### I: State Information

**Plan Year**
- **Start Year:** 2012
- **End Year:** 2013

**State DUNS Number**
- **Number:** 067919071

### I. State Agency to be the Grantee for the Block Grant

**Agency Name**
- Illinois Department of Human Services

**Organizational Unit**
- Division of Mental Health

**Mailing Address**
- 160 North LaSalle St., 10th Flr

**City**
- Chicago

**Zip Code**
- 60601

### II. Contact Person for the Grantee of the Block Grant

**First Name**
- Mary

**Last Name**
- Smith

**Agency Name**
- IL DHS/Division of Mental Health

**Mailing Address**
- 160 North LaSalle Street, 10th Flr

**City**
- Chicago

**Zip Code**
- 60601

**Telephone**
- 312-814-4948

**Fax**
- 312-814-2964

**Email Address**
- MaryE.Smith@illinois.gov

### III. State Expenditure Period (Most recent State expenditure period that is closed out)

- **From:** 7/1/2009
- **To:** 6/30/2010

### IV. Date Submitted

OMB No. 0930-0168  Approved: 07/19/2011  Expires: 07/31/2014
V. Contact Person Responsible for Application Submission

First Name
Mary

Last Name
Smith

Telephone
312-814-4948

Fax
312-814-2964

Email Address
MaryE.Smith@illinois.gov

Footnotes:
I: State Information

Assurances - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including 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 the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM’s Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-161), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.


10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the Environmental Quality Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-252); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).


14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

<table>
<thead>
<tr>
<th>Name</th>
<th>Michelle Saddler</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Secretary</td>
</tr>
<tr>
<td>Organization</td>
<td>Illinois Dept of Human Services</td>
</tr>
</tbody>
</table>

Signature: ___________________________ Date: ________________

**Footnotes:**
I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

   a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

   b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

   c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

   d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

   a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

   b. Establishing an ongoing drug-free awareness program to inform employees about--

      1. The dangers of drug abuse in the workplace;

      2. The grantee's policy of maintaining a drug-free workplace;

      3. Any available drug counseling, rehabilitation, and employee assistance programs; and

      4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

   c. Making it a requirement that each employee be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

   d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--

      1. Abide by the terms of the statement; and

      2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

   e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

   f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?

      1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

      2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

   g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statement or claim may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

<table>
<thead>
<tr>
<th>Name</th>
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</table>

Signature: ________________________________ Date: __________________

Footnotes:
I: State Information

Chief Executive Officer’s Funding
Agreements/Certifications (Form 3)

Community Mental Health Services Block Grant Funding Agreements
FISCAL YEAR 2012

I hereby certify that Illinois agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:
   Subject to Section 1916, the State will expend the grant only for the purpose of:
   i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:
      ii. Evaluating programs and services carried out under the plan; and
      iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:
   (c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms “adults with a serious mental illness” and “children with a severe emotional disturbance” and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:
   (a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

   [A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

   (b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

   (b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

   (C)(1) With respect to mental health services, the centers provide services as follows:

      (A) Services principally to individuals residing in a defined geographic area (referred to as a “service area”)
      (B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
      (C) 24-hour-a-day emergency care services.
      (D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
      (E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

   (2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

   (3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. Section 1914:

   The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

   (b) The duties of the Council are:
      (1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
      (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
      (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.
VIII.

(a) The State has in effect a system to protect from inappropriate development

(b) The State has in effect a system to protect from inappropriate development

(c) The State will make copies of the reports and audits described in this section available for public inspection within the State; and

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(b) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:

(a)(1) The State agrees that it will not expend the grant:

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

(c) The State will:

 VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]

(c) The State will:

IX. Section 1943:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.
Notice: Should the President’s FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

Name: Michelle Saddler
Title: Secretary
Organization: Illinois Dept of Human Services

________________________________________
Signature: _________________________________ Date: ________________________

Footnotes:
I: State Information

Disclosure of Lobbying Activities (SF-LLL)

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Footnotes:
II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations
Page 22 of the Application Guidance

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.

Footnotes:
SECTION II-A: STATE PLAN-ADULT SERVICES

I. Assessment of Strengths and Needs

A. Description/Overview of the State's Mental Health System

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

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

Statewide efforts to maintain and improve the system of care are coordinated through the Division of Mental Health Central Office based in both Springfield and Chicago. Planning and program implementation are accomplished in conjunction with five regional administrators. The Central Office is responsible for oversight of the system, policy formulation and review, the operation of nine state hospitals, planning, services evaluation, and allocation of funds. Interagency collaborative efforts and leadership in initiatives such as activities related to transformation, consumer participation and involvement, the promotion of evidence-based practices, planning for clinical services, forensic services, and child and adolescent services are carried out by statewide administrative staff. As of July 2011, the DMH Central Office had 72 FTE positions.

The Community-Based Mental Health Service System

Community services are considered the cornerstone of the mental health delivery system. Services provided and purchased by the DMH are geographically based. The DMH is organized into five Comprehensive Community Service Regions (CCSRs). Through these Regions, the DMH operates nine state hospitals, contracts with 174 community-based outpatient/rehabilitation agencies across the state. Comprehensive Community Service Regions are charged with the responsibility for managing care, developing the capacity and expertise of providers, monitoring service provision and increasing the quality and the quantity of participation from persons who receive mental health services. Two
Regions are located in the Chicago Metropolitan area and surrounding suburbs, and three Regions cover the central, southern and metro-east southern (East St. Louis region) areas of the State. Administratively, each Region has an Executive Director, a lead Clinical Director, a lead Recovery Services Development Specialist, and a Coordinator of Forensic Services.

The DMH continually seeks input from consumers, family members, advocates, and representatives of public and private organizations through the framework of the Illinois Mental Health Planning and Advisory Council (IMHPAC) to aid in planning efforts. The DMH uses emerging developments at the local, state and national levels as a basis for strategically setting statewide parameters and goals, with the CCSR s carrying the responsibility for the development of congruent local systems of care. CCSR Strategic Plans reflect the overall goal of the development of a recovery-oriented service system. Ongoing strategic thinking and planning efforts with Regional stakeholders are designed to uniquely meet local area needs within each Region. The DMH is able to improve linkage and insure that treatment occurs in the least restrictive and most cost-effective settings by integrating hospital-based services into a network of community outpatient services and supports that are coordinated across service providers and consumers. By building on the strengths of communities in which consumers live, the CCSR s are able to manage DMH funds, and coordinate the most effective use of the local tax dollars and private resources budgeted for public mental health services.

The CCSR s are also responsible for integration of a comprehensive care system that includes mental health, rehabilitation, substance abuse, social services, criminal justice, and education. Each CCSR has assigned staff specially designated to address child and adolescent and Forensic services. Being part of IDHS has provided an opportunity for the DMH to address a number of challenges within the shared mission of one Department, including: disability determination for persons with serious mental illnesses (SMI), integration of vocational and psychiatric rehabilitation services, coordination and development of Mental Illness and Substance Abuse (MISA) services and, through the coordinated intake process, an opportunity to enhance case finding, early identification, and outreach efforts.

The Growth of Community-Based Services

Within Illinois there are numerous private practitioners, community mental health agencies, community hospitals providing inpatient psychiatric care, and community long-term care facilities providing services to individuals with serious mental illnesses. Over the past 30 years the locus of treatment for persons with mental illness has shifted from institutions to community-based settings. In FY1973, 8% of the DMH’s budget was allocated for community services. Until recently, approximately 70% of DMH expenditures have been allocated for community-based services. However, due to continuing budget reductions, the balance between community based and state hospital expenditures has begun to shift. In FY2010, the DMH purchased community based services for 124,253 adults and 36,219 children and provided state hospital services for approximately 10,200 individuals.

The Illinois Mental Health Collaborative for Access and Choice
In Fall 2007 a national behavioral health company was selected to assist DHS/DMH in implementing a number of contractual objectives. This Administrative Services Organization, called the Illinois Mental Health Collaborative for Access and Choice (Collaborative), began operations in FY2008. The role and function of the Collaborative in the management of the public mental health system in Illinois encompasses a broad spectrum of administrative activity.

