a cessation in funding for special initiatives. In the past, this objective was addressed largely by collaborative meetings relevant to the planning and oversight of the four co-location projects described below. In FY2009, due to budget cutbacks in the Division of Alcoholism and Substance Abuse, funding for these co-location projects was eliminated and the collaborative programming for this initiative was no longer sustainable.

Background: The Division of Mental Health (DMH) and the Division of Alcohol and Substance Abuse (DASA) have worked diligently over the years to collaborate, develop and implement initiatives focusing on consumers with co-occurring disorders. These collaborations included co-location projects that continued through FY2008 at four state hospitals; Elgin, Chicago Read, Madden, and McFarland. Sharing service delivery site resources had allowed DASA funded providers to perform screening and assessment for consumers on-site, and to provide consultation to DMH staff regarding the substance

abuse treatment needs of consumers when these services are warranted. Sharing facilities resulted in the development of more hospital staff training and expanded the role of the DASA providers to perform linkage and engagement activities. In FY2009, the General Assembly substantially reduced the DASA budget as a cost-saving measure. Although collaborative contacts between DMH and DASA staff are continuing to address regional and local concerns and to fund providers to treat individuals with co-occurring disorders, funds are currently not available from either DASA or DMH to support special targeted projects.

Objectives Related To National Outcome Measure Performance Indicators

Objective A1.17 (NOM): Continue efforts to increase the implementation of Evidence Based Practices.
Indicator:

- **Number of EBPs implemented.**
- **Number of individuals receiving each EBP.**

This continuing objective has been met for FY2009. Three Evidenced Based Practices were implemented. Two Evidence Based practices, Assertive Community Treatment (ACT) and Supported Employment (EBSE), were implemented with accompanying efforts to increase fidelity to the national models. (See Objectives A1.6 and A1.7) Statewide, 653 individuals received ACT services in FY2009. For EBSE, a total of 1,916 individuals (unduplicated count) were enrolled in Supported Employment programs. Additionally, the implementation of Permanent Supportive Housing was initiated in FY2009 and 168 consumers were successful in accessing housing through the initiative (Objective A1.4). Efforts continued toward increasing the use of Medication Algorithms (Objective A1.5) and developing and establishing the implementation of Family Psycho-education (Objective A1.8).

Decreased Rate of Civil Readmissions
Objective A1.18 (NOM): Continue efforts to decrease 30 day and 180 day readmission rates to DMH state hospitals.
Indicators:

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

This objective continues to be addressed.
DMH continues to monitor the number of adults readmitted to state hospitals within 30 days of discharge and the number of adults readmitted to state hospitals within 180 days of discharge with the goal of maintaining or decreasing the level of re-hospitalization through the use of community based services that provide alternatives to hospitalization. However, it is to be expected that individuals with serious mental illnesses, may, at times of crisis and relapse, require access to inpatient services for evaluation and stabilization in a safe, structured, and supportive environment. See the Report on FY2009 Adult

Performance Indicators section for data and information about these indicators which are a National Outcome Measure (NOM)

Objective A1.19 (NOM): The percentage of consumers reporting positive outcome will increase in FY 2009.
Indicator:

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

This objective is currently in process. During December 2009, the FY2009 Consumer Survey will be mailed to a random sample of 5,200 consumers (2,600 adult consumers and 2,600 families of children ages 11 and under) receiving services in June 2009. It is anticipated that an analysis of the responses will be completed in February 2010. The FY2008 Consumer Survey was completed during FY2009 and serves as the baseline from which to track consumer satisfaction with services and the newly developed national outcome measures for social connectedness and improved functioning.

The FY2008 Consumer Surveys
The Division has adopted the MHSIP: Adult Consumer Survey to collect feedback from adult recipients of community mental health services funded by the DMH. Information is collected on 7 domains including access to services and outcomes; with additional questions on the impact of services on criminal justice involvement. Other variables of note include: severity of mental illness, race/ethnicity, and length of time in treatment.

A random sample of consumers, stratified by race and ethnicity, was drawn from all adults, aged 18 and over, receiving services from DMH providers in June 2008. A response set of 385 was needed to achieve a 95% confidence level for reporting statewide. While the response set was not large enough for valid conclusions to be drawn based on small subgroups (like racial or age groups), it is useful in pointing to areas for further investigation when a larger sample can be assessed. The survey was administered via the mail to consumer's home address. An introductory letter was sent with the three page survey and a postage paid return envelope. Consumers and caregivers were asked to indicate their response on a Likert scale of 1 to 5 whether they agreed or disagreed with the statements. Respondents were asked to think about the services they received in the last six months. 2600 surveys were sent out.

The number of consumers who responded to the survey was 462, a response rate of 22%. Of the 462 consumers responding: 66% are considered "target" or "priority" population i.e. they have a serious mental illness; 37% are male; 56% female and 8% no response on gender. Ninety-one percent of respondents were receiving services; 18% received services for less than one year; 48% for five years or more.

The following are the percent of positive responses to the 7 domains overall. The results are listed by descending order showing the greatest number of positive responses were in the general satisfaction domain, the least in the functioning and outcome domains.

Reporting Positively about General Satisfaction	83%
Reporting Positively about Quality and Appropriateness	82%
Reporting Positively about Access	77%
Reporting Positively about Participation in Treatment Planning	73%
Reporting Positively about Social Connectedness	63%
Reporting Positively about Functioning	62%
Reporting Positively about Outcomes	60%

As an evaluation tool of DMH services, this consumer survey has created a picture of services where consumers feel positively about the quality and are generally satisfied with the services they receive. However, in questions pertaining to outcomes, more than a third of consumers did not feel better at handling daily life as a result of services in the past 6 months even though 81% of the respondents were in services for one year or more; and half of those were receiving services for five years or more. These results present further proof of the need for an evidence-based, outcome driven mental health system. Other key findings included:

- 58% of the respondents no longer receiving services, reported a problem with access to services.
- Persons aged 45-64 were significantly more satisfied with the services than those aged 25-44.
- 97% of Hispanic adults agreed with the statement that "Staff were sensitive to my cultural background (race, religion, language, etc).
- When comparing responses from consumers residing in Chicago, Suburban Cook County, Collar Counties, Rural Counties and Urban Counties, there was no significant difference in domain responses by geographic location of residence.

For children, the Division has adopted the MHSIP:Youth Services Survey for Families to collect feedback from caregivers of children ages 0 through 11 who are receiving community mental health services funded by the DMH. In 2008, a representative sample of 431 caregivers responded to the survey statewide. A random sample of children, stratified by race/ethnicity, was drawn from all children receiving services from DMH providers in June 2008. Only children aged 0-11 were chosen. The decision to exclude adolescents aged 12-17 was made because some adolescents seek help without their parent's knowledge and receiving a survey at home may compromise that decision. The sample was created in November 2008.

The percent of positive responses to the 7 domains overall are listed below in descending order from the greatest number of positive responses (cultural sensitivity) to the least Outcomes).

Reporting Positively About Cultural Sensitivity of Staff	89%
Reporting Positively about Participation in Treatment Planning	81%
Reporting Positively about Social Connectedness	75%

Reporting Positively about General Satisfaction	71%
Reporting Positively about Access	71%
Reporting Positively about Functioning	54%
Reporting Positively about Outcomes	52%

Overall, as an evaluation tool of DMH services, this consumer survey has drawn a picture of services where caregivers feel like they participate in their child's services and they also felt that the service providers were respectful and sensitive to their cultural/ethnic background. On questions pertaining to outcomes, only half of the parents agreed that their child is better at handling daily life, or is doing better in school as a result of services. This trend mirrors results seen nationally and presents further proof of the need for an evidence-based, outcome driven mental health system. Other findings include:

- 1 out of 4 of respondents reported a problem with access to services.
- Roughly 3 out of 4 respondents reported being satisfied with the services their children receive.
- Caregivers of children currently receiving services were much more satisfied with the care than those whose children were no longer receiving services.
- When comparing children residing in Chicago, Suburban Cook County, Collar Counties, Rural Counties and Urban Counties, there was no significant difference in domain responses by geographic location of residence.

Criterion II: There are no objectives for this criterion. See the Performance Indicator Section of this Report for the quantitative measures on access to services.

Criterion IV:

Project for Assistance in Transition from Homelessness (PATH)

Objective A4.1: By the end of FY2009, target case management services to 200 more PATH eligible consumers than were served in FY2008.
Indicators:

- **Number of persons receiving case management services under the PATH initiative by the end of FY2009.**
- **Number of persons identified as eligible for enrollment and receiving PATH services by the end of FY 2009 will show an increase of 10% over the total number of persons served in FY 2008.**

This objective has been substantially exceeded. PATH programs (18 providers) served 3,077 individuals in FY2008 and 3,798 individuals in FY2009, an increase of 23.4%. The targeted number of persons receiving case management services was exceeded by 521 individuals for an attainment level of 360.5% !

Background: Since 1991, Illinois has been a recipient of federal funds provided through Projects for Assistance in Transition from Homelessness (PATH), a federal formula funding award governed by the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), and the Center for Mental Health Services (CMHS). Illinois providers have developed an array

of services that include in vivo case management, crisis intervention services, a day center/drop-in-program, and two (2) mobile assessment units in the City of Chicago. Allocations for the PATH program have fluctuated in recent years, and providers have diligently continued to use funds to expand and enhance services to homeless persons with mental illness. Currently, all PATH funding is used for the provision of case management services with the exception of $103,000 for a drop-in center (Rockford) and $653,000 in two Mobile Assessment Units (Chicago) operated by Thresholds - which do in vivo outreach and engagement. In the past three years the number of individuals served has steadily increased from 2,763 in FY2006, 2,830 in FY2007, and 3,077 individuals were served in FY2008.

In FY2009, the PATH allocation for Illinois was $2,686,000, an increase of $320,000 from FY2008. The additional funds are being utilized in FY2010 to increase the allocations and numbers of people served by two (2) programs: Beacon Therapeutic Diagnostic and Treatment Center (Chicago) - which serves homeless families, and Shelter Care Ministries (Rockford) - which provides a drop-in center for individuals who are homeless, and to collaborate with the Illinois Department of Corrections Office of Mental Health (IDOC/OMH) to develop three (3) Full Time Equivalent positions to work in conjunction with IDOC/OMH - Parole/Placement Resource Unit (PRU) on the PATH Ex-Offender's Re-Entry Initiative which targets ex-offenders with serious mental illness returning to these communities who are homeless thereby increasing the availability of much-needed services.

Objective A4.2: In FY2009, convene the 1st Annual PATH Provider's Conference: "PATH: Bridging the Gap Between Mental Illness and Homelessness".
Indicators:

- **Number of attendees at the Conference who represent mental health and homeless interests outside the PATH service system.**
- **Number of PATH Providers in attendance.**
- **Number of Consumers in attendance.**
- **Number of Evaluation forms completed.**
- **Number of Conference Evaluations showing successful scores.**

This objective was successfully accomplished. The first Illinois PATH Providers Conference was held in Bloomington; September 18-19, 2008. There were more than sixty persons in attendance including 12 consumers and 10 attendees representing mental health and homeless interests outside the PATH service system. In reference to the evaluation, more than half the participants returned evaluation forms. Nine out of every ten participants who submitted an evaluation rated the event as very successful.

The Conference objectives included trainings on innovative strategies, opportunities for cross-pollination of ideas and techniques, and the initiation of an expanded network which will be beneficial to consumers. The following sessions were provided to attendees: (a) Psychopharmacology, (b) Outreach and Engagement to PATH-eligible individuals: Chicago-Style, (c) Dual Diagnosis: Translating Science to Practice, (d) Diagnostic Training for Staff without Clinical Backgrounds, (e) Working with

Individuals who have a history of Incarceration, (f) Recovery and Wellness for the Homeless Services Team and Consumers, and (g) Practical Approaches to Helping Homeless and at-risk persons with Mental Illness secure SSI/SSDI Benefits. Subsequent Conferences are to be developed on a biennial basis. The next Conference is scheduled to take place September, 2010; in Springfield, Illinois.

Services To Older Adults

Objective A4.3. In collaboration with the Illinois Department On Aging (IDOA), convene meetings with stakeholders to improve access to treatment by older adults.
Indicator:

- **Number of meetings convened in FY 2009.**

This objective has been satisfactorily accomplished at both the state and local levels. At the State Level, the DMH liaison to the Department of Aging participated in 20 meetings and three planned Conferences in which collaborative efforts to improve access to mental health treatment by older adults was discussed. Locally, mostly in rural areas of the state, Geropsychiatric specialists convened or participated in 310 Systems Integration meetings. Of the 2,766 aggregated participants in these meetings, 890 were mental health providers, 1,056 were Department of Aging providers, 28 were substance abuse providers, 171 were primary care providers, and 80 were consumers.

Collaborative Efforts in Mental Health and Aging: The Division of Mental Health convenes an Advisory Committee on Geriatric Services jointly with the Illinois Department on Aging (DOA). This Advisory Committee has focused its efforts on the assessment of the mental health needs of the elderly, identification of model programs, best practices and staff competencies, and increased awareness of geriatric mental health concerns. Training, consultation, and technical assistance in the area of mental health and aging continue to be provided through the efforts of the Advisory Committee. The Council promotes increased awareness of geriatric mental health concerns and has developed a position paper on issues of Self-Neglect that was used widely throughout the state.

The Division of Mental Health and the Illinois Department of Aging also collaborated with resources and expertise to develop, market and present three conferences: An Annual Statewide Mental Health and Aging Conference – the most recent one was held in April, 2009 and was attended by well over 300 people –setting a record for the highest attendance for this yearly conference. The keynote theme of the conference was suicide prevention for older persons. A Behavioral Health, Aging and Wellness Conference took place in September, 2009; and the Central Illinois Mental Health and Aging Conference occurred in October.

The Geropsychiatry Initiative establishes a geropsychiatric specialist in a comprehensive community mental health center with access to a psychiatrist, board certified in Geropsychiatry, to improve access, availability and quality of mental health services for older adults (age 60 and older) with mental health needs. The program strives to positively enhance integration of mental health, aging, primary medical care and public

health systems and focuses on three key areas: systems integration, mental health services/consultation and training/education. Five funded positions for Geriatric Specialists cover 27 counties throughout the southern part of the state. Geriatric Specialists also provide treatment and education resources for mental health services to the aging throughout the state. The Initiative has received national recognition including the American Society on Aging/Pfizer Award of Excellence in 2005---the only mental health program which ever received this award- and recognition as an exemplary program by the National Technical Assistance Center for Older Adult, Mental Health, and Substance Abuse Services in 2006. Statewide expansion of the program has been proposed by the Illinois Department on Aging, but acquisition of sufficient funding continues to be an obstacle to further development of this valuable resource. The Division of Mental Health also serves in an advisory capacity to the Statewide, Northern, and Southern Mental Health and Aging Coalitions and contributes staff to participate in projects convened by the Illinois Department on Aging such as the Self-Neglect Task Force and the "Grandparents Raising Grandchildren Task Force".

Criterion V:

Increasing Federal Financial Participation (FFP)

Objective A5.1/C5.1. Increase Medicaid funding for the Illinois mental health service system. This will be accomplished by:

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

Indicator:

- **Amount of FFP generated in FY 2009.**

This continuing objective is currently in process.

Final figures for FFP in FY2009 are not as yet available. As of mid-November 2009, Medicaid billing for FY2009 stood at $166,063,587. FFP Trust Fund deposits for FY2009 stood at $83,031,793. As billing and reimbursement for the previous fiscal year continues well into FY2010, it is anticipated that the final figure will exceed this amount. In FY2008, $86,875,992 was deposited. $84.4 million was deposited in the Trust Fund in FY2007.

Medicaid billing has risen substantially over the years. In FY2005 Medicaid billing for adults had risen to $129,028,640 and in the following year it was $149,599,641. By FY2007 it rose to $164,742,868 and increased substantially in FY2008 to $173,751,984. Currently it is difficult to estimate the final level of the Medicaid

billing and Trust Fund deposits due to (1) a decrease in the number of individuals served in FY2009 attributable to the impact of the economic recession that occurred in the final quarter of FY2009 and (2) the recent restructuring of the MIS data system which initially delayed submission, analysis, and reporting processes. As a result some billing for FY2009 is still being processed.