The prominent activity of the Collaborative is assistance to DMH in continued efforts to transition the mental health system to a consumer/ family-centered recovery and resilience-oriented service system. Some of the accomplishments of the Collaborative have included: (1) Assisting DMH in post-payment review of services. (2) Authorization of intensive services such as Assertive Community Treatment (ACT), Community Support Teams (CST), and Individual Care Grants (ICG) for children with serious emotional disturbance. (3) Working with DMH to convene and plan annual conferences on Evidence Based and Evidence Informed Practices. (4) Collaborating with DMH on the development and maintenance of an integrated Management Information System (MIS). (5) Assisting DMH Recovery staff in convening regional consumer conferences. (6) Development and implementation of a Consumer Warm Line and a Consumer Family Care Line. (7) Completion, dissemination, and posting of a variety of mental health reports, manuals, and handbooks including a provider manual, consumer and family handbook, and a study guide for the CRSS credential. Clearly, the work of the Collaborative has been very valuable in advancing the goals of DMH with regard to the mental health service delivery system.

**Consumer Supports**

The Collaborative has established a statewide “warm line” as a cutting edge source of peer and family support. Staffed by five Peer and Family Support specialists, the toll-free number is operational Monday through Friday, 8am to 5pm except holidays and 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. The warm line has been 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 is among the very few states known to operate statewide Warm Lines. In addition to the Warm Line, consumers and family members may contact the 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. Written feedback is provided to consumers and family members on the progress or resolution of their complaints and assistance is offered to obtain further review or to appeal a decision. In FY2011, the Collaborative received and responded to a total of 53 complaints, investigated eight (8) complaints related to adults, and two complaints as well as one appeal which were related to children and adolescents.
Impact of the Current Economic Recession
Beginning in FY2009, economic conditions in Illinois significantly deteriorated. The Illinois Department of Revenue (IDOR) reports that the Total Revenue Collected (not including taxes collected for local governments) dropped from $29,150,982,929 for SFY2008 to $26,831,571,515 in SFY2009 resulting in a deficit to the state in excess of $2.3 billion due to a 7.9% drop in revenue. Concurrently, the Illinois Department of Employment Security (IDES) reported that the state’s Unemployment Rate (Seasonally Adjusted) steadily increased from 6.6 in July 2008, at the beginning of the state fiscal year to 8.1 in January, 2009 and reached 11.1 by the end of December, 2009. The number of persons employed dropped from 6,237,500 to 5,863,200 during the same period. The Annual Average of Unemployment rose dramatically from 6.4 in CY2008 to 10.0 in CY2009 reflecting an increase in the average number of Unemployed persons from 425,500 in CY2008 to 659,900 in CY2009.

The vast majority of individuals served in the Illinois public mental health system are unable to pay for their behavioral health care. They are either Medicaid–eligible or their services have been supported through DMH capacity grants. Beginning in FY2011, economic hardship has necessitated a demarcation of those consumers who are enrolled in Medicaid and those who are not. Medicaid recipients continue to receive the normal array of services while those who are not Medicaid eligible will receive limited service packages to be paid for with the minimal funding DMH has available. Service provision and coverage for them is now based on clinical criteria and financial eligibility. Those individuals and families below 200% of federal poverty level (FPL) are fully covered for the cost of the service packages, partially covered from 200 – 400%, and not covered at all when over 400%. Providers now need to obtain definitive information from clients regarding their household income and family size. As the data system integrates the updated financial information, DMH will be able identify the size of the currently uninsured consumer group and address capacity needs in a focused manner. As additional funding becomes available due to the ACA, mental health providers anticipate being able to enhance their clinical programs and increase their capacity to provide the necessary quantity and quality in services to more consumers. Every effort is currently being undertaken to support consumers who qualify to apply for Medicaid eligibility.

Illinois is on an annual budget cycle. Budget reductions are occurring in FY2012 and are expected to continue into FY2013. This year, a 20% to 25% statewide reduction in community services is anticipated unless the General Assembly restores some or all of the $40 million taken from this year’s budget. The outlook for any new funding for mental health services remains extremely bleak. In this constricted environment, DMH is making every effort to maintain essential mental health services for persons with the most serious mental illnesses through reallocation existing funds and has developed a very limited set of service packages to carry individuals who are not enrolled in Medicaid through this fiscal year.

Current Initiatives-Adult Services
Community Support Teams
Since FY2008, Community Support Teams (CST) has been operational as a core service to support recovery/resilience. Community Support Team services consist of therapeutic interventions delivered by a team that facilitate illness self-management, skill building, use of natural supports, and community resources to decrease crisis episodes and hospitalizations, and assist the client to achieve rehabilitative, resiliency and recovery goals. Interventions and activities are delivered in natural settings and are targeted toward the management and reduction of symptoms as well as the promotion of stability and independence. The aim of Community Support is to build capacity by assisting the individual to do for self. Reimbursement is based on medical necessity requiring documentation of psychiatric disability (diagnosis), currently assessed need, an existing service plan with allowable interventions, and continuing assessment of progress toward achieving recovery and resilience goals. Due to budget shortfalls, CST is limited to those consumers who are enrolled in Medicaid and are clinically suitable for this intensive service. Currently, fourteen community mental health centers are providing CST in Illinois.

Permanent Supportive Housing
Permanent Supportive Housing (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. A growing body of knowledge has documented the effectiveness of PSH and helped generate the systems changes needed to create it. The Division of Mental Health is committed to develop an array of Permanent Supportive Housing consistent with the flexible needs of consumers and associated with other new initiatives, i.e., Money Follows the Person (MFP) demonstration project, the Williams vs. Quinn legal settlement, and supportive employment. A concerted redirection of energy and resources has been necessary to ensure that consumers have choice on housing alternatives and that this choice has a foundation based on principles of recovery thereby expanding options for consumers to live independently.

Supportive Employment
Supported Employment (EBSE) is an evidence-based practice that has been shown to improve employment rates of persons with serious mental illness by as much as 60%. EBSE services in Illinois are based on integration of the DHS Division of Rehabilitation Services (DRS) funded vocational services and resources with DMH funded mental health treatment and supportive services. DMH and DRS have collaborated closely in this joint effort to increase access to Individual Placement and Support (IPS) supportive employment for persons with serious mental illnesses and to improve the coordination of psychiatric and vocational services. Locally, services are obtained through joint planning and service efforts by community mental health centers (CMHCs) and local offices of DRS. This evidence-based practice initiative has been supported by two grants: 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 number of mental health agencies working to implement EBSE and reaching fidelity to standards of EBSE based upon the Individual Placement and Support (IPS) model has steadily increased to 23 locations in the State meeting fidelity standards at the end of FY2011.

**Transitions to Community from Long Term Care**

There are a substantial number of individuals with serious mental illnesses who require long-term care services. Some require this level of care because of functional limitations associated with their mental illness, and others require it for functional limitations associated with both mental illness and medical needs. In either case, the lack of viable community alternatives for persons in this situation frequently necessitates their admission and continued care in longer term care facilities. The Illinois Department of Public Health (DPH) is responsible for monitoring the licensing requirements of nursing facilities, and the Department of Healthcare and Family Services (DHFS) oversees Medicaid funding. The DMH has made a concerted effort to assist community providers and these two state agencies to understand the service needs of persons with serious and disabling mental illnesses and the long term care service options that are available. DMH is currently working extensively through the initiatives described below to develop community-based alternatives to accommodate the needs of this population.

**The “Money Follows the Person” Federal Demonstration**

Illinois is receiving $55.7 million dollars in federal Medicaid reimbursement to assist individuals who have serious mental illnesses and who are living in non-IMD nursing facilities with seamless transition to community residential alternatives-(non-group home settings) and necessary support services. The “Money Follows the Person”(MFP) demonstration will facilitate the transition of approximately 3500 persons, between the involved state Departments, into their home communities over the course of several years. Over 500 individuals falling within the DMH identified priority population are to be transitioned. The Department of Healthcare and Family Services, the lead agency for the initiative, is working closely with the IDHS divisions of Developmental Disabilities (DDD), Rehabilitation Services (DORS) and DMH, the Department on Aging, and the Illinois Housing Development Authority (IHDA) on the project. IDHS is committed to maximizing reimbursement in support of the goals of consumer self-direction, independence and community reintegration. Programs under the MFP are designed to: (1) Eliminate barriers or mechanisms that prevent Medicaid–eligible individuals from receiving support for appropriate and necessary long-term services in the setting of their choice; (2) Increase the ability of the state Medicaid program to assure continued provision of home and community-based long term care services to eligible individuals who choose to move from an institutional to a community setting; and (3) Ensure that procedures are in place to provide for continuous quality improvement in these services for individuals receiving Medicaid home and community–based long-term care. DMH participates in the identification of appropriate candidates for transition to the community and contracts with provider agencies for the provision of services.
During Calendar Year 2010, the number of persons originally targeted to be transitioned by DMH (72) was exceeded and 99 persons were actually transitioned. By the end of CY2010, 126 persons had been transitioned since the demonstration project began at a total expenditure of over $4.2 million. The current goal is to transition a total of 108 by the end of December 2011. It is anticipated that at least 60% of this group will have been transitioned by the end of this fiscal year (June 30, 2011).

**Rapid Reintegration Pilot Project**

Through the use of Hospital Tax dollars, DMH initiated and has maintained a small scale pilot project in central and northern Illinois. While the MFP demonstration targets persons who have been in long term care for 90 days or longer, DMH’s Rapid Reintegration Pilot Project targets persons who have been in nursing homes for a year or less. Two CMHCs, one in Rockford, and one in Springfield, have been working to transition persons into community-based options since October 2008. As of July 2010, 42 persons had been transitioned.

**Williams vs. Quinn Consent Decree**

During FY2010 there was a Class Action Court Settlement to be finalized in FY2011 that may require additional financial resources available to the Department for mental health services. The Williams’ Suit targets individuals who are residents of Institutes for Mental Disease (IMD), Nursing Facilities in which more than 50% of the population is diagnosed with Serious Mental Illness. As such, an IMD cannot bill for federal Medicaid reimbursement and are 100% funded out of State General Revenue Funds. The premise of the Williams’ suit is that individuals with serious mental illness have not been afforded due process to move out of these facilities when they no longer require or desire this level of nursing care. There are 4,500 class members involved in this suit.

Key terms in the Consent Decree include the following:

- Development of community capacity. This requires the State to ensure the availability of services, supports, and other resources to meet its obligations under the Decree.
- Development of a service plan. For individuals currently residing in IMDs who do not oppose moving to a community-based setting and who are otherwise appropriate for community placement, the State will develop a service plan specific to each person.

The settlement, approved in September 2010 requires that all class members will be assessed and given the choice to transition to the most appropriate integrated community based options with support services over the course of 5 years. The ultimate goal is to transition them into independent living/permanent supportive housing. A Draft Implementation Plan detailing the steps to be taken by the State and the timelines towards reaching this goal was completed in February, 2011. Additional financial resources are anticipated by the Department to meet these mental health service needs. As all the class members may not be ready for independent living at the initial stage of transitioning, the service system is required to develop an array of housing options and clinical support.
services to best accommodate members' immediate transition needs. Concurrently, the state will have to ensure that transitioning consumers, who do qualify, based on clinical and functional criteria, for independent living can afford to live in community based housing. Expanding funding resources to ensure the availability of Bridge Subsidies (until permanent rental subsidies or Section 8 housing choice vouchers can be secured) for those who do qualify for Permanent Supportive Housing will be paramount.

However, to assure success, Illinois further recognizes that an array of available Community Services, including some non-Medicaid services, will be critical in achieving and sustaining the successful community placement of Williams Class Members. The existing infrastructure of services in the Illinois Medicaid State Plan is inclusive of mental health rehabilitation services, substance abuse and co-occurring services, services for persons with developmental disabilities and physical healthcare services that will be beneficial for Class Members. Twenty-five to 50% of Class Members seeking community placement are likely to have a co-occurring substance use disorder. Thus, coordination with DHS/Division of Alcohol and Substance Abuse Services (DASA) is critical for these individuals. DHS/DASA and DHS/DMH have a foundation in collaborating in the development and implementation of services for individuals with these co-occurring disorders.

A parallel Class Action Suit, Colbert, is currently being developed and targets nursing facilities that are not IMDs in the City of Chicago boundaries, only, and across disability populations. The total class for Colbert is 10,000. Potentially, there are an additional 5,000 individuals with mental illness in this Class. Like Williams, mental health services (including residential supports) and affordable housing will be necessary to ensure seamless and safe transitioning for this population. Accommodating the residential and support service needs of these legal settlements will necessitate extensive enhancement to the existing public mental health service delivery system.

**Framework for Continuing Collaborative Planning-Mental Health and Substance Abuse Prevention and Treatment**

DMH is in constant cross-divisional conversations with our sister agency, the DHS Division of Alcohol and Substance Abuse (DASA). Most recently, the divisions worked together in planning and convening a policy summit on bi-directional integration of behavioral health and primary health care. DMH and DASA have worked diligently together 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 FY2009 at four state hospitals; Elgin, Chicago Read, Madden, and McFarland. Sharing service delivery site resources 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 were warranted. Sharing facilities has resulted in the development of more hospital staff training and expanded the role of the DASA providers to perform linkage and engagement activities. In the past year, funding for these efforts has not been available. However, both divisions continue to highlight the clinical importance of integrated treatment for individuals who are dually diagnosed. Several sessions at the DMH EBP Conference held in April 2010 were focused on IDDT as an EBP sorely
requiring further development in Illinois. Treatment funded by DHS/DASA in Illinois emphasizes services that are consumer-oriented, geographically accessible, comprehensive, bridging continuing care responsibilities between all levels of an integrated system of care. Specialized training, technical assistance and case consultation are available from the Illinois Co-Occurring Center for Excellence (ICOCE) formerly, the MISA Institute, to assist providers in acquiring skills to assure the highest quality of integrated care is provided. The concepts, practices, and skills developed from IDDT and ICOCE, continue to be useful in addressing the treatment needs of individuals with co-occurring disorders.

Bi-Directional Integration of Behavioral health and Primary Care Services

In collaboration with the DHS Division of Alcohol and Substance Abuse (DASA), the Illinois Department of Healthcare and Family Services, and the Illinois Department of Public Health (IDPH), DMH planned and convened “Beginning the Conversation: A Statewide Policy Summit on Advancing Bidirectional Behavioral Health and Primary Care Integration” in Chicago, IL on June 22, 2011 – which focused on bi-directional service delivery models and convened key partners across State, County, providers and consumers from behavioral health and primary care to hear from national and local expert faculty about:

- Emerging evidence-based and best practice models and outcomes in integrated health care;
- Concepts of person-centered healthcare homes and accountable care organizations;
- Financing and payment reforms;
- Existing integrated models of care in Illinois;
- Involving consumers and family members in wellness and prevention services;
- Workforce implications for integrated care;
- Using health information technology to promote integrated care; and sharing information on existing integrated models of care within Illinois.

The goals of the Summit were achieved by bringing together a diverse group of healthcare providers, all of whom share the DHS mission to assume bidirectional integrated care delivery within local communities. Throughout the one day event, formally and informally, the Summit jump-started discussion and strategic planning among primary care and behavioral health providers and policymakers. The participants issued a resounding call to continue the discussions needed to further activate collaboration across the State.

DMH is maintaining a Summit Website as a means of continuing to share information and developments and build participation into the process. Since the Summit itself, several new items have been added to the “Related Links” website section including a link to videos of the entire day at “Summit Speaker Presentations – Web Links”; A “Final Summit Agenda and Workbook” ; and a list of all in-person “Summit Participants”. A “Summary of Small Group / Technical Assistance Recommendations” plus a “Summary
of Summit Evaluations” will be added to the website shortly. The Summit Website may be accessed at: http://www.dhs.state.il.us/page.aspx?item=55312

DMH is currently considering the development of a series of focused follow-up meetings and anticipates assuming an active role in a working partnership with DASA, DPH, and DHFS in accomplishing the tasks required to move forward in bi-directional integration of primary health care and behavioral health. These tasks include: assisting in needs assessments, formulating recommendations on reforming the delivery system for chronic disease prevention and health promotion, ensuring adequate funding for infrastructure and delivery of programs, addressing health disparities, and considering the role of health promotion and chronic disease prevention in support of state spending on health care.

Issues related to primary health care in other venues continue to be addressed with a special emphasis on the relationship between primary health care and mental illness. These include the following activities.