Accomplishments in FY2009 include:

- ✓ Revisions to the state's Mental Health Medicaid Rule (Rule 132) were implemented in FY2009. These revisions clarify and enhance standards for services and other provisions of the Rule. Additional revisions are anticipated in future years in an effort to keep the Rule as current as possible.
- ✓ In collaboration with the Department of Healthcare and Family Services, the state's Medicaid agency, DMH has initiated a project to automate the Medicaid "spend down" provisions for eligible individuals with serious mental illness.
- ✓ An Administrative Services Organization (ASO) has assumed operational responsibilities for prior approval processes for some of the most expensive services funded by DHS/DMH since the end of FY2008. The ASO provides technology and statewide consistency making this service utilization management process efficient and effective. As more data becomes available and analyses completed, it is anticipated that additional service utilization processes will be implemented to ensure that the right consumers are receiving the right services in the right amount at the right time.
- ✓ In FY2009, with legislative guidance, DMH continued a process of more closely relating providers' payments to the amount of services actually delivered to consumers (as contrasted with the previous payment system that focused dollars actually expended, rather than services delivered). For FY 2009 providers with billing performance at the extremely high or low ends had their estimated contract amounts for FY 2009 adjusted to more closely reflect their actual level of service provision and billing. These steps toward fee-for-service will continue.
- ✓ Through the Medicaid Rule revision, DMH has improved and clarified the documentation requirements to enhance providers' and states compliance with federal and state Medicaid regulations and expectations.

Background: The Illinois State Plan Amendment for Medicaid was approved by CMS on March 14, 2007. The revised Medicaid Rule (132) was approved in the State on April 18, 2007. These products were based on extensive work directed toward simplifying and clarifying DMH Medicaid policies and procedures, reducing and eliminating barriers to increasing Medicaid billing, and clarifying service definitions. A major training effort was undertaken in Spring of 2007 to educate providers and stakeholders on the new definitions and requirements and to prepare providers to use revised and updated billing procedures. By the end of FY2007, DMH had completed more than three years of work on System Restructuring Initiative (SRI) and conversion to a fee for service payment mechanism with extensive input from stakeholders that included more than 27 consumer and family focus groups, task-oriented workgroups with over 300 participants, and the ongoing work of an SRI Task Group. Since then, the process has shifted primarily from input and planning to initial statewide implementation. In addition to revising Medicaid reimbursement procedures, DMH developed a fee for service approach to additional

services not qualified under Medicaid including outreach and engagement, stakeholder education, vocational services, and forensic services. Concurrently, new recovery-oriented services and definitions were developed.

Adult - Report Summary of the most significant events that impacted the mental health system of the State in the previous FY

ADULT-SIGNIFICANT EVENTS AND CHANGES IN FY2009

REPORT ON THE 2009 ADULT PLAN

Developments and Issues Affecting Mental Health Service Delivery

DHS Division of Alcohol and Substance Abuse (DASA) Budget Reduction

In FY2009, DHS/DASA experienced a 20% reduction in its operating budget that resulted in the elimination of funding for many collaborative projects including the co-location projects at state hospitals described in Objective A1.16.

Impact of the Economic Recession

Illinois is facing a $9 billion deficit this year. The General Assembly rejected the Governor's proposal for a 50% increase in the state income tax. The current budget, which was passed on July 15, 2009, calls for downsizing of state government and reductions in spending General Revenue Funds, a process which is slowly unfolding. The outlook for any new funding for mental health services is bleak. DHS/ DMH recently (mid-August) announced an 8% reduction ($42,000,000) in FY2010 from the FY2009 budget for community mental health services. Because of the draconian nature of these cuts, DMH is not projecting an increase in access to programs. In this environment, DMH is making every effort to maintain core mental health services and to provide a consistent level of access to them.

Several programs previously described in the block grant such as: Qualified Mental Health Professional (QMHP) liaisons to DHS/DHCD Family Community Resource Centers, Screening Assessment and Support Service Flexible Funds, (discretionary funding for non-traditional support services such as special programming components of Wrap Around planning), the Multi-disciplinary Specialty Assessment program that funded specialty assessments such neurological testing and learning disability assessments, five of the ten Mental Health Transition pilot programs and five of the ten Mental Health Early Intervention pilots (See the Child-System of Integrated Services Section for further detail) have not been funded in FY2010.

The Warm Line

In the past year, the Collaborative established a statewide "warm line". The warm line is a cutting edge source of peer and family support. Staffed by five Peer and Family support specialists, the toll-free number receives 60 to 120 calls per week. These professionals are persons in recovery, or family members of persons in recovery, who are trained to effectively support recovery in other individuals' lives. They reaffirm, reconnect, and renew hope, and provide practical assistance for overcoming mental illnesses to persons who are striving to live, learn, work, and participate fully in their communities. Warm Line Peer and Family Support Specialists offer emotional support by listening and understanding; recovery education by providing and linking persons to new mental health recovery information; self-advocacy guidance by helping individuals

learn to communicate effectively to ensure that their needs are met; and mentoring, through boosting the confidence of individuals as they progress toward their recovery goals. The warm line has already become a successful DHS/DMH investment by assuring the accessibility of a human connection at a time when it is needed now more than ever. Although warm lines are found throughout the U.S., Illinois and Maine reportedly are the only states known to operate statewide Warm Lines.

The Consumer and Family Care Line

In addition to the Warm Line, consumers and family members may contact the Collaborative's toll-free Consumer and Family Care Line with compliments and complaints about the mental health services they receive. Each complaint is reviewed by the staff, referred to the appropriate agency or authority for investigation or resolution, and followed up. Feedback is provided to consumers and family members in writing on the progress and resolution of their complaints. Assistance and coaching are offered to help an individual pursue a review of a complaint or to appeal a decision.

Mental Health Services to Veterans

The Illinois Warrior Assistance Program provides confidential assistance to Illinois Veterans as they transition back to their everyday lives after serving our country. The goal of the program is to help service members and their families deal with the emotional and psychological challenges they may be facing. A 24-hour, toll free helpline is staffed by health professionals to assist veterans day or night, with any of the symptoms associated with Post Traumatic Stress Disorder (PTSD). Traumatic Brain Injury (TBI) screenings are provided to all interested veterans. TBI screenings are mandatory for all returning members of the Illinois Army National Guard and Air National Guard.

Veterans Reintegration Initiative (VRI)

Veterans in the criminal justice system with mental illness and combat-related trauma disorders represent a growing population with unique service needs. Critical barriers to successful reintegration for this population include lack of interface between veteran, justice, and treatment systems and lack of access to dedicated services such as mental health and substance abuse treatment, housing, and trauma-informed treatment. In Illinois, the paucity of military base communities amplifies the need for community and systems-level responses to support this population. The significant number of returning veterans to Illinois also underscores the importance of adapting current training and treatment strategies to meet the needs of returning soldiers and their families. Without these services, veterans with mental health disorders or co-morbid substance abuse may lack the supports necessary to achieve successful reintegration, and find themselves caught in a cycle of homelessness, hospitalization, and incarceration.

The State of Illinois was one of six states awarded the Substance Abuse and Mental Health Services Administration Jail Diversion – Trauma Recovery (Priority to veterans). This grant, for approximately $2 million over 5 years has enabled the Illinois Department of Human Services, Division of Mental Health (IDHS/DMH) to establish the Illinois

Veterans Reintegration Initiative (VRI) to increase diversion for criminal justice-involved veterans with trauma histories in Cook and Rock Island counties. The VRI is expected to result in the delivery of trauma-informed, evidence-based treatment to 120 consumers per year over a 5-year program period, as well as specialized training for 1,000 police officers in street-level responses to veterans demonstrating mental illness. The VRI is a collaborative effort of stakeholders from the veterans, justice and treatment systems. The planning phase of the project has included the participation of key stakeholders in Cook County and Rock Island County and will culminate with a comprehensive strategic plan that establishes a formal link between veterans services and justice/treatment interventions in each of the project sites. The VRI is expected to strengthen partnerships among justice agencies and service providers, expand diversion opportunities, and establish an infrastructure for intervention and service delivery that can be replicated across the State.

Permanent Supportive Housing

FY 2009 was the first year of actual implementation of the Permanent Supportive Housing (PSH) initiative. PSH refers to integrated permanent housing (typically rental apartments) linked with flexible community-based mental health services that are available to tenants/consumers when they need them, but are not mandated as a condition of occupancy. The PSH model is based on a philosophy that supports consumer choice and empowerment, rights and responsibilities of tenancy, and appropriate, flexible, accessible, and available support services that meet each consumer's changing needs. By increasing the supply of safe, decent, and affordable PSH units,-DMH will significantly improve its capacity to help consumers obtain permanent housing that meets their preferences and needs. In most cases and for most individuals the support services necessary to assure successful tenancy are already reimbursable by Medicaid under the Community Support service definition or under other Medicaid plan services (e.g., medication management, psychiatry, outpatient counseling). DMH has provided extensive training to DMH staff members who serve as Regional Housing Support Facilitators (one for each Region), as well as all DMH community mental health providers, and participating subsidy administrators. A real time web-based housing search website (Ilhousingsearch.org) became active as of 6/15/09 and is open to everyone in Illinois to search for housing opportunities.

Public Awareness (Anti-Stigma) Campaign

In FY2008 and FY2009, DMH established and implemented its public awareness initiative targeting adults and children by launching the **Say It Out Loud** campaign which is continuing. Say It Out Loud is a groundbreaking statewide campaign to promote good mental health. It is co-sponsored by IDHS/DMH and the Illinois Children's Mental Health Partnership. Research tells us that the best way to reduce the biases associated with mental illness is by sharing experiences. This can be accomplished specifically through interaction with family, employers, colleagues, neighbors and friends, as well as medical and mental health professionals. Based on current research, the campaign seeks to address the misperceptions associated with mental illnesses by giving people the

opportunity to engage with one another on the subject in a meaningful way and to share their experiences and knowledge. Thus, the campaign has used the stories of real people in advertisements distributed to newspapers and radio stations in every county of the state, and through videos featured on the campaign's new Web site: www.mentalhealthillinois.org.

Evidence Based Practices

In May 2009, the DMH convened a second annual statewide conference on EBPs, entitled Implementing and Sustaining Evidence-Based Practices For Recovery, Resilience and Hope. Experts on each of the EBPs made presentations on focusing on implementation, organizational and financing issues that should be taken into consideration when planning for implementation. More than 300 individuals (consumers, family members, advocate, providers and state agency staff) attended the two-day conference. DMH continues to address SAMHSA'S National Outcome Measure of Implementing Evidence-Based Practices and strives to make EBPs available throughout the state by providing training and technical assistance to mental health agencies, and by involving mental health consumers and families in the expansion of such practices in Illinois.

Program Enhancement

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

Fee For Service

The DMH has revised Medicaid Rule 132 to support the service system changes that will be necessary in the transition to a Fee-for-Service System. Planning efforts and gradual implementation of this initiative in key program areas has continued in FY2009. DMH also continues to work with consultants to identify technical assistance needs of providers and to provide technical assistance to support the move to the fee-for-service system.

Information Technology

DMH continues its efforts to refine and streamline data collection efforts to provide information that supports decision-making. As noted above, DMH, working with the Mental Health Collaborative for Access and Choice (MHCAC), has redesigned and implemented a new management information system (MIS). All providers now report data to the new system. This work included the development of a data warehouse that

houses eligibility, registration, billing/services information, a provider database, and service authorization in one place.

Grants

In FY2009, the DMH completed the SAMHSA Targeted Capacity Expansion - Jail Diversion grant called the *Community Reintegration Collaborative* to support the DMH Jail Data Linkage Program; and the SAMHSA Transformation Transfer Initiative grant for $105,000 to fund a statewide mental health/criminal justice needs assessment and system mapping initiative. DMH received continuation grants for the following areas: Data Infrastructure for Quality Improvement; Work Incentive and Planning Assistance Services for SSI/SSDI Beneficiaries, and Supported Employment. DMH is partnering with staff of the Illinois Department of Healthcare and Family Services (DHFS) in implementing a federal Medical Emergency Room Diversion (ERD) Grant from CMS. The grant provides $2 million over a two-year period to improve access and the quality of primary health care services. Illinois was one of six states awarded the Substance Abuse and Mental Health Services Administration Jail Diversion – Trauma Recovery (priority to veterans) grant. This grant, for approximately $2 million over 5 years has enabled the establishment of the Illinois *Veterans Reintegration Initiative (VRI)* to increase diversion for criminal justice-involved veterans with trauma histories in Cook and Rock Island counties. (See Above)

Adult - A report on the purpose for which the block grant monies for State FY were expended, the recipients of grant funds, and a description of activities funded by the grant.

ADULT- PURPOSE OF BLOCK GRANT EXPENDITURES AND ACTIVITIES IN FY2009

REPORT ON THE 2009 ADULT PLAN

Expenditure Of Block Grant Dollars In FY2009- Adults

The Illinois expenditure of the FY2009 Community Mental Health Services Block Grant was directed at providing services in community settings for adults with serious mental illness and children and adolescents with serious emotional disturbances. The Illinois block grant fund amount for FY2009 was $16,103,252. Slightly less than 5% ($684,388) of this amount was expended on administrative expenses. In FY2009, block grant dollars were allocated (for adults and children combined) as follows:

- Community Consumer Support - $3,392,210.00
- Psychiatrist Services In Mental Health Centers (Psychiatric Leadership)- $11,619,701.00
- Special Projects - $180,000.00

A table detailing allocation of dollars to agencies providing services to adults and children has been included in the appendix.

Block Grant Expenditure - Adult Population

Block grant dollars were directed toward psychiatric leadership, community consumer support which is a component of psychosocial rehabilitation, and crisis care to serve individuals with serious mental illnesses. These programs are designed to provide the necessary intermediate and ongoing support and supervision for individuals who are transitioning from a state hospital to the community. The adult service funding allocation is consistent with the State Mental Health Plan, especially the need to provide community-based services as alternatives to hospitalization so that the need for state hospitals is reduced.

Child - Report Summary of areas which the State identified in the prior FY's approved Plan as needing improvement

IMPLEMENTATION REPORT

NARRATIVE: CHILD- SUMMARY OF PROGRESS IN FY2009

REPORT ON THE FY2009 CHILD AND ADOLESCENT (C&A) PLAN

INTRODUCTION

This report provides detailed information regarding the implementation of the Illinois DMH State Block Grant Plan for FY 2009. This first section of the Narrative for the Child Report summarizes Illinois' progress in addressing areas in need of improvement based upon the outcomes of the stated objectives in the FY 2009 Child & Adolescent Plan. The narrative description which follows addresses each objective and provides a statement of the level of attainment, information on how the objective was attained, and background information that provides context and purpose for the objective. The objectives discussed in this section have been a crucial part of ongoing DMH planning and service delivery. The next Section provides a description of significant events that have impacted the Child & Adolescent mental health service system in the past year. Information regarding specific allocation of block grant funds is provided in the last section of the Narrative.

Criterion I:

Family Participation

Objective C1.1. Continue to work with parents and parent-led organizations to facilitate parent-to-parent support through the use of Family Resource Developers (FRDs) and work with parent and parent led organization to encourage substantive feedback on enhancing the quality of services at all levels of care.

Indicators:

- **Number of Family Resource Developers hired by SASS programs to facilitate parent-to-parent support.**
- **Percentage of FRD positions filled in FY 2009.**
- **Number of FRD's hired in C & A programs other than SASS.**
- **Number of Family Consumer Specialists hired by DMH to provide family voice to the DMH system and to increase the extent to which the DMH service system is family driven.**

This objective has been achieved.

In FY2009, 44 Family Resource Developers (FRDs) were employed in SASS programs to facilitate parent-to-parent support. Eighty-two percent of the SASS programs in the state had an FRD employed. Some had more than one. DMH

encourages C&A programs to utilize FRDs but information about FRD's employed in C&A programs other than SASS agencies has been difficult to track.

Five Family Consumer Specialists (FCS) are now employed as C & A staff members of DMH in each region of the state. Four new full time positions were added statewide in FY2008 and the fifth FCS staff member was hired for the Southern Region of Illinois in early FY2009 (October 2008). All five of the DMH regions now have a Family Consumer Specialist actively involved.

Additionally, Family Advisory Councils comprised of parents and youth were established during FY2009 in each DMH region of the State and are now operating with leadership provided by the Family Consumer Specialists. (See Objective C1.2)

Background: The participation of parents/caregivers and adolescents in planning and evaluating the quality of mental health services is an important aspect of the Illinois public mental health system. DMH has maintained this effort as a priority during FY2009 as demonstrated by the following activities directed toward increasing family voice and participation in the provision of C&A services statewide and in DMH Regions.

- DMH requires Family Resource Developers (FRDs) to be hired in Screening Assessment and Support Services (SASS) programs. Increasing value has been placed on the expertise FRDs bring to the SASS teams. The support role of the FRDs has expanded with some agencies using FRDs to assist with Individual Care Grant application processes and service planning and some have hired more than one FRD into their agency as they continue to recognize the value of the position.
- Monthly meetings are held for the FRDs in order to provide education, resource development and support for the positions. For example, in May and June of 2009 the Family Consumer Specialists held trainings for the FRD's on Medicaid Billing procedures and sustainability of their positions. DMH also contracts for assistance and training for FRD's through the Illinois Federation of Families.
- Regional family advisory councils are now operating under the leadership of the family consumer specialists in each region.
- In FY 2009 the Child and Adolescent Services Sub-committee of the Illinois Mental Health Planning and Advisory Council successfully maintained its leadership in planning and advocacy with a parent and a community mental health director as co-chairs. This committee has become increasingly influential within the IMHPAC.
- The Mental Health Juvenile Justice Initiative is working on increasing parent-to-parent support.
- The ICG Parent Group is a parent-led support group that is concerned with the enhancement of the quality of services in the Individual Care Grant (ICG) program through the provision of technical assistance and continues to be a robust voice in the development of child services in Illinois. DMH staff members provide logistical support to the ICG Parent Group including family notifications,

supporting costs for meeting space, and technical assistance and education.

Teen Advisory Group

Objective C1.2. Continue efforts to develop and enhance the role of the DMH C&A Teen Advisory Group.
Indicators:

- **Monthly meetings of the teen advisory group held in FY 2009.**
- **Documentation of Teen Advisory Group participation and input into the larger DMH arena.**

This objective was modified and enhanced during the course of the year. After discussions with other states on the models in use to ensure youth and family participation, a strategic decision was made to change the Teen Advisory structure and broaden representation to include the entire state. Instead of the one Teen Advisory Council the state currently operates five (5) 'Family Advisory Councils', one in each DMH region. These Family Advisory Councils include both parents and youth and are convened by the DMH Family Consumer Specialist in each region. The Councils are also part of the effort to move the system towards Family Driven Care.

Meetings of the Teen Advisory Council were suspended in Summer 2008 due to significant changes in members' education status and summer jobs. The liaisons to the group considered the value of having youth who represented a limited geographic area compared to developing a larger representation of youth for the state as a whole. Additionally in 2009, Illinois was one of six states that received a SAMHSA award which paid expenses to participate in a policy academy focused on Family Driven Care. The voice of youth and families in each of the DMH regions in the state was considered to be a crucial element in this project that also supports collaboration with other child serving systems and supporters (DCFS, ISBE, CHP, DJJ, DASA, IFF, ICMHP) to address the extent to which the service system is Family Driven. Family Advisory Councils are participating in and coordinating the qualitative and quantitative surveys of youth and families in each region required by the initiative.

Evidence-Informed and Evidence-Based Practices

Objective C1.3. Continue to advance the implementation of evidence-informed practices in the child and adolescent service system:

- **In FY09, explore the possibility of utilizing video based training methodologies in an effort to further disseminate the current training resources to the more rural areas of the state.**
- **Contract with a fourth training University in the southern area of the state to broaden the impact of the C & A EBP certification program outreach.**
- **Monitor the number of agencies who are utilizing the web-based outcomes analysis system and provide further technical assistance regarding the clinical**

utility of this system.

Indicators:

- **Number of training sessions using the curriculum that are scheduled and held.**
- **An approved plan for the use of video-based training methodologies in rural areas or their actual demonstrated use by the end of FY2009.**
- **A contract and curriculum is established with a fourth university to provide certification at the graduate level.**
- **The number of agencies utilizing the web-based outcomes analysis system with technical assistance.**

This objective has largely been accomplished in FY2009.

Training in evidence–based engagement strategies and evidence –informed practices has been ongoing in several venues, making it difficult to track down a precise number of sessions. The training sessions in FY2009 included:

- **Enrollment of a third cohort of providers in November 2008 for the training series on evidence-informed practice. As of the end of FY2009, 27 agency groups have participated in this series. (It is noteworthy here that the evaluation of this project in the Spring of 2009 indicated that youth treated by the clinicians who participated in these trainings improved at statistically superior rates versus those treated by comparison clinicians. The training model has been adapted, and outcomes for each cohort will continue to be evaluated to rate the impact of the model with youth outcomes.)**
- **In FY2009, seven training sessions were offered statewide on the topics of evidence based engagement strategies, and use of outcome instruments.**
- **Training was provided on the OHIO Scales and in using measurement in clinical care.**
- **A four part training series on using cognitive behavioral therapy with youth suffering from anxiety disorders was provided by an expert consultant.**
- **In FY2009 Illinois initiated a Learning Collaborative pilot with twelve community mental health agencies. This learning collaborative group met monthly for six months and focused on evidence based engagement strategies with the support of an expert technical consultant. The initial response was extremely positive from the participants. The pilot ended in October and the experience is currently being evaluated both internally and by the consultant.**
- **Consumer conferences for parents on evidence-based practices have been held across the state. A brochure for parents was designed and distributed to agencies on Evidence Informed Practice in order to help families know what to ask for and expect regarding care for their children. Family Consumer Specialists host monthly statewide 'Parent Empowerment Calls' to provide parents with information, including evidence-based and evidence-informed practices that will allow them to more effectively drive and evaluate their children's care and the system at large.**

Northern Illinois University is in the process of developing a virtual classroom that can be used by all the community mental health providers serving children, and another that will support information for families. The content of these sites is being developed and will include evidence-based interventions. Clinicians will be able to earn continuing education credits (CEUs). Roll out of the system has been delayed but is expected to occur by the end of this calendar year.

In FY2008, three Masters level training programs across the state began to graduate students with certifications in evidence based child and adolescent services. These three programs have continued and are graduating their second cohort. A fourth university has not yet been located. Efforts are continuing to add a fourth program in the southern part of the state. This initiative will increase the ability of the workforce to provide evidence-based intervention to youth in Illinois in the long term.

As of the end of the fiscal year, there were 142 agencies participating in the web-based clinical outcomes analysis system with 1,934 users in the system. As of June 1st 19,796 youth had received assessments and 29,724 Ohio Scales had been completed. Progress continues to be noted in the most recent data report. As of 10/15/09, 145 agencies are participating with 1923 users in the system. A total of 24,033 youth have received assessments and 44,421Ohio scales have been completed. (See Objective C2.1 for further information)

Background: DMH formed an evidence based practice subcommittee that is co-chaired by DMH staff and a leader of the Community Behavioral Healthcare Association, the trade organization of the mental health centers. This committee is comprised of a diverse membership; including parents, university professors, child advocacy organizations, community mental health agencies and DMH staff. Recognizing the extreme diversity of the population in Illinois and the narrow definition of specific EBP models, the EBP committee advised the DMH C&A Statewide Office to actively promote Evidence Informed Practice (EIP). Evidence Informed Practice is defined as "*a collaborative effort by children, families and practitioners to identify and implement practices that are appropriate to the needs of the child and family, reflective of available research, and measured to ensure the selected practices lead to improved meaningful outcomes"*.

A five-pronged strategy, adopted in FY2006, for moving Illinois forward in its use of Evidence-informed practice for children and adolescents is being pursued:

1. Educate C & A agency leadership on an Evidence Based Practice Paradigm.
2. Train providers in specific evidence-based treatments.
3. Develop partnerships between universities that train the C & A workforce and the community provider, agencies. Develop the ability of training institutions to teach evidence-based practice during the early training of practitioners.

4. Review the extent to which Division of Mental Health policy supports or impedes evidence based practices.
5. Provide education to consumers on evidence-based practice.

During FY 2009 a significant amount of progress has been achieved toward these strategies.

As Illinois has opted to actualize evidence-informed practices for children, the three Evidence-Based Practices that are National Outcome Measures (NOMs) are not being implemented in Illinois. These are:

- Number of Persons with SED Receiving Therapeutic Foster Care
- Number of Persons with SED Receiving Multi-Systemic Therapy
- Number of Persons with SED Receiving Family Functional Therapy

Individual Care Grants for Children with Mental Illness

Objective C1.4. Continue to strengthen community service options in the DMH ICG program and increase the number of youth served.

Indicator:

- **Number of children served through ICG community service options in FY 2009.**

This objective was accomplished.

In FY2009 the percentage of children and adolescents receiving intensive community-based services has been successfully maintained in spite of a decline (10.3%) in the overall number of youth served in the ICG program. Nearly forty percent (175) of the ICG recipients used this option. Additionally, the program was qualitatively strengthened with new management and fiscal resources, and the initiation of outcomes measurement.

Progress in FY2009

In FY2009 the ICG program received 1041 requests for applications. Of the 189 applications returned to the ICG program for eligibility determination, 68 grants were awarded this fiscal year. This is an increase of seven awards over FY2008. In FY2008, 203 youth were served in community-based care out of the 496 youth in the program which represented 41% of the total population, and is consistent with the percent served in community based care in FY2007. In FY2009, the ICG program served a total of 445 youth, a decline of 51 recipients from FY2008. Of these, 175 ICG youth (39.3%) were served in community-based treatment as of June 30, 2009 representing a slight proportionate decrease compared to FY2008. As of June 30, 2009, there were 369 active grants in the ICG program.

As of April 2009 administrative procedures were transitioned to the Illinois Mental Health Collaborative for Access and Choice (hereafter the Collaborative), the administrative service organization for the Division of Mental Health. This transition involved the implementation of the Illinois Medicaid Rule (59 Illinois Administrative Code 132) for fee-for-service billing by the Collaborative. All treatment encounters were

billed as fee for service in accordance with the State of Illinois Community Mental Health Services Service Definitions and Reimbursement Manual. To accomplish the transition to fee-for service under Medicaid, weekly technical assistance calls were made with providers in order to address questions pertaining to ICG policy, procedures, and billing. Additionally, an ICG Services Provider Manual was written and posted on the collaborative website. At this point the transition is completed. ICG recipients did not experience any interruption of services due to the transition of administrative procedures to the Collaborative as the Individual Treatment Plans and mental health services that were in place for each recipient at the time of transition remained in place.

In FY2009 the ICG program began the implementation of the Ohio Scales and the Columbia Impairment Scale as outcome measures for ICG recipients. Residential and community-based providers now report this data on a quarterly basis. This information is available for provider review and analysis of treatment progress of ICG youth. From July 1, 2008 to July 1, 2009 outcome baselines utilizing the Ohio Scales and the Columbia Impairment Scale were obtained. This data is currently being processed.

Background: The DMH Individual Care Grant **(**ICG) Program provides funds for residential treatment or intensive community treatment for children and adolescents with serious emotional disturbances who meet the criteria of severe mental illness and impaired reality testing. The ICG program is unique in the sense that parents do not have to relinquish custody of their children to obtain these services. The ICG program is family driven, meaning that families make the decision regarding whether they wish to utilize their grant for residential or community based services. These decisions are generally made with consultation from the mental health providers working with the family. An ICG Advisory Council was established in FY2001 and continues to provide input to planning and service delivery.

Community-based ICG services are available across the state and are coordinated through agencies funded to provide SASS services. SASS agency staff work with families to identify appropriate support services and the agency serves as a fiscal agent by purchasing the services specified in the approved plan and monitoring their effectiveness in meeting the youth's clinical needs. Services provided include intensive, home-based support, treatment, and therapeutic stabilization services that allow the child to remain at home.

For some youth, the Community Based ICG program serves as an excellent "step down" transition from residential care, for others, the community-based services are effective in preventing the need for institutional placement. Community-based ICG services are also an effective transitional support for the movement from child and adolescent services to adult services. Considerable efforts have gone into providing up to twelve months of post ICG funding to facilitate transitional integration into the community and into the adult service system. The program offers a number of supports, including child support services, case coordination services, behavior management services, and therapeutic stabilization services. Collaborations have been developed between special recreation

associations and community SASS programs to assist youth in developing supportive relationships and new behavior patterns in the community.

Public Awareness Campaign

Objective C1.5. In collaboration with the Children's Mental Health Partnership, continue to advance the public awareness campaign to reduce negative portrayals associated with mental illnesses. Expand the focus to greater access to mental health services and the interaction of mental health, the experience of violence, and applicable prevention/intervention efforts .

Indicators:

- **Number of focus groups or expert panels conducted by contractor to obtain information to evaluate and expand the campaign.**
- **Materials developed for dissemination that address resource and access issues.**
- **Materials developed for dissemination that address the interaction of mental health, mental illness, and violence.**
- **A report of the key achievements of the campaign and the significant public venues utilized to bring the message to all the citizens of Illinois.**

The DMH "Say It Out Loud" Campaign is directed to adults, children and families. This objective is the same as Objective A1.9 in the Adult Report. For a report of the campaign's progress in FY2009, see the Adult Report-Summary of Areas section.

ICMHP Grants

The Report of the President's New Freedom Commission on Mental Health noted that the "stigma that surrounds mental illnesses is one of three major obstacles preventing Americans with mental illnesses from getting the excellent care that they deserve". The Illinois Children's Mental Health Partnership, in collaboration with DMH, has emphasized educating the public and other key target audiences about the importance of children's mental health. One way in which to address this issue is to implement strategies geared toward reducing the stigma families and children experience when afflicted with serious emotional disturbances and mental disorders. Grants were awarded to 15 community groups (e.g., schools, non-profit organizations) for the development of locally targeted Say It Out Loud campaign efforts. An example of such an effort involved the Child Abuse Council, Transitions Mental Health Services, and NAMI of Rock Island and Mercer Counties. As a recipient of the Say It Out Loud grant, the Child Abuse Council partnered with Transitions Mental Health Services and NAMI to offer a free movie and pizza event at a local theatre in November. The movie- "The Soloist" was shown followed by a short panel discussion.

Criterion II:

Child and Adolescent Outcomes Analysis

Objective C2.1: By the end of FY2009, all DMH funded child serving agencies will be able to participate in the web-based Clinical Outcomes Analysis system and initial reports showing data trends in service outcomes will be produced and disseminated.

Indicators:

- **Number of agencies participating by the end of FY2009.**
- **A system-wide data report will be generated, approved and disseminated.**

This objective has been successfully accomplished. The web-based Outcomes Analysis System was initiated in July of 2008. Implementation of the system has gone well. As of the end of FY2009, 142 agencies were participating. The system-wide data report generated in June 2009 was based on the input from 1,934 users of the system. As of June 1st 19,796 youth had received assessments and 29,724 Ohio Scales had been completed. Reassessment occurs every 90 days. Comparatively, the statewide Initial Problem Ohio Score was 23.35 and the 90 day Problem Ohio Score decreased to 19.01. The statewide Initial Functioning Ohio score was 46.34 and the 90-day Functioning score increased to 49.44.

As of October 15th, 145 agencies were participating with 1923 users in the system. A total of 24,033 youth have received assessments and 44,421Ohio scales have been completed. The average initial score statewide on the Columbia Scale-Parent Version was 22.48 and 22.33 at the 90 day reassessment. On the Columbia Scale – Youth Version, the statewide initial score was 17.92 decreasing to 16.17 at 90 days. The Initial Ohio Problem Score was 23.48 decreasing to 19.96 at 90 days (a 17% reduction), and the Initial Ohio Functioning Score was 46.25 increasing to 48.94. These results indicate improvement in the youth who have so far been assessed and it is clear that the youth in receiving services from the public mental health system are overall, making progress in their care.

Background: DMH has required C &A providers to participate in a web based outcomes analysis system effective on 7/1/09. This system allows families, providers, supervisors, agency directors and the state mental health authority to access data which can be used to inform decisions regarding effectiveness of service, training needs of the system, and a description of the system as a whole. Clinicians use the OHIO Scale and families and youth complete the Columbia Impairment Scale on a quarterly basis. Training efforts have been underway to orient the child serving agencies to effectively utilize these instruments and technologies. Web based training was provided utilizing a train – the – trainer model to orient staff to the web based system. Training was also provided in the fall of 2008 on the Ohio Scales, and a monthly TA call and Net meeting is held for users of the system.

In FY2010 the Outcomes system is being expanded to include the Devereux Early Childhood Assessment Scales (DECA), an instrument to be used with children age 0 – 5.

The DECA assessments for infants, toddlers and clinicians will be added to the web system and trainings will be held for providers on both use of the instruments and mental health work with young children.