DMH is a charter member of the Illinois Department of Public Health’s Chronic Disease Prevention Task Force and is actively collaborating with other member agencies in developing management strategies to address issues relevant to individuals with behavioral health needs who also suffer with chronic diseases.

DMH continues to emphasize the importance of assisting adult consumers in the completion of applications for Medicaid benefits as one means of assuring that access to health services are available. Individuals with serious mental illnesses who are Medicaid recipients are entitled to the range of health services covered in the Illinois Medicaid plan.

Programs implemented by the Department of Health Care and Family Services (DHFS) follow a Disease Management model. Illinois Health Connect is a statewide Primary Care Case Management (PCCM) Program for most persons covered by DHFS medical programs. DMH is collaborating with DHFS on two distinct projects that impact Medicaid recipients. Under the Primary Care Case Management (PCCM) – Disease management (DM) program (Health Care Connect), DMH facilitates an active team process that links mental health providers with PCCM/DM case managers in order to (1) assure the most active linkage of the enrollee and the Primary Care Provider, and (2) facilitate an exchange of information and a combined work effort from both PCCM and MHC providers in identifying, assessing, treating, tracking, monitoring and engaging all enrollees with mental illnesses. The most recent focus has been on those persons assessed by the PCMM/DM team as high and medium risk. People who are enrolled in Illinois Health Connect have a “medical home” through a Primary Care Provider (PCP) who coordinates and manages their care.

In FY2011, DMH is working with DHFS, to pilot an integrated managed care system in Suburban Cook County and adjacent counties in the Chicago Metropolitan Area (not including the City of Chicago) which will include behavioral health with primary health care. This project is currently in the enrollment phase and has not yet been fully implemented. Medicaid AABD (aged, blind and disabled) recipients are being placed into a managed care arrangement with vendors who will be implementing a fully integrated
service delivery system, DMH is acting as the subject matter expert and facilitator for mental health matters.

The establishment of relationships between Federally Qualified Health Centers (FQHCs) and DMH funded community mental health agencies is also being emphasized. DMH continues to explore options for more extensive collaboration with Health Resources and Services Administration (HRSA) funded Federally Qualified Health Centers (FQHCs) in Illinois. CMHC’S in rural areas have been interested in this collaboration as a means of integrating services in order to provide greater access for rural residents. Several have participated in joint piloting efforts.

**Provision of Recovery Support Services**

The provision of mental health care that is consumer and family driven is an important priority of the Illinois Division of Mental Health. This priority is consistent with the current emphasis on involving consumers and families in orienting the mental health system towards recovery, and to improving access to, and accountability for mental health services. Consumer participation block grant objectives for FY 2012/2013 support the DMH priority for furthering work on the recovery vision in Illinois, by encouraging consumers and family members to participate in decision-making and service planning efforts. Some of these objectives are continuations of efforts initiated in prior fiscal years.

Recovery oriented training sessions were held in a variety of venues for all interested stakeholders in FY2011. Audiences for these sessions included diverse stakeholder groups and focused on 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 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). Access to this credential became available through the ICB beginning in July of 2007. 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 will provide quality services. 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. As of May 1, 2011, 132 individuals had achieved their CRSS certification, and all were in good standing with the Illinois Certification Board (ICB).

In FY2011, the DMH Office of Recovery Support Services continued 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 credential. Webinars for provider agencies are planned in FY2012 to help increase agencies’ understanding of the role, value, function, and advantages of hiring CRSS professionals. The aim is to increase the number of agencies hiring CRSS professionals in FY2013.

Moving toward a recovery-oriented system of care requires the utilization of evidence-based and promising practices related to locus of service delivery and the use of technology in the delivery of mental health and substance abuse services. The Wellness Recovery Action Plan (WRAP) model has been established and is fully operational in Illinois. Through provision 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 evidence-based practice in recovery-oriented services.

The principles of Recovery overlap both mental health and substance abuse. A clear statement of these principles is provided in the CSAT White Paper: Guiding Principles and Elements of Recovery-Oriented Systems of Care

Briefly stated they are:

- There are many pathways to recovery.
- Recovery is self-directed and empowering.
- Recovery involves a personal recognition of the need for change and transformation.
- Recovery is holistic.
- Recovery has cultural dimensions.
- Recovery exists on a continuum of improved health and wellness.
- Recovery is supported by peers and allies.
- Recovery emerges from hope and gratitude.
- Recovery involves a process of healing and self-redefinition.
- Recovery involves addressing discrimination and transcending shame and stigma.
- Recovery involves (re)joining and (re)building a life in the community.
- Recovery is a reality. It can, will, and does happen.

For DMH and DASA, cross training of key leadership staff has been a prominent activity related to Recovery. DMH has provided WRAP Training for DASA at the management level, and also at DASA’s annual AATI conference. DASA has very recently (within the past year) been rolling out the new ROSC (Recovery Oriented Systems of Care) training and DMH executive staff were among the initial group that received the training. This has resulted in a cross-fertilization of staff and a development of an understanding of recovery principles.

DASA is currently intending to develop a five year state plan organized around a recovery-oriented system of care (ROSC) to ensure that an appropriate mix of substance abuse services and recovery supports for both youth and adults is available and accessible throughout the state. As part of this effort, DASA has actively been moving forward in redefining a new business model that reorients away from compliance and oversight.
related activities toward a focus on quality of services, program performance and outcomes.

To develop a statewide infrastructure to effectively and efficiently integrate ROSC principles, practices, and services into the existing prevention and treatment service system in Illinois, DASA is providing training for DASA staff, stakeholders and providers on ROSC principles and practices and is planning to use therapeutic and clinical interventions and non-clinical community-based resources that support recovery, early identification, engagement, and sustenance of the recovery process for individuals and families. Recovery Support services included in the planning process are funded and provided through Access to Recovery (ATR), a Presidential initiative to provide client choice among substance abuse clinical treatment and recovery support service providers, as well as to expand access to a comprehensive array of clinical treatment and recovery support options, including faith-based programmatic options. ATR offers a wide array of services to clients in need, including:

- Outpatient and Intensive Outpatient treatment for methamphetamine and National Guard clients
- Continuing Care
- Employment Coaching
- Pastoral Counseling
- Peer Coaching
- Recovery Coaching
- Recovery Home for National Guard Clients
- Recovery Skills
- Spiritual Support
- Transportation Assistance
- Vocational Training

**Collaborative Focus on Military Personnel and Veterans**

Military personnel returning from the wars in Iraq and Afghanistan are at increased risk of traumatic brain injury, post-traumatic stress disorder, depression, anxiety and other mental health symptoms as well as new-onset heavy drinking, binge drinking and other alcohol-related problems. Anxiety, depression and engagement in high risk behaviors, such as substance abuse, are more likely among adolescents in families with a deployed parent than among similar adolescents in non-deployed families (Chandra et al., 2009). Given the increasing recovery needs among returning military personnel and their families, both DMH and DASA are working to improve partnerships with the Illinois National Guard and Illinois Department of Veterans Affairs in order to improve access to mental health services, alcohol and other drug treatment, and recovery support services among military personnel returning from deployment and their families. Through proposed grants, DASA is seeking to provide substance abuse treatment and/or recovery support services to at least 200 returning Illinois National Guard members and to increase treatment outreach efforts to engage teens with substance abuse problems and who either currently have or have had a deployed parent. Through a SAMHSA grant of approximately $2 million over 5 years, DMH has established 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.

**Expenditures and Services for Co-Occurring Mental Health Disorder and Substance Abuse Disorders**

Budgetary constraints in Illinois have impeded funding for any special initiatives to address the needs of consumers with co-occurring disorders. However, DMH and DASA have collaborated to address services for individuals with co-occurring disorders for many years. Initiatives have included the establishment of consortiums comprised of mental health and substance abuse providers to collaborate on treatment provision, cross-training of providers from both service systems focusing on integrated treatment, and the funding of an institute to provide training to service providers across the state. DMH and DASA have jointly participated in the SAMHSA National Policy Academy on co-occurring disorders. Staff of both Divisions have been actively working together to implement integrated treatment. The DMH and DASA collaborated to apply for a SAMHSA grant to train providers and evaluate the implementation of Integrated Dual Diagnosis Treatment (IDDT) in 2003 which resulted in an award. The grant ended in FY2007 with fairly successful results. Since then, DMH has continually assessed the feasibility of realigning those activities with new funding which has not become available.