Criterion III:

Mental Health and Juvenile Justice

Objective C3.1. In FY2009, increase the number of youth receiving services through the Mental Health Juvenile Justice Initiative (MHJJ)
Indicators:

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

This objective has been accomplished. In FY2009, 621 youth were enrolled in the program, 82.5% were successfully linked to services, and 23.2% were re-arrested. Of 1,456 youth referred to the program, 706 (49%) were screened for eligibility, 651 were found eligible and 95% of those eligible were enrolled for services. When compared to data for FY2008, (when 1,395 youth were referred, 741 screened, 689 found eligible, and 592 were enrolled) the number enrolled in the program increased by 5% in FY2009. The number linked has been maintained and the number of youth rearrested has declined slightly (3.7%).

In FY2009, minority enrollment continued to increase. This trend is consistent with FY2008 findings. It is also reflective of the MHJJ program's targeted outreach to, and education of, referral sources regarding minority youth with serious mental illnesses. Both the percentage of minority youth referred (51.7%) and the percentage of minority youth enrolled (54.9%) increased this fiscal year. This will continue to be a priority objective for the program particularly in light of the overrepresentation of minority youth in the juvenile justice system.

Background: Mental Health Juvenile Justice Program (MHJJ) is designed to divert youth, with serious mental illnesses, from the juvenile justice system and into community-based care. The Division of Mental Health initially funded MHJJ as a pilot project in 2000 in just seven counties and was subsequently expanded to each of the 17 Illinois counties with a detention center and one county without a detention center. The program was initially conceived as an alternative to secure detention, though eligibility criteria have been expanded to intercept youth at the earliest stages of justice involvement. In FY2008 two additional community agencies in Cook County offered MHJJ services with the goal increasing outreach and linkage to the Latino community. The MHJJ program now covers 34 Illinois counties, involves 21 community agencies and has approximately 60 staff.

The MHJJ program aims to strengthen the linkages among the courts, probation, detention, schools, mental health, and other community-based services. In addition, MHJJ recognizes family engagement at all levels is vital to achieving best outcomes.

Consistent with this priority, a number of MHJJ agencies have been able to offer parent – to-parent support through their Family Resource Developers. Youth are referred to the MHJJ program from a variety of sources (judges, attorneys, probation officers, etc). Specially trained MHJJ liaisons then screen the youth for the presence of a serious mental illness such as a major affective disorder or psychosis. Once found eligible, a functional assessment is conducted. This assessment not only identifies areas of functional impairment, but also areas of strength that can be leveraged in the development of an individualized action plan. Based on the action plan, MHJJ liaisons link youth with appropriate community-based services and continue monitor the progress of each youth for a period of six months. Access to a flexible spending is available to supplement the youth's treatment ancillary services or family stabilization for which no other source of funding is available.

In FY2010, the overall mission of MHJJ remains unchanged and liaisons are continuing to increase their efforts to intercept youth at the earliest stages of their justice involvement. The program is working to increase the quality of services, especially the components which have been found to be associated with positive outcomes such as: the number of service sessions offered, individual treatment (therapy and substance abuse), and case management. Ongoing MHJJ evaluation findings have indicated that parent engagement is associated with the most positive outcomes. As a result, a focus of program enhancement in FY2010 will be on family engagement and working with agencies to increase the number of parent liaisons available. In addition, increasing the rate of program completion will also be a key objective. The annual evaluations and outcome analyses of the program have consistently demonstrated that completion of the MHJJ program is associated with overall clinical improvement, decreased functional impairment, and reduced rates of recidivism for youth.

Mental Health Transitional Services

Objective C3.2: During FY 2009, continue to monitor and evaluate each transitional service site with special emphasis on: determination of appropriate utilization rates and service outcomes; identification of effective intervention strategies; and identification of regional similarities or differences relevant to service need and delivery.

Indicators:

- **Total number of transitioning youth served at each site.**
- **Total amount of services reported and Medicaid billed to DMH's electronic data reporting system.**
- **Provider documentation of outcomes, lessons learned, gaps and challenges in the service system, networking, and successful or promising service delivery strategies and/or innovations.**
- **Number of meetings held with all the providers to share experiences and solutions to problematic issues**.

This objective has been successfully accomplished. By the end of FY2009, the transitional pilot programs served a total of 435 youth. Of these, 320 were youth

ages 16-18, with Serious Emotional Disturbance who required transitional services and 115 were transitioning from juvenile justice settings. Transition age and newly paroled youth and their families received 5,060 hours of direct clinical, case management and support services and a total of $175,000 was billed to Medicaid. Providers submitted a quarterly statistical and narrative report detailing program operations and service outcomes. As part of that report, the providers documented lessons learned, gaps and challenges in developing their local system of care, networking activities, and successful or promising service delivery strategies and/or innovation.

The challenges providers experienced were:

- **Engaging families or other significant supports in the treatment process,**
- **Maintaining youth in treatment, and**
- **Obtaining financial resources to assist youth with daily expenses like transportation and housing.**

Successes reported by providers were:

- **Establishment of working relationship with local providers of adult mental health services,**
- **Implementation of groups designed to assist youth toward developing adult life skills, and**
- **Demonstration of significant improvement in functioning by those youth engaged.**

Providers and the DMH monitor met every other month during FY2009, a total of six (6) meetings were held. The meetings were designed to serve as a learning community in which participants shared experiences in implementing services and forming collaborations/networks. When needed, the providers collectively solved problems presented for the group's consideration. These pilot programs have provided vital information as to the service models and intervention strategies that work best for the target population groups addressed.

Background: DMH, in collaboration with ICMHP, solicited proposals to develop and provide mental health services that address the unique and special needs of older adolescents (16-17 years old) with SED who are transitioning from C&A services to adult services and for any youth with mental health needs and/or social/emotional impairment who is transitioning from correctional services to the community. In FY2007 and FY2008, DMH awarded a total of ten (10) pilot sites for $1,000,000 in statewide funding. In addition to providing an array of mental health services, all projects were expected to build community infrastructure that will facilitate and support expansion of transition services for youth and the effectiveness of services, as well as development of a system of care for transitioning youth. During FY2008, the ten (10) grant programs registered and served 245 youth with SED and 38 youth of various ages who returned to the community from the Illinois Department of Juvenile Justice. In FY2010, due to fiscal constraint and the lack of continuation funds, the five pilot programs originally funded for a three-year period in FY2007 have been discontinued. The five programs funded in FY2008 are continuing, one in each DMH region. The ICMHP and DMH are evaluating the data and information gained from the pilots so far with the aim of developing plans for statewide services to transitional youth for possible implementation in FY2011.

A salient concern expressed by members of the Illinois Mental Health Advisory Council has been that the pilots are focused on serving 16-18 year olds when adequate transitional support is required for young adults up to age 25. Programs that can cover the appropriate age range for the provision of adequate services to transitioning youth continue to be sorely needed. The Council (C&A Services Committee and the Council as a whole) has recommended that the age range for these projects be extended. The recommendation is currently under consideration in DMH.

Early Intervention

Objective C3.3: **In FY 2009, continue to monitor and evaluate each early intervention site with special emphasis on: determination of appropriate utilization rates and service outcomes; identification of effective intervention strategies; identification of regional similarities or differences relevant to service need and delivery; and identification of opportunities for additional expansion of the initiative to more providers and communities.**

Indicators:

- **Total number of children and families served by the end of the fiscal year.**
- **Total amount of services reported and Medicaid billed to DMH's electronic data reporting system.**
- **Provider reports that document outcomes, lessons learned, gaps and challenges in the service system, and networking outcomes.**
- **Provider documentation of successful or promising service delivery strategies, innovations and/or service models.**
- **An initial report documenting outcomes, lessons being learned, gaps and challenges in the service structure, and successful innovations in early intervention services to children and families is drafted, reviewed, approved, and disseminated.**

This objective has been substantively accomplished.

During FY 2009, agencies funded to provide early intervention services served 609 registered consumers and 891 unregistered consumers. They provided an array of clinical, case management, and support services. Direct service hours provided to consumers who were registered totaled 6,500 and 1,200 hours were provided to unregistered consumers. A total of $84,530 was billed to Medicaid. Providers submitted quarterly statistical and narrative reports that detailed program operations and service outcomes and incorporated documentation of lessons learned, gaps and challenges in developing the local system of care, networking activities, and successful or promising service delivery strategies and/or innovation. A fiscal year report was submitted to DMH Child and Adolescent Services leadership and to the leadership of the Illinois Children's Mental Health Partnership.

Successful engagement strategies identified in the quarterly reports included: (1) Services provided at daycares and pre-schools yield the best engagement outcomes

for the 0 to 5 year old group. (2) For older children providing services within the school setting is the most successful approach but parent participation is frequently lacking, and (3) Addressing the parent-child relationship is the most successful strategy in treating the behavior issues of young children.

Background: The Mental Health Early Intervention Initiative is a granting opportunity to agencies with the aim of identifying children and adolescents at risk, especially those at risk of mental health or social/emotional impairment, and to intervene early. Case finding needs to go on in venues outside the normal service paths for children with serious disturbances. In FY2007and FY2008, $1,000,000 was awarded to ten agencies. Two agencies in every region are now in a position to coordinate early intervention services. Flexibility has been emphasized as each agency developed its own plan and approach to early intervention based on the unique geographic, cultural, and interagency service environments in each region. A major goal of this initiative is to identify and engage children and adolescents with mental illness or social/emotional problems who are untreated, and those at risk of serious emotional disturbance or social/emotional problems. The objectives of this initiative are to work towards implementing a statewide system of early intervention services and to develop a network of providers. In FY2010, due to fiscal constraint and the lack of continuation funds, the five pilot programs originally funded for a three-year period in FY2007 have been discontinued. The five programs funded in FY2008 will continue, one in each DMH region. The ICMHP and DMH are evaluating the data and information gained from the pilots so far with the aim of developing a plan for statewide early intervention services with implementation possible in FY2011.

Early Childhood Mental Health

Objective C 3.4: During FY 2009, through monitoring and program evaluation determine whether each Early Childhood Mental Health program achieved the service and system development requirements of their grant and collaborate with providers to delineate program outcomes, identify unmet needs, identify strategies to address needs and gaps in each service region, and develop recommendations for evidence informed and best practice models in early childhood mental health that Illinois should consider implementing.

Indicators:

- **The number of children ages 0-5 served in FY2009.**
- **A description of services provided to children and their families/caretakers and the number of service hours provided for each service in FY2009.**
- **Number of meetings convened with participating providers to share information on best practices, program outcomes, unmet needs, and strategies to address service gaps and needs.**

This objective has been accomplished:

During FY2009 a total of 232 registered and 60 unregistered infants and young children and their families received clinical, case management and support services from providers funded by the initiative. More than 4,000 direct service hours were

delivered and over $60,000 was billed to Medicaid. The five most reported services delivered in the order of prevalence were: therapy or counseling with families, community support to an individual, case management/collaboration, mental health assessment, and therapy or counseling to an individual. Six (6) meetings were convened with participating providers during FY2009 that were designed to be a learning community in which participants shared experiences in service implementation, the development of collaborations and networks, and collective problem solving. This initiative is continuing in FY2010.

Background: The Early Childhood Mental Health Program was established during FY2008. DMH Child and Adolescent Services and the Illinois Children's Mental Health Partnership (ICMHP) have identified early childhood mental health as a priority in Illinois and collaborated in the release of a Request for Service Plan (RSP) that invited applications to provide an array of developmentally appropriate mental health services to children ages 0-5 who are experiencing mental health and/or social/emotional development problems. Five (5) child-serving mental health providers, one in each of the five regions, were funded to: a) provide mental health assessment and treatment services to children age 0 – 5 years with psychological or social/emotional development needs; b) provide parent support services to families of eligible children; c) provide services that are child focused and family driven: and d) develop connections to referral systems/networks for early childhood.

Criterion IV:

Objective C4.1: Implement a Tele-psychiatry pilot project in seven rural sites in Illinois. Establish baseline for service utilization and assess the need for further enhancement and expansion in FY2010.
Indicator:

- **Number of youth served in FY2009**
- **Number of psychiatry hours provided in FY2009.**

This objective has been met. A Tele-psychiatry pilot project was implemented in FY2009. in two predominantly rural regions in the State. Services began in July 2008. One agency opted out shortly before the project began, leaving six agencies in the two regions equipped to carry out tele-psychiatric consultations. By the end of FY2009, 168 children/adolescents and their families had benefited from Tele-psychiatry services and 939 psychiatry hours had been provided. Further enhancement and expansion is not realistic in FY2010 due to current fiscal constraints. The needs assessment for these services is continuing with a vision for possible implementation in the next fiscal year.

Background: In FY2008, DMH budgeted approximately $300,000 for a pilot project which allows six agencies to each purchase $50,000 of qualified psychiatric consultation time to be provided through a Tele-Psychiatry approach ranging from informal case discussions to formal case reviews, and a telemedicine approach in which the child is present for assessment. The Tele-psychiatry initiative was established in Regions 4 and

5. Six agencies are now involved in the two regions. The project was awarded in February 2008 to Aunt Martha's Youth Services as the vender. Services include assessment, treatment and ongoing monitoring of youth.

Criterion V:

Increasing Federal Financial Participation (FFP)

Objective A5.1/C5.1. Increase Medicaid funding for the Illinois mental health service system. This will be accomplished by:

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

Indicator:

- **Amount of FFP generated in FY 2009.**

This continuing objective has been accomplished.

Medicaid Billing for Children and Adolescents cannot be broken out. Therefore the combined figures given below meet the requirements for this objective. Please see the Adult Report on this objective for further detail and background.

Final figures for FFP in FY2009 are not as yet available. As of mid-November 2009, Medicaid billing for FY2009 stood at $166,063,587. FFP Trust Fund deposits for FY2009 stood at $83,031,793. As billing and reimbursement for the previous fiscal year continues well into FY2010, it is anticipated that the final figure will exceed this amount. In FY2008, $86,875,992 was deposited. $84.4 million was deposited in the Trust Fund in FY2007.

Medicaid billing has risen substantially over the years. In FY2005 Medicaid billing for adults had risen to $129,028,640 and in the following year it was $149,599,641. By FY2007 it rose to $164,742,868 and increased substantially in FY2008 to $173,751,984. Currently it is difficult to estimate the final level of the Medicaid billing and Trust Fund deposits due to (1) a decrease in the number of individuals served in FY2009 attributable to the impact of the economic recession that occurred in the final quarter of FY2009 and (2) the recent restructuring of the MIS data system which initially delayed submission, analysis, and reporting processes. As a result some billing for FY2009 is still being processed.

Child - Report Summary of the most significant events that impacted the mental health system of the State in the previous FY

NARRATIVE: CHILD- SIGNIFICANT EVENTS AND CHANGES IN FY2009

REPORT ON THE 2009 CHILD PLAN

Developments and Issues Affecting Mental Health Service Delivery

The following are significant events related primarily to Child & Adolescent Services.

Impact of the Economic Recession
See this section in the Adult Report for a discussion of how this event has negatively impacted services to both adults and children.

Family Driven Care
In FY2009, Illinois was one of six states to receive a limited award to develop an initiative addressing family driven care. Family Driven Care as defined by the Federation of Families for Children's Mental Health, means that families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes:

- Choosing culturally and linguistically competent supports, services, and providers;
- Setting goals;
- Designing, implementing and evaluating programs;
- Monitoring outcomes; and
- Partnering in funding decisions.

Members of the C&A Statewide staff attended a policy academy in which planning and implementation approaches were discussed. The award covered travel expenses and technical assistance costs over a period of six months. So far, a commission on Family Driven Care has been established and efforts are underway to conduct regional surveys of mental health needs and to assess family and provider satisfaction with the services currently available and the extent to which the system is responsive to the needs and issues encountered by families of youth with serious emotional disturbances.

Family Participation
In FY2009, Family Consumer Specialists (FCS) have been hired as C & A staff members of DMH in each region of the state. Four new full time positions were added statewide in FY2008. The fifth FCS staff member was hired for the Southern Region of Illinois in October of 2008. All five of the DMH regions now have a Family Consumer Specialist actively involved.

In FY2009 Family Advisory Councils were established in each DMH Region. These councils are composed of family members and youth who provide both a regional and statewide voice for family and consumer needs. Convened by the Family Consumer

Specialists, these councils are now providing input and feedback on a variety of issues confronted in the Child and Adolescent service system.

Public Awareness Campaign

In FY2008 and FY2009, DMH established and implemented its public awareness initiative targeting adults and children by launching the **Say It Out Loud** campaign which is continuing. Say It Out Loud is a groundbreaking statewide campaign to promote good mental health. It is co-sponsored by IDHS/DMH and the Illinois Children's Mental Health Partnership. (See this section in the Adult Report.)