DASA contracts with Heartland Alliance to fund the Illinois Co-Occurring Center for Excellence (ICOCE) to provide training, technical assistance, and consultation to agencies that provide dual diagnosis treatment. ICOCE defines its central role as fostering the use of evidence-based practice models for the treatment of co-occurring substance use and mental health disorders. Consultation is also provided in related areas such as recovery-oriented systems of care, supported employment, illness management, motivation to change and organizational change issues, cultural competence, HIV-AIDS, and trauma. Consultation and training are offered to DASA providers as requested and needed due to limited resources.

In reference to children and youth, DASA has been a leading participant in the DMH Family Driven Care initiative and has collaborated with DMH in providing training on trauma informed prevention, treatment and recovery as well as adolescent and family co-occurring disorders and their treatment. The DMH C & A Services unit in collaboration with DASA continues to explore the need for staff training and current program capacity issues to address the clinical needs of this population.

Currently, DMH continues to implement WRAP which is seen as bridging the gap between traditional mental health treatment and traditional substance abuse treatment for individuals with co-occurring disorders. The use of Wellness Recovery Action Planning principles of self-determination, personal responsibility, and empowering support are a means of addressing an individual’s divergent needs.
Providers who are funded by both DMH and DASA are positioned to work with clients with co-occurring disorders (COD). That value and vision is clearly espoused by both divisions. However, while some DASA and DMH providers are considered Capable of providing COD services, very few mental health programs in Illinois are fully enhanced to the point of following the IDDT model with adherence to most of its fidelity standards. The table below depicts the Integrated Treatment Continuum for COD which was extrapolated and condensed from the DDCAT by Mark McGovern and the SAMHSA IDDT Fidelity Scale and was used as a training tool during the course of the SAMHSA grant, to help conceptualize the continuum of care resulting in co-occurring enhanced substance abuse and mental health service delivery. It was based on seven criteria and differentiates the characteristics of being COD capable and being COD enhanced from the polar Substance Abuse and Mental Health perspectives. (See Table A)

The ongoing efforts of DMH and DASA in the areas of bidirectional integration, recovery and co-occurring disorders, although limited by budgetary constraints, clearly reflect vision and principles that emphasize behavioral health as an essential part of overall health in which prevention works, treatment is effective and people do recover. Working within the broader context and resources of the Illinois Department of Human Services, both divisions have a continuing commitment to building systems and continuums of care which are applicable to the provision of mental health and addiction services and cross the lifespan of individuals who need and use these services.
# Integrated Treatment Continuum for Co-Occurring Disorders

<table>
<thead>
<tr>
<th></th>
<th>COD-Substance Abuse</th>
<th>COD-Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Treatment Focus/Philosophy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SA only</td>
<td>Addiction only</td>
<td>Focus is on MI; COD patients are treated while adhering to some IDDT treatment philosophies</td>
</tr>
<tr>
<td>COD Capable</td>
<td>Primary Focus is an addiction, co-occurring disorders are treated</td>
<td></td>
</tr>
<tr>
<td>COD Enhanced</td>
<td>Primary Focus is COD patients</td>
<td>Focus is on COD patients with philosophy following the IDDT model</td>
</tr>
<tr>
<td>Coordination &amp; Collaboration between providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No document of formal coordination or collaboration</td>
<td>Formalized and documented coordination or collaboration with mental health agency</td>
<td>Full array of MH services with integrated substance abuse treatment. IDDT expert as team leader.</td>
</tr>
<tr>
<td>COD Capable</td>
<td>Formalized and documented coordination or collaboration with mental health agency</td>
<td>No IDDT expert some SA experience – some stage based treatment</td>
</tr>
<tr>
<td>COD Enhanced</td>
<td>Most services are integrated within the existing program or routine use of case management staff or staff exchange programs</td>
<td>Little to no SA expertise; only routine MH treatment offered.</td>
</tr>
<tr>
<td>COD Capable</td>
<td>Full array of MH services with integrated substance abuse treatment. IDDT expert as team leader.</td>
<td></td>
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<tr>
<td>MH only</td>
<td></td>
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<tr>
<td>Stage-wise treatment</td>
<td>Not assessed or documented</td>
<td>Clinician assessed and documented, used in planning; Individualized plan but not explicitly stage based</td>
</tr>
<tr>
<td>COD Capable</td>
<td>Clinician assessed and documented, used in planning; Individualized plan but not explicitly stage based</td>
<td>Clinician assessed and documented routinely, used in planning; not all interventions are stage based.</td>
</tr>
<tr>
<td>COD Enhanced</td>
<td>Formal measure used &amp; integrated in treatment planning; formally prescribed stage-wise treatments.</td>
<td>Only routine MH treatments</td>
</tr>
<tr>
<td>COD Capable</td>
<td>Formal measure used &amp; integrated in treatment planning; formally prescribed stage-wise treatments.</td>
<td></td>
</tr>
<tr>
<td>Motivational Interviewing &amp; Cognitive Behavioral</td>
<td>Rarely used or not at all</td>
<td>Used variably, by inexperienced practitioners not spread to entire</td>
</tr>
<tr>
<td>COD Capable</td>
<td>Used regularly with experienced practitioners at appropriate stage</td>
<td>Used regularly with experienced practitioners at appropriate stage</td>
</tr>
<tr>
<td>COD Enhanced</td>
<td>Used regularly with experienced practitioners at appropriate stage</td>
<td>Used variably, by inexperienced practitioners not spread to entire program</td>
</tr>
<tr>
<td>COD Capable</td>
<td>Used variably, by inexperienced practitioners not spread to entire program</td>
<td></td>
</tr>
<tr>
<td>MH only</td>
<td>Rarely used or not at all as applied to SA</td>
<td></td>
</tr>
<tr>
<td>Therapy</td>
<td>program</td>
<td>of treatment</td>
</tr>
<tr>
<td>------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Process Monitoring</td>
<td>Standardized monitoring at a minimum annually and is used to guide improvements</td>
<td>Standardized monitoring is only done annually and may not be used to guide improvements</td>
</tr>
<tr>
<td>Outcome Monitoring</td>
<td>Standardized COD outcome monitoring occurs at least once a year and results are shared with practitioners</td>
<td>Standardized COD outcome monitoring occurs at least once a year and results are shared with practitioners.</td>
</tr>
<tr>
<td>Family education and Support</td>
<td>For alcohol or drug problems only</td>
<td>Consultant or collaborative agreement with therapist for SUDs and MH onsite group</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Active family members are able to collaborate with treatment team, some education to family members variably given</td>
</tr>
</tbody>
</table>

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Trauma Initiatives

Consistent with Joint commission on Accreditation of Healthcare Organizations (JCAHO) Core Measures, beginning in 2009, a trauma screening is administered upon admission to any DMH hospital. Results of this screening are incorporated into an individualized Personal Safety Plan that identifies potential triggers for the re-experience of trauma as well as types of interventions likely to be most helpful and effective. DMH hospitals have also adopted the trauma sanctuary model, which establishes a therapeutic milieu for information sharing, communication and problem solving.

Since 2008, the Division of Mental Health has been offering Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) groups to youth incarcerated within the Department of Juvenile Justice’s Illinois Youth Centers. This program was in response to the growing body of research documenting the high incidence of trauma for youth involved in the juvenile justice system. Groups have been offered in three of the eight Illinois Youth Centers and initial analysis of outcome data has shown promising results.

Military Personnel

In 2008, the Division of Mental Health was awarded a $2 million grant (over 5 years) from the Substance Abuse Mental Health Services Administration. The grant, entitled Jail Diversion – Trauma Recovery (priority to veterans) is designed to divert individuals, with histories of trauma, from the criminal justice system, and into evidence-based trauma treatment in the community. The Illinois Project entitled: Veterans Reintegration Initiative, targets veterans of Iraq and Afghanistan showing trauma symptoms, for jail diversion and enrollment in trauma treatment. The Directors of the Division of Mental Health and the Department of Veterans Affairs co-chair the project’s Statewide Advisory Group, which is comprised of stakeholders from other state agencies, the Veterans Administration, the judiciary, community providers, private foundations and veterans with lived experience.