Systems Integration

The DMH continued collaborations with many system partners including, collaboration with the Education system on the Positive Behavior Interventions and Support Model. The DMH continued its partnership with the Illinois Department of Healthcare and Family Services (the Illinois Medicaid agency) and the Illinois Department of Children and Family Services (the Illinois Child Welfare Agency) on the purchase of Screening, Assessment and Support Services (SASS) for children and adolescents and their families.

Information Technology

DMH continues its efforts to refine and streamline data collection efforts to provide information that supports decision-making in children's services. DMH, working with the Mental Health Collaborative for Access and Choice (MHCAC), has redesigned and implemented a new management information system (MIS). All child-serving providers are now reporting data to this new system.This work included the development of a data warehouse that houses eligibility, registration, billing/services information, a provider database, and service authorization in one place.

Grants

DMH completed the SAMHSA System of Care-Chicago in FY2009. A second System of Care grant focusing on McHenry County originally awarded by SAMHSA in 2006 is continuing. In McHenry County, Family CARE stands for Child/Adolescent Recovery Experience and is a $9 million, six –year federal grant designed to involve families and youth in decision making related to treatment, goal-setting, designing and implementing programs, monitoring outcomes and determining the effectiveness of efforts that promote the well-being of children and youth. The grant is designed to improve access to services for five underserved populations who present with mental health and substance abuse issues: preschoolers with serious social/emotional problems, youth with mental disorders, youth with co-occurring mental health and substance abuse issues, young adults 18-21 years old, and Latino children.

As noted above, Illinois was one of six states that received a SAMHSA award which paid expenses to participate in a policy academy focused on Family Driven Care. This project has supported collaboration with other child serving systems and supporters (DCFS, ISBE, CHP, DJJ, DASA, IFF, ICMHP) to address the extent to which the system is Family Driven.

Two new System of Care grants have just been awarded to Illinois. The Division of Mental Health in collaboration with Champaign Mental Health Board (PROJECT ACCESS) and Egyptian Department of Health (PROJECT CONNECT) will implement the proposed system of care projects for youth with serious emotional disturbances and their families. Both grants are for $9 million each over a six-year period. The mission of these projects is to provide a system of care that is family-driven, youth-guided, strengths based, sustainable, culturally and linguistically competent.

Early Childhood Mental Health

The Early Childhood Mental Health Program was established through the collaboration of DMH Child and Adolescent Services and the Illinois Children's Mental Health Partnership (ICMHP) during FY2008 and continued in FY2009 with five funded pilot projects. The projects:

a) Provide mental health assessment and treatment services to children age 0 – 5 years with psychological or social/emotional development needs;
b) Provide parent support services to families of eligible children;
c) Provide services that are child focused and family driven: and
d) Develop connections to referral systems/networks for early childhood.

Child and Adolescent Outcomes Analysis:

A Web-based Clinical Outcomes Analysis system was completed and training of users had begun by the end of FY2008. The system consists of four measures: (1) The OHIO Scale-Worker version; (2) The Columbia Impairment Scale for Parents; (3) The Columbia Impairment Scale for Youth; and (4) Goal Attainment Scaling methodology (optional). The instruments are used at case opening, quarterly thereafter, and at closing. Users of the web-based system will be able to generate immediate feedback reports at each level of service. Clinicians are now able to generate reports and graphic profiles on their individual clients across specified time periods that are shared with the client and family. Access to this data is a valuable benefit to the client and family as a means of being able to see, use, and share an objective assessment of progress and accomplishments as well as identification of issues to work on. A term coined to describe this aspect is "refrigerator art"- something posted in a common place for all the family to see. The system was operational in FY2009 and aggregated data reports have been generated.

Tele-psychiatry

Recent legislation supported the establishment of the tele-psychiatry pilot project for children and adolescents which had its first year of actual implementation in FY2009. (See Objective C4.1-this Report) The experience and results of this project are pointing the way toward further development of this valuable resource.

Training in Trauma-Related Treatment

The Illinois Department of Children & Family Services (DCFS) has conducted a training initiative for child welfare staff and service providers to examine and respond to the trauma children and families have experienced as a result of physical abuse, neglect, sexual abuse and domestic violence and its impact on behavior, performance, and

adjustment to foster care and other supportive environments. The DMH statewide Child and Adolescent Services office has participated in the development of the initiative. In FY2008, funding was provided through the Illinois Children's Mental Health Partnership to expand this education and training initiative to mental health providers. DMH C&A staff worked closely with DCFS to adapt the components of the DCFS approach to a broader population and develop an effective training model to support mental health trauma work with children. The Train-the Trainer phase was completed in FY2008 and certified trainers are delivering training to DCFS and DMH funded provider staff in FY2009.

Child - A report on the purpose for which the block grant monies for State FY were expended, the recipients of grant funds, and a description of activities funded by the grant.

NARRATIVE: CHILD-PURPOSE OF BLOCK GRANT EXPENDITURES AND ACTIVITIES IN FY2009

REPORT ON THE 2009 CHILD & ADOLESCENT PLAN

Expenditure Of Block Grant Dollars In FY2009

The Illinois plan for the expenditure of the FY 2008 Community Mental Health Services Block Grant was directed at providing services in community settings for children and adolescents with serious emotional disturbances. The Illinois block grant fund amount for FY2009 was $16,103,252. Slightly less than 5% ($684,388) of this amount was expended on administrative expenses. A table detailing allocation of dollars to agencies providing services to adults and children has been included in the appendix.

In FY2009, block grant dollars were allocated (for adults and children combined) as follows:

- Community Consumer Support - $3,392,210.00
- Psychiatrist Services In Mental Health Centers (Psychiatric Leadership)- $11,619,701.00
- Special Projects - $180,000.00

Approximately 23% of block grant funds are allocated to C&A Services For FY2010, block grant funds will be directed toward the following community-based services for youths with serious emotional disturbances: psychiatric services and crisis services. The child and adolescent funding allocation of mental health block grant dollars is consistent with the State Mental Health Plan for Children and Adolescents.

Allocations to specific agencies for service provision to Children and Adolescents are displayed in Table 10 which is appended.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☑

Name of Implementation Report Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	141,807	142,492	142,000	129,419	91.14
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: To monitor access to services.

Target: Maintain or increase access to services for adults with mental illnesses at the FY 2008 level.

Population: Adults with mental illnesses.

Criterion: 2:Mental Health System Data Epidemiology
3:Children's Services

Indicator: Increased access to services

Measure: Number of adults receiving services from DMH-funded community-based providers.

Sources of Information: DMH ASO Community Reporting System and data warehouse. This indicator is generated from URS Tables 2A and 2B

Special Issues:

Significance: Adults with mental illnesses should have access to treatment.

Activities and strategies/ changes/ innovative or exemplary model: DMH will continue to collect data to track the number of persons receiving services from DMH-funded community-based providers in FY 2010. DMH community funded providers by contract must submit registration and claims data for all individuals receiving services funded using DMH dollars. Data is submitted daily or weekly to the community reporting system maintained by the DMH's Administrative Services Organization (ASO), the Illinois Mental Health Collaborative For Access and Choice. Once this data is processed, it is then transferred to the DMH Data Warehouse for storage. This information is then used to develop reports that are the basis for the URS tables.

Target Achieved or Not Achieved/If Not, Explain Why: Not Achieved. There was approximately a 10% reduction in the number of individuals receiving treatment in FY 2009. At this point in time, it is unclear why this occurred.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	15.99	13.39	15	13.19	113.72
Numerator	1,785	1,366	--	1,353	--
Denominator	11,165	10,205	--	10,256	--

Table Descriptors:

Goal: To decrease readmissions of individuals to state hospitals within 30 days by providing treatment that results in sufficient clinical stabilization so that subsequent treatment is provided in the least restrictive setting.

Target: Maintain or decrease readmissions within 30 days to state hospitals.

Population: Adults with serious mental illness.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 Days

Measure: Numerator: Number of adults readmitted to a state hospital within thirty days of being discharged from a state hospital.
Denominator: Total number of civil discharges from state hospitals in a fiscal year.

Sources of Information: Inpatient Clinical Information System (CIS).

Special Issues:

Significance:

Activities and strategies/ changes/ innovative or exemplary model: DMH will continue to monitor the number of adults readmitted to state hospitals within 30 days of discharge with the goal of decreasing the level of re-hospitalization by providing services in the community that provide alternatives to hospitalization. Please note that although the DMH has as a goal decreasing the utilization of state hospitals, individuals with serious mental illnesses may at times, need access to inpatient hospitalization.

Target Achieved or Not Achieved/If Not, Explain Why: Achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	11.43	23.37	11	22.86	48.12
Numerator	1,276	2,385	--	2,345	--
Denominator	11,165	10,205	--	10,256	--

Table Descriptors:

Goal: To decrease readmissions of individuals to state hospitals within 180 days by providing treatment that results in sufficient clinical stabilization so that subsequent treatment is provided in the least restrictive setting.

Target: Maintain or decrease the percentage of readmissions within 180 Days to state hospitals.

Population: Adults with Serious mental illneses.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 Days

Measure: Numerator: Number of civil readmissions to any state hospital within 180 days.
Denominator: Total number of civil discharges in the year.

Sources of Information: DMH Inpatient Clinical Information System.

Special Issues: Please note that an incorrect value of 11.43 was reported for FY2007. The FY2008 actual reported value of 23.37 is however correct. FY2009 and FY2010 projections are based on this value.

Significance:

Activities and strategies/ changes/ innovative or exemplary model: DMH will continue to monitor the number of adults readmitted to state hospitals within 180 days of discharge with a FY 2009 goal of maintaining or decreasing the level of re-hospitalization by maintaining services in the community that provide alternatives to re-hospitalization.
DMH continues to implement initiatives that provide community-based alternatives to inpatient hospitalization. However, individuals with serious mental illnesses may still require access to inpatient treatment.

Target Achieved or Not Achieved/If Not, Explain Why: Not Achieved. The FY 2009 target was based on the FY 2007 data that was inaccurate. This resulted in a large underestimate with regard to rehospitalizations within 180 days.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	2	2	3	3	100
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: To maintain the availability of EBPs within the state

Target: Maintain/increase number of EBPs available within the state.

Population: Adults with serious mental illnesses.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of EBPs Implemented in Illinois

Measure: Number of EBPs Implemented in Illinois

Sources of Information: DMH ASO Community Reporting System and structured program reports collected by DMH staff from community agencies.

Special Issues: EBPs are very difficult to implement requiring the dedication of many resources. However, DMH has a goal of increasing the number and type of EBPs provided within the state. During the past few years, DMH has focused on Supported Employment (SE), Assertive community Treatment (ACT) and Permanent Supported Housing (PSH). Although there is much discussion with regard to Integrated Dual Diagnosis Treatment, Illness Self-Management, and Medication Algorithms there is still much work to do in this arena.

Significance: Adults with serious mental illnesses should have access to evidence-based practices.

Activities and strategies/ changes/ innovative or exemplary model: As discussed in the narrative, DMH worked with its ASO to implement a new Community Services Reporting System in FY2009. DMH community funded providers by contract must submit registration and claims data for all individuals receiving services funded using DMH dollars. Data is submitted daily or weekly to the community reporting system maintained by the DMH's Administrative Services Organization (ASO), the Illinois Mental Health Collaborative For Access and Choice. Once this data is processed, it is then transferred to the DMH Data Warehouse for storage. This information is then used to develop reports. The DMH has created special codes for the reporting of ACT and to some extent, SE. Data related to PSH will be collected in FY 2010.

Target Achieved or Not Achieved/If Not, Explain Why: Target Achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Evidence Based - Adults with SMI Receiving Supported Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	N/A	150	N/A	N/A
Numerator	N/A	0	--	303	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: Provide Permanent Supported Housing to adults needing these services

Target: Increase the number of individuals with SMI receiving permanent supportive housing by 150 in FY 2009

Population: Adults with serious mental illnesses

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of adults with SMI residing in Permanent Supported Housing.

Measure: Numerator: Number of adults with SMI residing in permanent supported housing.

Sources of Information: This data will be generated from the DMH ASO community reporting system and a web-based database created especially for this initiative.

Special Issues:

Significance: Adults with serious mental illnesses who are in need of supported permanent housing should have access to it.

Activities and strategies/ changes/ innovative or exemplary model: The DMH has implemented Permanent Supportive Housing. DMH staff work with its ASO to receive and evaluate applications for permanent supportive housing. A web-based data base has been created to record this data. Data is also being collected to track the services and clinical/demographic characteristics of individuals residing in PSH.

Target Achieved or Not Achieved/If Not, Explain Why: Target Achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Evidence Based - Adults with SMI Receiving Supported Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	0	N/A	1,100	N/A	N/A
Numerator	1,100	1,738	--	2,026	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: Provide Supported Employment to individuals with SMI who want to receive this service.

Target: Maintain the availability of supported employment to those individuals receiving this service.

Population: Adults with serious mental illnesses

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of adults with SMI receiving supported employment.

Measure: Number of adults with SMI receiving supported employment

Sources of Information: Reports submitted to the DMH Central Office supported employment coordinator by agencies providing this service.

Special Issues: All SE data has not yet integrated been into the DMH ASO Community Reporting System; Data is being collected through a data base designed for this purpose.

Significance: Adults with serious mental illnesses who want to work should be able to secure competitive employment. Supported employment supports adults with SMI in their recovery.

Activities and strategies/ changes/ innovative or exemplary model: DMH staff have been working with DMH funded community providers to streamline reporting of data and to report in a more consistent manner. Data regarding some key services has been integrated into the DMH ASO Community Reporting System, however, data for key indicators related to fidelity and outcomes has not. DMH Decision Support staff are working to develop a web-based reporting system to collect this data. It is expected that the design will be complete and available for data submission by late FY2010.

Target Achieved or Not Achieved/If Not, Explain Why: Target achieved and exceeded.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Evidence Based - Adults with SMI Receiving Assertive Community Treatment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	0	0	0	N/A	N/A
Numerator	2,904	674	--	653	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: Provide access to assertive community treatment

Target: No target was established for FY 2009 due to the fact that ACT was revamped within the state to ensure that this EBP has fidelity to the national model.

Population: Adults with serious mental illnesses with multiple psychiatric hospitalizations

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of adults with SMI receiving ACT

Measure: Number of adults with SMI receiving ACT

Sources of Information: DMH ASO Community Reporting System..

Special Issues: During FY2009 DMH undertook an effort to ensure that assertive community treatment is being provided. All teams underwent a fidelity assessment this year. Fidelity assessments will also be undertaken in FY2010

Significance: ACT should be available to individuals who will benefit from this service

Activities and strategies/ changes/ innovative or exemplary model: DMH community funded providers by contract must submit registration and claims data for all individuals receiving services funded using DMH dollars. Data is submitted daily or weekly to the community reporting system maintained by the DMH's Administrative Services Organization (ASO), the Illinois Mental Health Collaborative For Access and Choice. Once this data is processed, it is then transferred to the DMH Data Warehouse for storage. This information is then used to develop reports. This system will be utilized to obtain data for FY2010.

Target Achieved or Not Achieved/If Not, Explain Why: Not Applicable (see above).

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Evidence Based - Adults with SMI Receiving Family Psychoeducation (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: NOT APPLICABLE: Currently developing a plan to implement family psychoeducation.

Target: No target; implementation planning underway

Population: Adults with mental illnesses.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of adults with SMI receiving family psychoeducation.

Measure: Number of adults with SMI receiving family psychoeducation.

Sources of Information: Not currently collected.

Special Issues: Planning is occurring-not yet implemented.

Significance:

Activities and strategies/ changes/ innovative or exemplary model: Planning is ongoing. Several agencies in one DMH region are piloting this EBP.

Target Achieved or Not Achieved/If Not, Explain Why: Not Applicable.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Evidence Based - Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders(MISA) (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: NOT APPLICABLE: DMH is currently undertaking planning to continue implementation of Integrated Dual Diagnosis Treatment (IDDT).

Target: No target; implementation planning underway

Population: Adults with co-occurring serious mental illnesses and substance abuse disorders.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of adults with SMI receiving IDDT services.

Measure: Number of adults with SMI receiving IDDT services.

Sources of Information: Not available.

Special Issues: IDDT is one of the more difficult EBPs to implement. Although DMH worked on a pilot project with community agencies to implement this EBP, widespread implementation has not occurred.

Significance: It has been estimated that 50% or more of individuals with serious mental illnesses have co-occurring substance abuse disorders. Integrated treatment is the most effective means of treating these disorders.

Activities and strategies/ changes/ innovative or exemplary model: DMH will continue its efforts to implement IDDT during FY2009.

Target Achieved or Not Achieved/If Not, Explain Why: Not Applicable.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Evidence Based - Adults with SMI Receiving Illness Self-Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: NOT APPLICABLE: Currently this EBP is not available in Illinois.

Target: No target; continuing efforts to implement this EBP.

Population: Adults with serious mental illnesses.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of individuals with SMI receiving Illness Self-Management.

Measure: Number of individuals with SMI receiving Illness Self-Management.

Sources of Information: Not currently collected.

Special Issues:

Significance: Illness self-management should be accessible to individuals with serious mental illnesses.

Activities and strategies/ changes/ innovative or exemplary model: The DMH will continue its work on planning for implementation of this service.

Target Achieved or Not Achieved/If Not, Explain Why: Not Applicable.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Evidence Based - Adults with SMI Receiving Medication Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: Not applicable--Currently this EBP is not available in Illinois.

Target: No target; continuing efforts to strenghten work in this area.

Population: Adult with serious mental illnesses with specified diagnoses receiving psychotropic medication.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of individuals with SMI receiving Medication Management.

Measure: Number of individuals with SMI receiving Medication Management.

Sources of Information: Not applicable.

Special Issues:

Significance: Medication management is a key to the provision of service resulting in positive outcomes for certain diagnoses.

Activities and strategies/ changes/ innovative or exemplary model: The DMH will continue its work to implement medication algorithms in state hospitals and community agencies during FY2010.

Target Achieved or Not Achieved/If Not, Explain Why: Not Applicable.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	63.03	60.42	66	N/A	N/A
Numerator	300	258	--	N/A	--
Denominator	476	427	--	N/A	--

Table Descriptors:

Goal: Provide services which increase consumer perception of positive treatment outcomes.

Target: Increase percentage of consumers with perception of positive treatment outcomes by 3%.

Population: Adults with mental illnesses receiving mental health treatment

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percentage of adult consumers reporting positively about outcomes.

Measure: Numerator: Number of adults reporting positively about outcomes using the MHSIP Adult Survey
Denominator: Total number of adult responses regarding perception of outcomes completing the MHSIP Adult Survey

Sources of Information: MHSIP Adult Consumer Survey - Reported in Table 11 URS Tables

Special Issues:

Significance: Mental health services should result in positive outcomes.

Activities and strategies/ changes/ innovative or exemplary model: DMH has selected a random stratified sample of individuals receiving treatment in June 2009. This sample is the basis for the survey which will be disseminated in December 2009. Data will be available by February 2010.

Target Achieved or Not Achieved/If Not, Explain Why: Not applicable--Data will be available by February 2010.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Adult - Increase/Retained Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	23.43	23.49	23	23.81	103.52
Numerator	30,004	28,199	--	26,172	--
Denominator	128,081	120,058	--	109,924	--

Table Descriptors:

Goal: Increase in competitive employment status by adults with mental illnesses receiving treatment

Target: General target is to increase competitive employment rate of individuals receiving treatment. However, currently this data is only collected at intake prior to treatment, therefore there is no expectation that there will be an increase. Such a target will be set when we begin collecting data at T1 and T2.

Population: Adults with mental illnesses receiving treatment

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Percent of adult clients who are competitively employed.

Measure: Numerator: Number of adult consumers competitively employed full or part time (includes supported employment) .
Denominator: Number of adult consumers competitively employed full or part time (includes supported employment) plus number of persons unemployed plus number of persons who are not in the labor force (includes retired, sheltered employment, sheltered workshops, and other). The denominator does not include persons whose employment status is "not available".

Sources of Information: DMH ASO Community Reporting System.

Special Issues: Change in status requires the ability to collect data at multiple points in time. These issues are still being discussed by the states, NRI and CMHS.

Significance: Employment is an important variable contributing to recovery.

Activities and strategies/ changes/ innovative or exemplary model: Employment is an important variable contributing to recovery.
Although the states, CMHS and the DIG State Data Infrastructure Coordinating Center are still working to define measures for change in Employment status for individuals receiving treatment,the DMH has implemented a policy that requires 6 month updates of employment status for consumers. This new requirement will be instrumental in helping to track this important variable across time. Once the quality of data is ascertained through a data integrity plan which is in process of being implemented, DMH will be able to report change in employment status. Employment status will continue to be reported on URS Table 4.

Target Achieved or Not Achieved/If Not, Explain Why: Not applicable.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Adult - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	66.67	80.77	N/A	N/A	N/A
Numerator	14	21	--	N/A	--
Denominator	21	26	--	N/A	--

Table Descriptors:

Goal: Decreased involvement with the justice system by adults with serious mental illnesses

Target: No target established due to developmental nature of indicator.

Population: Adults with serious mental illnesses who have had involvement with the justice system

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percent of adult consumers arrested in Year 1 who were not rearrested in Year 2.

Measure: Numerator: Number of adult consumers arrested in T1 who were not rearrested in T2 (new and continuing clients combined).
Denominator: Number of adult consumers arrested in T1 (new and continuing clients combined).

Sources of Information: This indicator was collected using the MHSIP Survey in FY 2008 and will be collected again by this method in FY 2009.

Special Issues:

Significance: There is an expectation that adults receiving mental health services who have been involved with the justice system will decrease this involvement, however questions remain regarding the appropriateness of this measure.

Activities and strategies/ changes/ innovative or exemplary model: Illinois will collect this data using the MHSIP Consumer Survey in 2009; however, due to the small response rate and the developmental nature of the measure no target was been established for FY 2009.

Target Achieved or Not Achieved/If Not, Explain Why: Not applicable.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Adult - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	5.03	5.52	5	4.58	109.17
Numerator	6,649	7,414	--	5,554	--
Denominator	132,060	134,288	--	121,392	--

Table Descriptors:

Goal: Improve stability of housing for adults with serious mental illnesses

Target: Decrease the number of individuals who are homeless. However, since currently this data is collected only at intake prior to treatment we do not expect change to occur, therefore no target is projected. Once we begin to track data at T1 and T2 we will specify a target. The data reported simply reflects status at intake.

Population: Adults with serious mental illnesses

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Increased Stability in Housing.

Measure: Numerator: Number of adult consumers who are homeless or living in shelters.
Denominator: All adult consumers with living situation excluding persons with Living Situation reported as "Not Available".

Sources of Information: DMH ASO Community Reporting System; This indicator is generated from URS Table 15.

Special Issues: Although the states, CMHS and the DIG State Data Infrastructure Coordinating Center are still working to define measures for increased stability in housing, the Illinois DMH has implemented a policy requiring 6 month updates of living status for consumers. This new requirement will be instrumental in supporting DMH in its quest to measure change across time for this NOM. Once the quality of data is ascertained through a data integrity plan which is in process of being implemented, DMH will be able to report change in living status.

Significance: Adults with serious mental illnesses should have access to stable living environments.

Activities and strategies/ changes/ innovative or exemplary model: DMH community funded providers by contract must submit registration and claims data for all individuals receiving services funded using DMH dollars. Data is submitted daily or weekly to the community reporting system maintained by the DMH's Administrative Services Organization (ASO), the Illinois Mental Health Collaborative For Access and Choice. Once this data is processed, it is then transferred to the DMH Data Warehouse for storage. This information is then used to develop reports. As noted above, DMH has established a policy requiring providers to update this information on a bi-annual basis. Once it has been determined that the quality of the data is good, DMH will begin to report change data for this variable.

Target Achieved or Not Achieved/If Not, Explain Why: Not applicable. Target specified reports only on consumers' status at admission to treatment.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Adult - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	63.06	62.79	N/A	N/A	N/A
Numerator	297	275	--	N/A	--
Denominator	471	438	--	N/A	--

Table Descriptors:

Goal: Increased perception of social support/connectedness for individuals participating in treatment

Target: No Target specified.

Population: Adults with serious mental illnesses

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percent of adult consumers reporting positively about social supports/social connectedness.

Measure: Numerator: Number of adult consumers reporting positively about social connectedness.
Denominator: Total number of family responses regarding social connectedness.

Sources of Information: TThis information is being collected as a component of the FY2009 Adult MHSIP Survey.

Special Issues: This indicator is developmental and still being refined.

Significance: Availability of social support may be related to support for recovery.

Activities and strategies/ changes/ innovative or exemplary model: The DMH will continue to work with CMHS, NRI and the states to refine this indicator. DMH has selected a random stratified sample of individuals receiving treatment in June 2009. This sample is the basis for the survey which will be disseminated in December 2009. Data will be available by February 2010.

Target Achieved or Not Achieved/If Not, Explain Why: Not Applicable. Due to the developmental nature of this indicator no target was projected.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Adult - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	61.47	61.98	N/A	N/A	N/A
Numerator	292	269	--	N/A	--
Denominator	475	434	--	N/A	--

Table Descriptors:

Goal: Improved functioning for adults with mental illnesses receiving services

Target: None - Developmental Measure - No basis on which to set target.

Population: Adults with mental illnesses receiving treatment

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
4:Targeted Services to Rural and Homeless Populations

Indicator: Percent of adult consumers reporting positively about functioning.

Measure: Numerator: Number of adult consumers reporting positively about functioning.
Denominator: Total number of adult consumer responses regarding functioning.

Sources of Information: MSHIP Consumer Survey; This indicator is reported in URS Table 11.

Special Issues:

Significance: Mental health services should result in improved functioning and reduction in symptoms.

Activities and strategies/ changes/ innovative or exemplary model: Continue working with the NRI, CMHS and the states to refine/develop this indicator. DMH has selected a random stratified sample of individuals receiving treatment in June 2009. This sample is the basis for the survey which will be disseminated in December 2009. Data will be available by February 2010.

Target Achieved or Not Achieved/If Not, Explain Why: Not Applicable. Due to the developmental nature of this indicator, no target was projected for FY2009.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: ACT SERVICE HOURS IN COMMUNITY

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	67	63	67	68	101
Numerator	143,527	38,034	--	42,651	--
Denominator	214,280	60,714	--	62,302	--

Table Descriptors:

Goal: To assure that a significant amount of services delivered within the (ACT) programs are provided in the most normalized community-based settings possible, rather than within providers offices or clinics.

Target: Maintenance of the 67% level of ACT Services delivered in community settings.

Population: Adults with serious mental illnesses.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of ACT service hours provided in community settingsfor adults being served by the DMH-funded Assertive Community
Treatment (ACT) Programs.

Measure: Numerator: The number of hours of service provided by the DMH-funded (ACT) Programs that occur outside of providers offices or clinics.
Denominator: The total number of hours of ACT service provided by the DMH-funded (ACT) Programs.

Sources of Information: DMH ASO Community Reporting System;.

Special Issues:

Significance: The ACT model emphasizes provision of services outside of traditional service settings.

Activities and strategies/ changes/ innovative or exemplary model: DMH will continue to monitor service provision of ACT programs in order to maintain current levels of services delivered in community settings.

Target Achieved or Not Achieved/If Not, Explain Why: Target Achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: CASE MANAGEMENT

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	46.90	N/A	0	N/A	N/A
Numerator	40,423	N/A	--	N/A	--
Denominator	86,161	N/A	--	N/A	--

Table Descriptors:

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

Target: No specific target for FY2009. Because of changes to the service taxonomy no target was specified.

Population: Adult's with mental illnesses.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

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

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

Sources of Information: DMH ASO Community Reporting System.

Special Issues: DMH has recently revamped its services taxonomy. There is an expectation that many case management services will be subsumed in "Community Support Services". Therefore, we will track the amount of case management services provided in FY 2009.

Significance: There may be a direct relationship between the amount of case management services provided and resilience and recovery rates.

Activities and strategies/ changes/ innovative or exemplary model: Not applicable.

Target Achieved or Not Achieved/If Not, Explain Why:

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: CO-OCCURRING DISORDERS -ADULTS

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	12.36	13.60	12.10	9.50	79
Numerator	17,532	19,740	--	12,575	--
Denominator	141,807	144,845	--	131,702	--

Table Descriptors:

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

Target: No target specified. Tracking access to services by individuals with co-occurring disorders

Population: Adults with mental illness.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

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

Measure: Numerator: Number of adults served in the community with a co-occurring mental health and substance abuse diagnosis at intake.
Denominator: Total number of adults served in the fiscal year.

Sources of Information: DMH ASO Community Reporting System.

Special Issues: DMH notes that the percentage reported is likely an underestimate.

Significance: A little less than 10% of DMH consumers were identified at intake as having co-occurring mental illness and substance abuse diagnoses in FY2009. This is likely to be an under-estimate given national statistics and demonstrates the importance of ongoing training in identifying and treating persons with dual disorders (MISA).

Activities and strategies/ changes/ innovative or exemplary model: DMH continues to encourage and support increased training for community mental health professionals in the identification, reporting and treatment of co-occurring disorders. DMH will continue to track the number of individuals reported with co-occurring disorders at intake.

Target Achieved or Not Achieved/If Not, Explain Why: Not applicable. The figures displayed simply reflect consumer status at intake.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: ELIGIBLE POPULATION - ADULTS

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	94	90.20	95	95.20	100
Numerator	132,787	130,675	--	123,175	--
Denominator	141,807	144,845	--	129,419	--

Table Descriptors:

Goal: To assure access to services by the DMH eligible population

Target: Maintain/increase the percentage of individuals meeting DMH eligibility criteria receiving DMH community-based providers.

Population: Adults with mental illnesses.

Criterion: 2:Mental Health System Data Epidemiology

Indicator: Percent of adults receiving services from DMH-funded community-based providers who meet the established criteria for "eligible population" at the time of entry into services.

Measure: Numerator: Number of individuals being served by DMH-funded community-based providers who meet the established criteria for "eligible population" at the time of entry into services. Denominator: Total number of individuals being served by DMH-funded community-based providers.

Sources of Information: DMH ASO Community Reporting System.

Special Issues:

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

Activities and strategies/ changes/ innovative or exemplary model: DMH aims to maintain or increase the proportion of persons served who meet the established criteria for "eligible population" at the time of entry into services.

Target Achieved or Not Achieved/If Not, Explain Why: Target achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Employment

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	20.73	23.40	20.50	20.20	100
Numerator	29,406	28,199	--	26,172	--
Denominator	141,807	120,058	--	129,419	--

Table Descriptors:

Goal: Continue tracking employment status of consumers at case opening

Target: Track number of individuals employed at case opening

Population: Adults with mental illnesses

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of adults engaged in full or part time employment that is unsubsidized at case opening

Measure: Numerator: Number of adults reported as employed full or part time in unsubsidized employment at case opening
Denominator: Total number of adults receiving services within the fiscal year.

Sources of Information: DMH ASO Community Reporting System. Employment status is currently reported at case opening or admission.

Special Issues:

Significance: Employment is an important variable contributing to recovery.

Activities and strategies/ changes/ innovative or exemplary model:

Target Achieved or Not Achieved/If Not, Explain Why: Not achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Forensic Outpatient

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	1.83	1.80	1.80	1.10	62
Numerator	2,597	2,665	--	1,442	--
Denominator	141,807	144,845	--	129,419	--

Table Descriptors:

Goal:	To track forensic status of adult consumers served by the Mental Health system.
Target:	Track the forensic status of consumers accessing mental health treatment.
Population:	Adults with mental illnesses.
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems
Indicator:	Percentage of adult clients who were court ordered into treatment due to a finding of Not Guilty by Reason of Insanity (NGRI) or Unfit to Stand Trial (UST) by criminal court at the time of case opening.
Measure:	Numerator: Number of adults reported as unfit to stand trail, not guilty by reason of insanity or court ordered into treatment at the time of case opening. Denominator: Total number of adults served in the fiscal year.
Sources of Information:	DMH ASO Community Reporting System.
Special Issues:	
Significance:	Community mental health staff track forensic outpatient status at the time of case opening.
Activities and strategies/ changes/ innovative or exemplary model:	DMH plans to continue tracking forensic outpatient information at intake. DMH efforts to link mental health databases with county jails are ongoing and provide another means of identifying persons involved in the criminal justice system, as well as facilitating service provision.
Target Achieved or Not Achieved/If Not, Explain Why:	Not applicable. Numbers reported reflect status at intake.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: HISTORY OF INVOLVEMENT WITH THE CRIMINAL JUSTICE SYSTEM

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	2.27	2.20	2.30	1.93	84
Numerator	3,215	3,185	--	2,497	--
Denominator	141,807	144,845	--	129,419	--

Table Descriptors:

Goal: To track justice system involvement of adult consumers served by the Illinois Mental Health system.

Target: Track the justice system involvement status of consumers accessing mental health services.