In 2008, the Illinois Legislature enacted Public Act 095-0576 directing the Department of Veterans Affairs, in consultation with the Department of Human Services, to contract with professional counseling specialists to provide a range of confidential and direct treatment services to veterans. The Department of Veterans Affairs, in consultation with the Division of Mental Health, established the Illinois Warrior Assistance Program (IWAP), staffed by mental health professionals through Magellan Health Services. IWAP provides a 24-hour, toll free number for confidential assistance with emotional challenges veterans may face reintegrating into civilian life. Screenings for traumatic brain injury and post-combat trauma reactions are also available through IWAP.

Public Act 095-0576 also directs the Department of Veterans Affairs, in consultation with the Department of Human Services, to:
• Develop an educational program designed to train and inform primary health care professionals, including mental health care professionals, on the effects of war-related stress and trauma.

• Provide informational and counseling services for the purpose of establishing and fostering peer support networks through the state for families of deployed members of the reserves and National Guard.

• Provide veterans’ families with a referral network of providers skilled in treating deployment stress, combat stress, and post-deployment stress.

The Division of Mental Health, as a member of the Illinois Families of Fallen Service Member Task Force, has offered the first in a series of outreach events to surviving families of fallen service members.

The Division of Mental Health has longstanding partnerships with members of the judiciary (both local and statewide) and has supported the establishment of Veterans’ Specialty Courts throughout the State. The Division of Mental Health has also offered consultation to local private foundations (the Michael Reese Health Trust and McCormick Foundation) regarding their desire to establish outreach services to veterans and their families.

**Strengths, Needs, and Priorities of the System**

The vision for mental health services in Illinois as articulated in previous plans continues. We envision a well resourced and transformed mental health system that is consumer directed and community driven providing a continuum of culturally inclusive programs which are integrated and effective, a range of direct and support services (including prevention, early intervention, treatment and supports), that support healthy lifelong development through equal access and promote recovery and resilience. The Illinois Vision for Mental Health is that:

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"All persons with mental illnesses can recover and participate fully in community life:

- The expectation is recovery
- The consumer is central
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Many of the activities in which the DMH is engaged are providing the foundation to make this vision a reality even in an era of great fiscal challenge.

Important strengths of Illinois’ community-based mental health system for adults are described below. It is important to note that while we aptly describe our strengths, significant challenges continue to confront the public mental health service system. Fiscal constraint in the past few years has resulted in limited growth and implementation of a number of initiatives and the discontinuation of others. With the creativity and innovation of the past several years, there has also been increasing awareness of the lack of sufficient resources with which to actualize and transform the service system to fully and rapidly achieve the vision articulated below. In FY2012/FY2013, the system is facing serious fiscal challenges and is anticipating further reduction instead of growth. DMH efforts are currently geared towards finding practical solutions to challenges and sustaining gradual and incremental progress where possible.
Current strengths in the system are:

✓ The array of core services available to adults with serious mental illnesses who are enrolled in Medicaid and the crisis services available to all consumers.
✓ Commitment to a recovery orientation by mental health system stakeholders.
✓ The focus on consumer and family driven care.
✓ Commitment to the implementation of evidence-based practices within budgetary constraints.
✓ Involvement of consumers in planning, implementing and evaluating the initiatives and ongoing activities of the public mental health system.
✓ Ongoing emphasis and efforts to reduce hospitalization.
✓ Effective collaborations with other divisions of the IDHS and with other state agencies have been a successful strategy for improving and enhancing services throughout the system.
✓ A recently established data warehouse and improvements to the Management Information System expanding access to data which is vital to support decision making.
✓ Through external resources, such as the Data Infrastructure Grant, federally funded studies, and DMH initiatives, our databases and analytic capabilities have steadily grown to an extensive array of computerized information that provides an important resource for analyzing service provision and service needs.
✓ Continuing commitment to develop and implement service models for persons with mental illnesses who are homeless, such as the innovative use of PATH funds. Illinois has continually increased services including expanded intensive outreach to homeless individuals with serious mental illnesses.
✓ Active collaboration and effort to develop and evaluate approaches to improving housing services such as Permanent Supportive Housing (PSH) and successful advocacy for appropriations from the state legislature to support these promising approaches.
✓ The DMH has made a substantial commitment toward increasing the portion of the DMH funds allocated to community-based treatment versus inpatient services for persons with mental illnesses.
✓ In recognition of the increasing role played by federal Medicaid funds, the DMH has worked successfully to increase this revenue source.
✓ The DMH has maintained a strong joint public and academic program which continues to include Departments of Psychiatry, Social Work, Psychology, and Nursing in universities across the State. All state hospitals in Illinois have agreements with universities to serve as training sites for psychiatric residency programs. Similar programs with Departments of Social Work, Psychology, and Nursing in universities across the state provide fertile ground for the recruitment of program graduates who are well grounded in public mental health as a result of their residencies.
SECTION II-B
STATE PLAN- CHILD & ADOLESCENT SERVICES

I. Assessment of Strengths and Needs

DESCRIPTION AND OVERVIEW OF CHILD AND ADOLESCENT SERVICES
Illinois has made substantive progress in developing a comprehensive mental health service system for youth with serious emotional disturbances (SED) and their families. In Child and Adolescent services, the emphasis is on resilience and evidence informed practice as components in the systemic transformation process. Many of the activities in which the DMH is engaged are providing the foundation to make this vision a reality.

The Child and Adolescent Services office is led by a board certified Child and Adolescent Psychiatrist and consists of Statewide C&A Staff, some of whom are geographically located in each of five regions of the state. Specialty program grants specific to children and adolescents are managed by Central Office Child and Adolescent Services staff who have expertise in such areas as mental health services in schools, transition services for youth, early childhood services, and mental health prevention and early intervention for children and youth.

The five geographic Comprehensive Community Service Regions (CCSRs) are responsible for contracting activities with 124 child serving agencies which either provide specialized services or are community mental health centers with children’s programming. They also collaborate with and monitor local hospitals that provide psychiatric programs for youth. The localized integration of a comprehensive care system including mental health, substance abuse, child welfare, juvenile justice, and education is within their purview. Each CCSR has access to C&A staff specially designated to address child and adolescent and juvenile forensic service issues. Consumer parents (Family Consumer Specialists) are regionally based and function in the critical system role of connecting DMH services to their communities while providing DMH with the consumer family voice and input from their communities.

Being part of DHS has provided an opportunity for the DMH to address a number of challenges within the shared mission of one Department such as: prevention, early intervention, integration of vocational and educational services, coordination and development of Mental Illness and Substance Abuse (MISA) services and, through the coordinated intake process, an opportunity to enhance case finding, early identification, and outreach efforts.

Illinois Systems of Care

System of Care (SOC) grants are funded by the United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. These grants are awarded to the state and local governments to develop and build systems of care for children, youth, and their families. The grants
are usually awarded for five year periods. There are three SOC grants currently active in Illinois. Additionally, DMH has applied to SAMHSA for a one year grant to seed a statewide approach to building systems of care. The three current projects are:

The McHenry County System of Care:
A System of Care grant was awarded to McHenry County and funded in 2006. DMH has partnered with the McHenry County Mental Health Board to implement system of care transformation, on a local level. The mission of this project “is to meet the social and/or emotional needs of families, children, and youth by providing leadership to develop and sustain a community of care that provides continuous support and easy access at every level of care. The grant will improve access to services for four underserved populations: preschoolers with serious social/emotional problems, youth with serious emotional disturbances and co-occurring substance abuse problems, young adults 18-21 years old with mental illnesses, and Latino children.

Champaign County- ACCESS Initiative
Through the ACCESS Initiative, the Division of Mental Health together with youth, families, and child-serving agencies in Champaign County will increase capacity to serve children and youth with serious emotional disturbances and their families by transforming the county’s services into an integrated network of community-based services and supports that are family-driven, youth-guided and culturally competent. The grant was awarded in FY2010. This initiative is community-based, using a public health facility located in close proximity to at-risk neighborhoods to reduce stigma and promote linkage between physical and behavioral health services and is targeting African American youth with SED, ages 10-17 who are involved with (or at risk of involvement with) the juvenile justice system.