Population: Adults with mental illnesses.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of adult consumers reporting justice system involvement at the time of case opening.

Measure: Numerator: Number of adults reported as being involved with the justice system at the time of case opening.
Denominator: Total number of adults receiving services.

Sources of Information: DMH ASO Community Reporting System.

Special Issues:

Significance: Identifying individuals involvemed with the justice system at time of case opening can increase coordination of services that increase the chances of recovery from mental illness and the rate of recidivism and involvement with the criminal justice system. Slightly less than 2% of all persons served due to mental illness have some involvement with the justice system.

Activities and strategies/ changes/ innovative or exemplary model: DMH plans to continue tracking justice system involvement information at intake. DMH efforts to link
mental health databases with county jails are ongoing and provide another means of identifying
persons with current involvement in the criminal justice system, as well as facilitating service
provision and coordination.

Target Achieved or Not Achieved/If Not, Explain Why: Not applicable.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Living Independently

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	79	79	79	78.20	100
Numerator	112,380	114,101	--	101,199	--
Denominator	141,807	144,845	--	129,419	--

Table Descriptors:

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

Target: Track number of individuals living independently as reported at case opening. No increase is projected as this data is collected at intake prior to treatment.

Population: Adults with mental illness.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

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

Measure: Numerator: Number of adults living in private residence, unsupervised, and considered to be living independently at the time of case opening.
Denominator: Total number of adults served in the fiscal year.

Sources of Information: DMH ASO Community Reporting System.

Special Issues:

Significance: The proportion of individuals reported as living independently at intake has increased from about 63% to nearly 80% over the past several years. This demonstrates the need for ongoing attention to housing services for individuals with mental illnesses.

Activities and strategies/ changes/ innovative or exemplary model: DMH will continue to assess living arrangements at intake as a means of having baseline data on this indicator regarding the individuals who access DMH funded services.

Target Achieved or Not Achieved/If Not, Explain Why: Not applicable. There is no established target for this indicator.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: RURAL RESIDENTS SERVED - ADULTS

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	34,807	35,146	35,000	28,166	80
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: To assure that individuals with mental illnesses who reside in rural areas have access to the DMH-funded community-based mental health services.

Target: DMH has set a target of identifying and providing services to 35,000 persons with mental illness in rural areas of the state.

Population: Adults with mental illness.

Criterion: 4:Targeted Services to Rural and Homeless Populations

Indicator: Number of individuals being served by DMH-funded community-based providers who are residents of rural areas at the time of entry into services.

Measure: Number of individuals reported by DMH-funded community-based providers who are residents of rural areas at the time of entry into services.

Sources of Information: DMH ASO Community Reporting Services.

Special Issues:

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

Activities and strategies/ changes/ innovative or exemplary model: DMH aims to expand access to community mental health services for persons residing in rural areas.

Target Achieved or Not Achieved/If Not, Explain Why: Not achieved. There was an overall decrease in individuals receiving services in FY 2009.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: TARGET POPULATION - ADULTS

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	56.40	56	62	61.30	99
Numerator	80,060	81,144	--	79,321	--
Denominator	141,807	144,845	--	129,419	--

Table Descriptors:

Goal: To assure that resources and services are provided to the DMH priority population.

Target: Maintain or increase service level for persons with serious mental illnesses receiving mental health services.

Population: Adults with serious mental illnesses.

Criterion: 2:Mental Health System Data Epidemiology

Indicator: Percentage of individuals being served by DMH-funded community-based providers who meet the established criteria for "target population" at the time of entry into services.

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

Sources of Information: DMH ASO Community Reporting Services.

Special Issues:

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

Activities and strategies/ changes/ innovative or exemplary model: DMH will continue to monitor service provision to assure that individuals with severe mental illness receive priority services.

Target Achieved or Not Achieved/If Not, Explain Why: Target achieved.

ADULT - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Vocational Placement

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	2.67	2.30	3	2	67
Numerator	3,791	3,287	--	2,675	--
Denominator	141,807	144,845	--	129,419	--

Table Descriptors:

Goal: To track demographic information on vocational placement for adult consumers.

Target: Track vocational placement status of consumers as reported at intake.

Population: Adults with mental illnesses.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of adults who have a vocational placement at the time of case opening.

Measure: Numerator: Number of adults reported as having a vocational placement at case opening
Denominator: Total number of adults served in the fiscal year.

Sources of Information: DMH ASO Community Reporting Services.

Special Issues:

Significance:

Activities and strategies/ changes/ innovative or exemplary model: DMH plans to continue tracking this data while developing specialized employment services.

Target Achieved or Not Achieved/If Not, Explain Why: DMH has not established a target for this indicator.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☑

Name of Implementation Report Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	37,773	40,313	38,500	36,768	95.50
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: Increased access to services

Target: Maintain or increase access to services for children and adolescents with serious emotional disturbances. (FY2009 Target was based on FY2007 actual data.)

Population: Children and adolescents with emotional and serious emotional disturbances

Criterion: 2:Mental Health System Data Epidemiology
3:Children's Services

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

Measure: Number of children/adolescents receiving services from DMH-funded community-based providers.

Sources of Information: DMH ASO Community Reporting System. This indicator is generated from URSTable 2A and Table 2B.

Special Issues:

Significance: Services should be accessible to children and adolescents with mental health needs.

Activities and strategies/ changes/ innovative or exemplary model: DMH community funded providers by contract must submit registration and claims data for all individuals receiving services funded using DMH dollars. Data is submitted daily or weekly to the community reporting system maintained by the DMH's Administrative Services Organization (ASO), the Illinois Mental Health Collaborative For Access and Choice. Once this data is processed, it is then transferred to the DMH Data Warehouse for storage. This information is then used to develop reports.

Target Achieved or Not Achieved/If Not, Explain Why: Target not achieved. There was an overall reduction in the number of individuals receiving services across the board in FY 2009. We are unsure of the reason for the reduction at this point in time.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	3.19	5	2	4.23	47.28
Numerator	3	4	--	3	--
Denominator	94	80	--	71	--

Table Descriptors:

Goal: To decrease readmissions of individuals to state hospitals within 30 days by providing treatment that results in sufficient clinical stabilization so that subsequent treatment is provided in the least restrictive setting.

Target: Maintain or decrease readmission rates of children and adolescents to DMH state hospitals

Population: Children and adolescents with serious emotional disturbances.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Decreased rate of civil readmissions to state psychiatric hospitals within 30 days.

Measure: Numerator: Number of civil readmissions to any state hospital within thirty days of being discharged.
Denominator: Total number of civil discharges in the year.

Sources of Information: DMH Inpatient Clinical Information System.

Special Issues: The Illinois DMH contracts the majority of inpatient services for children and adolescents to community hospitals, therefore the number of admissions and readmissions reported are very small. Data for private hospitals is not collected for the Inpatient Clinical Information System.

Significance: Individuals with mental illnesses should receive services in the least restrictive settings possible. However, there are times when access to inpatient services is required. Treatment provided in these settings should not result in an individuals return to the inpatient setting within a short period of time.

Activities and strategies/ changes/ innovative or exemplary model: DMH continues to monitor the number of Children and Adolescents readmitted to state hospitals within 30 days of discharge with a goal of maintaining or decreasing the Level of re-hospitalization by maintaining services in the community that provide alternatives to re-hospitalization.

Target Achieved or Not Achieved/If Not, Explain Why: Not achieved, however the numbers reported are so small that this information may not be meaningful.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	6.38	10	6	5.63	106.57
Numerator	6	8	--	4	--
Denominator	94	80	--	71	--

Table Descriptors:

Goal: To decrease readmissions of individuals to state hospitals within 30 days by providing treatment that results in sufficient clinical stabilization so that subsequent treatment is provided in the least restrictive setting.

Target: Maintain or decrease level of readmission rate to state hospitals

Population: Children and adolescents with serious emotional disturbances.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Decreased rate of civil readmissions to state psychiatric hospitals within 180 days.

Measure: Numerator: Number of civil readmissions to any state hospital within 180 days
Denominator: Total number of civil discharges in the year.

Sources of Information: DMH Inpatient Clinical Information System.

Special Issues: The Illinois DMH contracts the majority of inpatient services for children and adolescents to community hospitals, therefore the number of admissions and readmissions reported are very small.Data for private hospitals is not collected for the Inpatient Clinical Information System.

Significance: Individuals with mental illnesses should receive services in the least restrictive settings possible.However, there are times when access to inpatient services is required.

Activities and strategies/ changes/ innovative or exemplary model: Data from FY 2007 served as the baseline for this indicator. DMH will continue to monitor the number of Children and adolescents readmitted to state hospitals within 180 days of discharge with a goal of maintaining or decreasing the level of re-hospitalization by maintaining services in the community that provide alternatives to re-hospitalization.

Target Achieved or Not Achieved/If Not, Explain Why: Target achieved, however the numbers are so small that this indicator may not be meaningful.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: DMH is not currently implementing the EBPs that are part of the National Outcome Measures

Target: DMH is not currently implementing the EBPs that are part of the National Outcome Measures

Population: Children with serious emotional disturbances

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of Child/Adolescent EBPs implemented

Measure: Number of Child/Adolescent EBPs implemented

Sources of Information: DMH ASO Community Reporting System.

Special Issues:

Significance:

Activities and strategies/ changes/ innovative or exemplary model: DMH is not currently implementing the EBPs that are part of the National Outcome Measures (see capacity checklist)

Target Achieved or Not Achieved/If Not, Explain Why: Not applicable.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Evidence Based - Children with SED Receiving Therapeutic Foster Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	N/A	0	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: Not Applicable. Illinois is not implementing this EBP.

Target: The DMH is not currently planning to implement therapeutic foster care.

Population: Children and adolescents with serious emotional disturbances.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of children and adolescents receiving therapeutic foster care

Measure: Number of children and adolescents receiving therapeutic foster care

Sources of Information:

Special Issues: Foster care is provided through the state welfare agency. The DMH does not anticipate that it will implement this EBP.

Significance:

Activities and strategies/ changes/ innovative or exemplary model: The DMH has no current plans to implement therapeutic foster care as this service would be administered by the state child welfare agency.

Target Achieved or Not Achieved/If Not, Explain Why: Not applicable.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Evidence Based - Children with SED Receiving Multi-Systemic Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	N/A	0	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: NOT APPLICABLE. DMH has no plans to mplement multi-systemic family therapy in Illinois

Target: None. The DMH is not currently providing this EBP

Population: Children and adolescents with serious emotional disturbances

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of children/adolescents receiving multi-systemic therapy

Measure: Number of children/adolescents receiving multi-systemic therapy

Sources of Information:

Special Issues: The DMH is not currently implementing multi-systemic therapy. Rather it is focusing on evidence-informed practices.

Significance:

Activities and strategies/ changes/ innovative or exemplary model: While multi-systemic therapy is practiced by a few child serving agencies, the DMH is not currently implementing multi-systemic therapy with children. DMH is focusing on evidence-informed practices.

Target Achieved or Not Achieved/If Not, Explain Why: Not applicable.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Evidence Based - Children with SED Receiving Family Functional Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	N/A	0	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: NOT APPLICABLE. DMH has no plans to implement this EBP.

Target: DMH is not currently implementing this EBP.

Population: Children and adolescents with serious emotional disturbances.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of children/adolescents receiving family functional therapy

Measure: Number of children/adolescents receiving family functional therapy

Sources of Information:

Special Issues: DMH is focusing on evidence informed practices and has no specific plans to implement family functional therapy at this time.

Significance:

Activities and strategies/ changes/ innovative or exemplary model: The DMH has no plans at this time to implement family functional therapy as it is focusing its effort on evidence-informed practices.

Target Achieved or Not Achieved/If Not, Explain Why: Not applicable.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	55.29	52.11	60	N/A	N/A
Numerator	277	222	--	N/A	--
Denominator	501	426	--	N/A	--

Table Descriptors:

Goal: To increase the perception of positive outcomes by caregivers of children served by the DMH-funded community-based mental health service system.

Target: Increase percentage of caregivers reporting positive outcomes for their children/adolescents receiving DMH funded mental health services.

Population: Parents/caregivers of children/adolescents receiving DMH funded mental health services.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percentage of families reporting positively about outcomes.

Measure: Numerator: Number of caregivers reporting positively about outcomes of treatment
Denominator: Total number of family responses regarding perception of outcomes.

Sources of Information: This data is derived from the Youth Services Survey and is reported on URS Table 11.

Special Issues: DMH currently surveys only caregivers of youth 11 and younger due to concerns of maintaining confidentiality of youth 12 to 17.

Significance: Individuals receiving treatment should have positive outcomes for treatment.

Activities and strategies/ changes/ innovative or exemplary model: DMH aims to increase the percentage of caregivers reporting positive outcomes for the Child and Adolescent services. As in previous fiscal years, DMH has selected a random stratified sample of individuals receiving treatment in June 2009. This sample is the basis for the survey tobe disseminated in December 2009 with a goal of all data collected by early January 2010. DMHstaff will strive to complete the analysis as quickly as possible, however data may not be readily available until February 2010.

Target Achieved or Not Achieved/If Not, Explain Why: Not available until February 2010.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Child - Return to/Stay in School (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	64	43.02	0	N/A	N/A
Numerator	48	77	--	N/A	--
Denominator	75	179	--	N/A	--

Table Descriptors:

Goal: Improve school attendance of children/adolescents with serious emotional disturbances receiving mental health treatment

Target: No target set due to low response rate and developmental nature of the indicator.

Population: Children with emotional and serious emotional disturbances aged 0-11.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percent of parents/caregivers reporting improvement in child's school attendance.

Measure: Numerator: Number of parents reporting improvement in child's school attendance. (Both new and continuing clients.) Denominator: Total responses (excluding not available) new and continuing clients combined.

Sources of Information: Annual Youth Services Survey

Special Issues: Currently the data is derived from questions included on the Annual Youth Services Survey conducted by DMH. DMH is not projecting targets due to the low response rate for this variable as well as the developmental nature of the indicator.DMH currently surveys only caregivers of youth 11 and younger due to concerns of maintaining confidentiality of youth 12 to 17.

Significance: Children/adolescents with ED/SED should benefit from receiving mental health services

Activities and strategies/ changes/ innovative or exemplary model: DMH has selected a random stratified sample of individuals receiving treatment in June 2009. This sample is the basis for the survey to be disseminated in December 2009 with a goal of all data collected by early January 2010. DMH staff will strive to complete the analysis as quickly as possible, however data may not be readily available until February 2010.

Target Achieved or Not Achieved/If Not, Explain Why: Data for this indicator has been collected using the YSS/F MHSIP Survey. However, given the developmental nature of the indicator and the small numbers used for reporting, no target was established for FY2009. Data will be available in February 2010.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Child - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	33.33	55.45	0	N/A	N/A
Numerator	1	61	--	N/A	--
Denominator	3	110	--	N/A	--

Table Descriptors:

Goal: Decrease Juvenile Justice Involvement for children/adolescent with SED who are involved in the justice system.

Target: Data for this indicator was collected in FY2008. However, due to the developmental nature of the measure and the low response rate we elected not to set a target for FY2009.

Population: Children/ with serious emotional disturbances aged 0-11 who are involved with the justice system and who are receiving mental health services

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percent of children/youth consumers arrested in Year 1 who were not rearrested in Year 2.

Measure: Numerator: Number of children/youth consumers arrested in T1 who were not rearrested in T2. (new and continuing clients) Denominator: Number of children/youth consumers arrested in T1(new and continuing clients combined).

Sources of Information: Youth Services Survey for Families (Caregivers)

Special Issues: This indicator is still developmental; as such DMH is not projecting targets.

Significance: The provision of mental health services should have an impact on the outcomes for children/adolescents involved in the justice system.

Activities and strategies/ changes/ innovative or exemplary model: DMH will conduct the FY2009 survey in December 2009. The sample has been selected and mailing will begin within the next week. Data will be available for this indicator in February 2010.

Target Achieved or Not Achieved/If Not, Explain Why: Not applicable. Data for this indicator will be collected using the YSS/F MHSIP Survey. However, given the developmental nature of the indicator and the small numbers used for reporting, no target was established for FY2009.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Child - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	.83	.77	.83	.71	116.90
Numerator	295	293	--	240	--
Denominator	35,684	37,859	--	33,996	--

Table Descriptors:

Goal: Increase stability in housing by reducing the number of children who are homeless or living in shelters. Indicator specifies increase, however, it is currently only a snapshot of consumers' status at admission; thus we would not project an increase.

Target: Track percentage of children who are homeless or living in shelters. This data is collected at one point in time at intake prior to treatment.