Project Connect-White, Saline, and Gallatin Counties
This System of Care grant was awarded in FY2010. Project Connect is a collaborative initiative for youth with serious emotional disturbances and their families with the mission of providing a seamless System of Care for the three rural, southeastern Illinois counties (White, Saline, and Gallatin) that is family-driven, youth-guided, strengths-based, sustainable, culturally and linguistically competent. The three counties have high poverty rates, low levels of adult education, high levels of disability, and high Medicaid enrollment. The area is substantially underserved for mental health, with only 10% of the children and youth with serious emotional disturbances receiving special education services; outpatient services are limited, resulting in 10% of youth with serious emotional disturbances being hospitalized each year. Project Connect is available to all children, birth to age 21, in these counties, but targets three groups that are particularly in need of additional support: (1) Youth transitioning to adulthood (age 16-21), (2) youth receiving special education services, and (3) youth undergoing major developmental transitions (into grade school, into middle school, and into high school). The initiative is implementing universal screening of youth through the schools at three points in their K-12 education, hiring Family Resource Developers and Care Managers to work in concert with school-based social workers and mental health service providers in the community; and offering evidence-based practices to support youth and family development (such as
Wraparound services, parent skills training, and services focused on transitioning to adulthood).

**Illinois United for Youth-(IUY)**

In addition to the three current SOC Grants, a new grant application was submitted to SAMSHA for a 12 month System of Care Expansion Grant. The Illinois United for Youth System of Care Expansion Planning Initiative (IUY) will result in the development of a comprehensive strategic plan for integrating the system of care philosophy into the delivery of a full array of behavioral health services for youth with serious emotional disturbances statewide throughout Illinois. The objectives of IUY will build upon and reflect the goals of current system of care work including infrastructure development and sustainability, youth and family involvement, readiness for the adoption and implementation of core SOC principles across the state and the development of a statewide SOC blueprint including action steps that aim to create and sustain a statewide system of care. Of highest priority will be the development of a statewide lead family organization and an SOC primer training opportunity for key stakeholders.

The collective experience acquired from the three current SAMSHA funded Systems of Care in Illinois and the work of the Interagency Child Serving Clinical Care Coordination Committee, which has been planning for statewide change since Fall 2010 will provide direction for initiating, planning and implementation of the Initiative. As with the current grants, the strategic planning will leverage the commitment of youth, their families, the child serving state agencies that serve them and a myriad of stakeholders.

The IUY Planning Team looks forward to the opportunity to apply lessons learned from current SOC projects and the challenge of strategic planning for statewide expansion of SOC ideology should the Grant application be accepted.

System of Care concepts have also captured the attention of the Illinois Children's Healthcare Foundation (ILCHF) which has a single vision: to ensure every child in Illinois has the opportunity to grow up healthy and the philosophy that health care must address the whole child, and that the healthcare system in Illinois must be responsive to the needs of all children. Working through grantee partners across the state, the Foundation focuses its grant-making on identifying and funding solutions to the barriers that prevent children from accessing the ongoing health care they need. Through a process of research, listening, and planning, the Foundation has focused its current grant making in two high needs areas in children's health: Improving oral health of Illinois' children and addressing the mental health needs of children in Illinois. The Foundation believes the mental health of children is as important to their overall well-being as their physical health. Since its inception, ILCHF has supported efforts to bring together coordinated and integrated community-based primary care and mental health services for children.
Individual Care Grants for Children with Mental Illness

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 Illinois Mental Health Collaborative for Access and Choice (the Collaborative) provides support for administrative procedures. The ICG program is family driven, meaning that families make the decision regarding whether they wish to utilize their grant for residential or community based services. These decisions are generally made with consultation from the mental health providers working with the family. Services provided include intensive, home-based support, treatment, and therapeutic stabilization services that allow the child to remain at home. The ICG program is unique in the sense that parents do not have to relinquish custody of their children to obtain these services. An ICG Advisory Council was established in FY2001 and continues to provide input to planning and service delivery.

Community-based ICG services are coordinated through agencies funded to provide SASS services. 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. The SASS agencies work with families to identify appropriate support services, serve as a fiscal agent by purchasing the services specified in an approved plan, and monitor their effectiveness in meeting the youth's clinical needs. The program offers a number of supports, including child support services, case coordination services, behavior management services, and therapeutic stabilization services. In FY2010, 150 youth were served in Community-Based care out of the 374 youth in the ICG Program, which represented 40% of the total population and is consistent with the percent served in Community-Based care in previous years. ICG services are available across the state.

Early Intervention for Children of Incarcerated Parents

An early intervention program located in Chicago’s North Lawndale community, successfully piloted in the past few years, serves children of incarcerated parents. Utilizing a Multi-Family Group format, the 14-week curriculum of Strengthening Families for the Future Program designed for at risk families is employed to reconstruct relationships within the families. The program also provides case management, mentoring, tutoring, and individual/family therapy. Referrals to the program come from local elementary schools, social service agencies, Cook County Jail, and the state’s corrections system. There were several program service enhancements initiated over the last year including crisis counseling, career counseling and assessments and community education with presentations at schools, health fairs and local psychiatric hospitals. A total of 116 children and youth and 31 parents, totaling 147 families received direct service this year.
The success of this project led to its replication in Southern Illinois, in Madison and St. Clair Counties. This program employs clinicians that are responsible for the clinical work and for outreach as well as stakeholder education. Family support, case management, individual and group therapy are provided. Children and youth are eligible if they have at least one parent incarcerated with a release date no further out than two years and an intention of returning to a primary parenting role. Upon the parents’ release, they are reunified with their child and linked to the resources in the community. Currently there are twenty families being served.

**Mental Health and Juvenile Justice**

Youth in the juvenile justice system have disorders that can be effectively treated with psychopharmacological and behavioral interventions. These interventions are usually more successful when they are coordinated with other major service systems impacting the child and family. Research has demonstrated that the majority of juveniles in detention centers meet the criteria for a psychiatric diagnosis and one in six has a serious mental illness. Many of those also have a co-morbid substance abuse disorder (Teplin, et al. 2005). The juvenile justice system frequently either fails to identify these youth or fails to provide the necessary mental health treatment. The Mental Health Juvenile Justice (MHJJ) program was conceived and implemented to address this critical need. MHJJ provides an alternative to incarceration for juvenile detainees with serious mental illnesses, by arranging for the necessary mental health services to address individual clinical needs. The Division of Mental Health initially funded MHJJ as a pilot project in 2000 in just seven counties and subsequently expanded the project 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. Since FY2008 two community agencies in Cook County have offered MHJJ services with the goal of increasing outreach and linkage to the Latino community. The MHJJ program now covers 34 Illinois counties, involves 21 community agencies and has approximately 60 community-based clinical staff participating.

**Initiatives of the Illinois Department of Healthcare and Family Services (DHFS)**

DHFS, the Illinois Medicaid Agency, is implementing initiatives that impact mental health service delivery. One initiative is the All Kids insurance program that significantly expands medical and mental health services to children across the state. A second initiative is Disease Management, which seeks to manage and coordinate services across service systems for individuals with targeted diagnoses.

**Child and Adolescent Service System**

Illinois has made substantive progress in developing a comprehensive mental health service system for youth with serious emotional disturbances (SED) and their families. Illinois envisions a well resourced and transformed mental health system that is consumer directed and community driven with a continuum of integrated and effective culturally inclusive programs and services including prevention, early intervention and treatment that promote healthy lifelong development through equal access and support recovery and resilience. In Child and Adolescent services, the emphasis is on resilience and
evidence informed practice as components in the systemic transformation process. Many of the activities in which the DMH is engaged are providing the foundation to make this vision a reality even in an era of great fiscal challenge.

**Service System Strengths**

Important strengths of Illinois’ community-based mental health system in relation to children/adolescents are described below. It is important to note that while we aptly describe our strengths, significant challenges continue to confront the public mental health service system. Fiscal constraint in the past few years has resulted in limited growth and implementation of a number of initiatives and the discontinuation of some others. With the creativity and innovation of the past several years, there has also been increasing awareness of the lack of sufficient resources with which to actualize and transform the service system to fully and rapidly achieve the vision articulated below. In FY 2012, the system is facing significant fiscal challenges and is anticipating further reduction instead of growth. DMH efforts are currently geared towards finding practical solutions to challenges and sustaining gradual and incremental progress where possible.