Population: Children/Adolescents with serious emotional disturbances who are homeless and living in shelters.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percent of Child/Adolescent clients who are homeless and living in shelters.

Measure: Numerator: Number of Child/Adolescent clients who are homeless and living in shelters. Denominator: All child/adolescent clients with known living situation (excluding persons with Living Situation Not Available.

Sources of Information: DMH ASO Community Reporting System.

Special Issues: The data currently reported is point in time and only reflects youth status at intake/admission.Currently there is not a mechanism to track change over time, thus at this point DMH can only report status at intake.

Significance: Children/Adolescents with serious emotional disturbances should have access to stable living environments

Activities and strategies/ changes/ innovative or exemplary model: DMH community funded providers by contract must submit registration and claims data for all individuals receiving services funded using DMH dollars. Data is submitted daily or weekly to the community reporting system maintained by the DMH's Administrative Services Organization (ASO), the Illinois Mental Health Collaborative For Access and Choice. Once this data is processed, it is then transferred to the DMH Data Warehouse for storage. This information is then used to develop reports. As noted above , DMH has established a policy requiring providers to update this information on a bi-annual basis. Once it hasbeen determined that the quality of the data is good, DMH will begin to report change data for this variable

Target Achieved or Not Achieved/If Not, Explain Why: No target established (see above).

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Child - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	78.84	74.58	0	N/A	N/A
Numerator	395	311	--	N/A	--
Denominator	501	417	--	N/A	--

Table Descriptors:

Goal: Monitor caregivers perception that their children'ssocial connected ness has improved as a result of participating in treatment.

Target: Developmental Measure - No target established

Population: Children/adolescents with serious emotional disturbances age 0-11.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percent of caregivers reporting positively about social connectedness.

Measure: Numerator: Number of caregivers of child/adolescent consumers reporting positive perception regarding social connectedness of their child.
Denominator: Total number of family responses regarding social connectedness.

Sources of Information: Annual Youth Services Survey for Families (Caregivers)

Special Issues: Currently the data is derived from questions included on the Annual Youth Services Survey conducted by DMH. DMH is not projecting targets due to the response rate for this variable as well as the developmental nature of the indicator.DMH currently surveys only caregivers of youth 11 and younger due to concerns of maintaining confidentiality of youth 12 to 17.

Significance: Treatment should result in positive outcomes for children.

Activities and strategies/ changes/ innovative or exemplary model: DMH has selected a random stratified sample of individuals receiving treatment in June 2009. This sample is the basis for the survey to be disseminated in December 2009 with a goal of all data collected by early January 2010. DMH staff will strive to complete the analysis as quickly as possible, however data may not be readily available until February 2010.

Target Achieved or Not Achieved/If Not, Explain Why: Data for this indicator is collected using the YSS/F MHSIP Survey.However, given the developmental nature of the indicator and the small numbers used for reporting , no target was established for FY2009.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Child - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	56.89	61.98	0	N/A	N/A
Numerator	285	269	--	N/A	--
Denominator	501	434	--	N/A	--

Table Descriptors:

Goal: Increase caregivers' perception of functioning as a result of treatment.

Target: No target established- for FY2009 as there was no basis for establishing one.

Population: Children and adolescents with emotional/serious emotional disturbances

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
4:Targeted Services to Rural and Homeless Populations

Indicator: Percent of families reporting positively about functioning.

Measure: Numerator:Number of caregivers of child/adolescent consumers reporting positive perceptions about their child's functioning.
Denominator: Total number of family responses regarding functioning.

Sources of Information: Annual Youth Services Survey for Families (Caregivers)

Special Issues: Currently the data is derived from questions included on the Annual Youth Services Survey conducted by DMH. DMH is not projecting targets due to the response rate for this variable as well as the developmental nature of the indicator. DMH
currently surveys only caregivers of youth 11 and younger due to concerns of maintaining confidentiality of youth 12 to 17.

Significance: Treatment should result in positive outcomes for children.

Activities and strategies/ changes/ innovative or exemplary model: DMH has selected a random stratified sample of individuals receiving treatment in June 2009. This sample is the basis for the survey to be disseminated in December 2009 with a goal of all data collected by early January 2010. DMHstaff will strive to complete the analysis as quickly as possible, however data will not be available until February 2010.

Target Achieved or Not Achieved/If Not, Explain Why: Not applicable. Given the developmental nature of the indicator and the small numbers used for reporting a target has not been established.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: CORRECTIONS HISTORY - C&A

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	.92	1.10	1	.84	84
Numerator	347	456	--	310	--
Denominator	37,773	40,313	--	36,768	--

Table Descriptors:

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

Target: Track increase/decrease in individuals involved in the justice system who access services. This population expected to remain relatively constant at approximately 1%.

Population: Children and Adolescents with serious emotional disturbances.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

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

Measure: Numerator: Number of children and adolescents reported as Department of Corrections clients (e.g. probation, parole) at the time of case opening.
Denominator: Total number of children and adolescents served in the fiscal year.

Sources of Information: DMH ASO Community Reporting System.

Special Issues:

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

Activities and strategies/ changes/ innovative or exemplary model: Community mental health staff track the number of children and adolescents who are forensic outpatients (0.8%), as well as those who are on probation or parole (a little over 1%) at the time of case opening. This data is collected as part of clinical assessments. DMH will continue to track these percentages.

Target Achieved or Not Achieved/If Not, Explain Why: Not applicable.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: Co-Occurring Disorders C&A

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	1.05	1.10	1	1	100
Numerator	395	433	--	390	--
Denominator	37,773	40,313	--	36,768	--

Table Descriptors:

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

Target: Track the number of individuals with co-occuring disorders accessing services.

Population: Children and adolescents with serious emotional disturbances and co-occurring substance use disorders.

Criterion: 3:Children's Services

Indicator: Percentage of Children and Adolescents (C&A) with a mental illness and substance use diagnosis receiving services.

Measure: Numerator: Number of clients served in the community with a substance abuse diagnosis. Denominator: Total number of all child and adolescents receiving services.

Sources of Information: DMH ASO Community Reporting System.

Special Issues: It is likely that identification of these individuals is under-represented.

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

Activities and strategies/ changes/ innovative or exemplary model: DMH will continue to track this information in FY 2009 with a goal of increasing the capacity for identification of dually diagnosed youth.

Target Achieved or Not Achieved/If Not, Explain Why: Not applicable.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: ELIGIBLE POPULATION - C&A

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	87.78	88.43	90	95	105
Numerator	33,158	35,648	--	34,959	--
Denominator	37,773	40,313	--	36,768	--

Table Descriptors:

Goal: To provide access to services to children and adolescents meeting DMH eligibility for service criteria.

Target: Maintain the percentage of children and adolescents receiving mental health services who meet eligibility requirements.

Population: Children and adolescents with serious emotional disturbances

Criterion: 2:Mental Health System Data Epidemiology

Indicator: Percent of children and adolescents being served by DMH-funded community-based providers who meet the established criteria for "eligible population" at the time of entry into services.

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

Sources of Information: DMH ASO Community Reporting System.

Special Issues:

Significance: This indicator is part of the DMH monitoring process to ensure that mental health services are accessible to those individuals who need them most.

Activities and strategies/ changes/ innovative or exemplary model: DMH has a goal of increasing the proportion of children and adolescents served who meet the criteria for the eligible population.

Target Achieved or Not Achieved/If Not, Explain Why: Achieved.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: FORENSIC OUTPATIENT-C&A

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	.80	1.20	.80	.55	69
Numerator	303	483	--	204	--
Denominator	37,773	40,313	--	36,768	--

Table Descriptors:

Goal: To track forensic status of children and adolescents served by the Illinois mental health system

Target: Maintain access to services for children and adolescents who are involved with the juvenile justice system.

Population: Children and adolescents with serious emotional disturbances.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

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

Measure: Numerator: Number of children and adolescent clients reported as unfit to stand a trail, not guilty by reason of insanity, criminal, or directed for court ordered treatment at the time of case opening.
Denominator: Total number of children and adolescents served in the fiscal year.

Sources of Information: DMH ASO Community Reporting System.

Special Issues:

Significance: The service needs of this small but high risk group require that assessment and adequate services are provided and tracked.

Activities and strategies/ changes/ innovative or exemplary model: Community mental health staff track the number of children and adolescents who are forensic outpatients (0.8%), as well as those who are on probation or parole at the time of case opening (a little over 1%). This data is collected as part of clinical assessments. DMH will continue to track these percentages.

Target Achieved or Not Achieved/If Not, Explain Why: Not achieved. As noted previously, there has been an overall decrease in the number of individuals accessing services in FY 2009. This may have had an impact on this indicator.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: LIVING ARRANGEMENTS-C&A

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	93.82	89	93	96	N/A
Numerator	35,438	35,956	--	32,648	--
Denominator	37,773	40,313	--	36,768	--

Table Descriptors:

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

Target: Track percentage of children and adolescents with mental emotional disturbances who live in private residences. No target established as information is only collected at intake.

Population: Children and adolescents with mental illness.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of children and adolescent clients living with parents or other relatives in private residences at the time of case opening.

Measure: Numerator: Number of children and adolescents reported as living with parents or other relatives in private residence at the time of case opening.
Denominator: Number of children/adolescents receiving services.
Denominator: Total number of children and adolescents served in the fiscal year with known living arrangements.

Sources of Information: DMH ASO Community Reporting System.

Special Issues:

Significance: Community mental health staff report living arrangements at intake for children and adolescents to assess service needs. At the time of case opening in FY 2009, the vast majority of children and adolescents lived with parents or other relatives in a private residence (96%).

Activities and strategies/ changes/ innovative or exemplary model: DMH will continue to track this indicator in FY 2010.

Target Achieved or Not Achieved/If Not, Explain Why: Not applicable.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: RURAL RESIDENTS SERVED - C&A

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	11,550	12,430	12,000	10,354	86
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

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

Target: Maintain the number of children/adolescents residing in rural areas who receive services by using Tel-psychiatry and other strategies.

Population: Children and adolescents with emtional disturbances who live in rural areas of the state.

Criterion: 4:Targeted Services to Rural and Homeless Populations

Indicator: Number of children being served by DMH-funded community-based providers who are residents of rural areas at the time of entry into services.

Measure: Number of children being served by DMH-funded community-based providers who are residents of rural areas at the time of entry into services.

Sources of Information: DMH ASO Community Reporting.

Special Issues:

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

Activities and strategies/ changes/ innovative or exemplary model: DMH aims to maintain or expand access to community mental health services for children and adolescents residing in rural areas.

Target Achieved or Not Achieved/If Not, Explain Why: Not achieved. As noted previously, the total number of individuals receiving services decreased in FY 2009. This may have an impact on this indicator.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: SASS SERVICE HOURS IN COMMUNITY

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	N/A	N/A	0	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

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

Target: A target is not set because the data source does not capture complete information at this point
in time.

Population: Children and adolescents with serious emotional disturbances.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of children identified as members of the DMH "target" population being served by the DMH-funded community-based service system who receive SASS services.

Measure: Numerator: Number of hours of service provided by the DMH-funded SASS Programs which occur outside of the provider's offices or clinics.
Denominator: Total number of hours of service provided by the DMH-funded SASS Programs.

Sources of Information: DMH ASO Community Reporting System.

Special Issues: This data is no longer reported directly to the DMH. Data was not available for FY 2007, 2008 and 2009. We will retain this indicator as a placeholder because of its importance. We hope to reacquire the information in FY 2010.

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

Activities and strategies/ changes/ innovative or exemplary model: DMH is still working to retrieve this information and is retaining this indicator as a place holder pending re-aquirement of this data as it is important to monitor delivery of these critical services.

Target Achieved or Not Achieved/If Not, Explain Why: Not applicable.

CHILD - IMPLEMENTATION REPORT

Transformation Activities: ☐

Name of Implementation Report Indicator: TARGET POPULATION - C & A

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Target	FY 2009 Actual	FY 2009 Percentage Attained
Performance Indicator	33	40	37	40	108
Numerator	12,579	16,166	--	14,773	--
Denominator	37,773	40,313	--	36,768	--

Table Descriptors:

Goal: To assure that resources and services are provided to children and adolescents who are the DMH priority population.

Target: To increase the percentage (by 2%) of child and adolescent mental health clients who have serious emotional disturbances receiving services.

Population: Children and adolescents with serious emotional disturbances.

Criterion: 2:Mental Health System Data Epidemiology

Indicator: Percentage of individuals being served by DMH-funded community-based providers who meet the established criteria for "target population" at the time of entry into services.

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

Sources of Information: DMH ASO Community Reporting System.

Special Issues:

Significance: Children and adolescents with severe emotional disturbances (SED) are the priority target for mental health services.

Activities and strategies/ changes/ innovative or exemplary model: DMH aims to increase the proportion of children and adolescents served who meet the DMH criteria for the target population.

Target Achieved or Not Achieved/If Not, Explain Why: Target Achieved.

Upload Planning Council Letter for the Implementation Report

ILLINOIS MENTAL HEALTH PLANNING AND ADVISORY COUNCIL

Co-Chairs: Linda Denson
John W. Shustitzky, PhD

160 North LaSalle Street
Chicago, IL 60601

November 30, 2009

Ms. Barbara Orlando
Grants Management Officer
SAMHSA OPS
Division of Grants Management
1 Choke Cherry Road, Room 7-1091
Rockville, Maryland 20850

Dear Ms. Orlando:

Together with the Co-Chair of the Illinois Mental Health Planning and Advisory Council, Linda Denson, I am pleased to add the Council's support for the 2009 Block Grant Implementation Report.

Our Council members, Planning Committee and our other committees work closely with the Illinois Division of Mental Health and stakeholders throughout our State to monitor the mental health services provided and to promote improvements wherever possible.

Sincerely,

John W. Shustitzky, PhD
Co-Chair

Behavioral Health Services
4840 W. Byron Street
Chicago, Illinois 60641
773.282.7800
773. 282.2163 Fax

Lutheran Social Services of Illinois

November 18, 2009

Mr. John Shustitsky, Co-Chair
Illinois Mental Health Planning and Advisory Council
Pillars
333 North La Grange Road, Suite One
La Grange Park, IL 60526

Ms. Linda Denson, Co-Chair
Illinois Mental Health Planning and Advisory Council
Sankofall Organization of Illinois
PO Box 607294
Richton, IL 60010

Dear John and Linda,

As co-chairs of the Planning Committee of the Illinois Mental Health Planning and Advisory Council, we are writing to provide our feedback and support of the 2009 Block Grant Implementation Report. As in the past, actual data for 2009 was not available at the time of our review. Illinois Department of Mental Health staff reported that they are still gathering the final information and anticipate its availability just prior to the Implementation Report's due date. Our committee met on November 12 to review the narrative that will accompany the report.

As noted in the block grant application, we hope to work with DMH staff to identify additional and more meaningful indicators of success within the various criterion defined in the block grant. In prior years, this data would have been nearly impossible to collect. Through work with the ASO in Illinois, we anticipate that the capacity for more in-depth evaluation will grow every year, as tools are refined and become more focused.

Some of the highlights of 2009 outcomes include:

- Continued outreach and recovery programs to involve consumers through education, training, and employment opportunities to provide peer support;
- Began establishing permanent supported housing for 168 out of 275 approved consumers;
- Increasing work in evidence based practices, particularly with evidence based supported employment;
- Establishing new billing codes to identify specific services that are provided.

* Tele-psychiatry services have been established and the number of locations continues to increase.

Some additional information we would like to have regarding these outcomes is the number of persons who are now employed after receiving Recovery Support Specialist certification; a breakdown of the prior residence status of persons who secured permanent housing; more details about people participating in supported employment; and the number of people on waiting lists for tele-psychiatry services.

Some areas of disappointment to all are:

- Decrease in the number of ACT services provided, due to agencies' inability to maintain fidelity to the evidence based practices required;
- Continued difficulty in coordination of services for people involved in the correctional systems; and
- Discontinued services for persons dually diagnosed with mental illness and substance abuse due to discontinued funding in the substance abuse system.

We are hopeful that efforts to increase Medicaid billing within the state will result in improved access to a broader array of services. The Council and DMH, along with many other bodies in the state, continue exploring means for accomplishing and improving this opportunity. At the same time, the state is in the midst of a funding crisis that imperils the ability to provide core services. We continue to advocate with and on behalf of consumers and their families to maintain access to quality services.

Sincerely,

Daniel B. Martinez, MD
Planning Committee Co-chair

Cathy St. Clair
Planning Committee Co-Chair

OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.