- The array of essential services that is available to youth with serious emotional disturbances who are enrolled in Medicaid and their families.
- The commitment to evidence informed practices and the dissemination of information regarding the implementation of evidence-informed practices that lead to resilience.
- The consistent commitment and ongoing efforts to divert children and adolescents from inpatient and residential treatment to services in their home communities as exemplified by the SASS (Screening, Assessment and Support Services) program and the DMH Individual Care Grant (ICG) Programs. These individualized ICG or SASS services include intensive home-based support, treatment and respite care which allow the child to remain at home.
- Planning for family driven care as the foundation for current and future planning efforts.
- The on-going collaboration with the Children’s’ Mental Health Partnership has been fruitful in providing the resources needed to advance several vitally needed initiatives including services to youth in transition, early intervention, and the promotion of Evidence Informed Practices.
- Family Resource Developer positions have been created and maintained across the state and have also been an active component of the System of Care initiatives.
- Collaborative efforts, pilot projects, and vocational/employment supports to address the needs of youth with serious emotional disturbance transitioning to adulthood, including those transitioning from correctional settings and the child welfare system.
- Maintenance and further expansion of the clinical outcomes analysis system for children/adolescents that can generate multi-level data reporting.
- The state health care coverage program that offers comprehensive, affordable health insurance for children in Illinois assures that every uninsured child,
regardless of income or medical condition has access to health care, including mental health services. Additionally healthcare coverage is extended to parents living with their children 18 years old or younger and relatives who are caring for children in place of their parents.

✓ Through external resources, such as the Data Infrastructure Grant, federally funded studies, and DMH initiatives, our databases and analytic capabilities have steadily grown to an extensive array of computerized information that provides an important resource for analyzing service provision and service needs.

✓ Collaboration with IDHS Divisions and state agencies to ensure continuity of care and service integration is a multifold strength of the DMH service delivery system for children and adolescents.

✓ The statewide Mental Health Juvenile Justice (MHJJ) program brings services to youth in county detention centers across the State in collaboration with juvenile justice.

✓ Long-standing collaborations are in place with the DCFS, the ISBE and the DASA. The DMH has partnered with these agencies to implement the wraparound approach to the delivery of children's services as well as to provide or coordinate delivery of mental health services. More recently, collaboration with DCFS and DHFS expanded the provision of SASS services.

✓ Three System of Care grants in Illinois are addressing collaborative issues and shaping service delivery systems. Illinois has applied for System of Care statewide planning grant.

✓ Innovative collaborative programs addressing the needs of children in the inner city including Project Launch and the Early Intervention for Children of Incarcerated Parents, both located in Chicago’s Westside communities.

✓ The IDHS Homeless Youth program has existed for many years and provides outreach and a range of services for homeless youth ages 14-21. In Chicago, Beacon Therapeutic Center's Shelter Outreach Services (S.O.S.) program utilizes a preventive model which focuses on intervention with children and parents in the shelter setting and provides targeted case management and mental health services to women and children in 22 shelters on the south, north, and west sides of Chicago. Services focus on the identification of untreated mental illness, developmental delays, substance abuse, needs assessment, advocacy, coordination services and follow-up supportive services.

✓ The DMH has made a substantial, successful and sustained commitment to increasing the portion of the DMH funds allocated to community-based treatment for children and adolescents with serious emotional disturbance and their families.

✓ In recognition of the increasing role played by federal Medicaid funds, the DMH has worked successfully to increase this revenue source to benefit children’s services.

✓ The DMH has maintained a strong joint public and academic program which continues to include Departments of Psychiatry, Social Work, Psychology, and Nursing in universities across the State as evidenced by specialization and curricula appropriate to children with SED.
II: Planning Steps

**Step 2: Identify the unmet service needs and critical gaps within the current system**

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**Narrative Question:**

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

**Footnotes:**
II. Adult-Unmet Service Needs and Critical Gaps in the Service System

DMH conducts ongoing and multi-pronged assessment activities and processes to identify unmet services needs and gaps in the service delivery system using data based processes. The following activities provide examples of these processes.

The DMH has developed an enterprise level management information system in collaboration with its’ Administrative Services Organization (ASO), the Illinois Mental Health Collaborative for Access and Choice. The data collection through this system is used by DMH to perform analyses to determine unmet service needs and gaps in the service delivery system. For example, merging access related data with consumer level demographic information is helpful in looking at the characteristics of persons being served and detecting disparities in access to treatment as well as potential service needs. DMH is also undertaking a geo-access analysis to look at the availability of specific key services across the state. Data collected through the MIS is also used to determine penetration rates using the prevalence data that is referenced below.

As discussed previously, the DMH service delivery system is regionally based. At the this level, assessments of local service needs and deficits are ongoing efforts performed by DMH and ASO staff during monitoring visits, and by convening regional advisory committee and other meetings with providers, and consumer and family members. Continuity of care is assessed and discussed in regional continuity of care work groups consisting of state hospital staff and community mental health providers convened by DMH regional staff.

The Illinois Mental Health Planning and Advisory Council (IMHPAC) and its sub-committees represent a wide range of constituencies who bring issues forward for attention and discussion. For example, the Child and Adolescent Committee which meets bimonthly and consists of more than 100 members from across the State representing providers, family members, and a range of stakeholders, regularly discusses issues and needs related to Child and Adolescent Services. In the adult arena, focus groups were recently convened to evaluate Olmstead-related transition needs of individuals with serious mental illnesses living in long term care facilities as part of the planning for the implementation of the Williams vs. Quinn Consent Decree. As a result of these activities DMH administrative staff are very aware of critical gaps and service needs in the service delivery system.

The advent of Health Care Reform will necessitate further assessment of the relationship of health services and behavioral health services: that is, the health care needs of persons with SMI and access to mental health services for persons with primary health care issues. The recent policy summit on bi-directional integration of primary and behavioral healthcare convened by DMH with the support of DASA, DPH, and DHFS, has begun the conversation and engendered thought about how to move forward, and will be instrumental in planning for unmet needs. As we know, individuals with serious mental illnesses are at risk of having higher morbidity and mortality rates when compared with other populations. Planning with regard to access to healthcare will be critical.
Block Grant Planning – Mental Health Planning Council
As an essential component of this year’s planning for the mental health block grant submission, the Planning Committee of IMHPAC asked the membership and subcommittees to discuss and identify unmet needs in the mental health service system and present their findings for discussion.

**Adult Services**
The following are Unmet Needs in the Adult Mental Health Service System which have been identified by the Illinois Mental Health Planning and Advisory Council:

- Access to Services by Uninsured and Under-Insured individuals
- Affordable Housing
- Psychiatric Services
- Medication for Indigent Populations—Specifically, individuals with Serious Mental Illnesses who are indigent need access to Psychiatrists and Physicians and the ability to obtain anti-psychotic medications at minimal or no cost.
- Mental Health services for individuals with mental illness who are homeless persons
- Mental Health services for veterans with mental illnesses
- Training and education in existing service venues on dynamic issues and mental health interventions in serving the LGBTQ population
- Reduction of the cracks and slippages in service for individuals with both Developmental Disability and Mental Illness.
- Restoration of funding for the Community Hospital Inpatient Service programs (CHIPs)
- Emphasize and increase consumer roles in service provision with support for Peer Run Services in the State

**Children and Adolescents-Unmet Service Needs and Critical Gaps**
The following are Unmet Needs specific to the Child Mental Health Service System which have been identified by the Illinois Mental Health Planning and Advisory Council:

- Assuring young children access to the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) which affords an array of services targeted to the prevention of behavioral health problems.
- Increase school-based counseling and mental health services
- Intensive Community Service programs for children and families (for families requiring longer term intervention beyond brief screening, assessment and support services (SASS), and for those that do not qualify for ICG community services)
- Restoration of Flexible Funding for special services for children with serious emotional disturbances (SED)
The “Prevalence and Access” Gap

Prevalence estimates and access data are gathered and reported yearly and reflect the gap that exists between the probable number of adults in the state with SMI and children/youth with SED and the actual numbers of those receiving services in the public mental health system.

Adults
The CMHS definition and methodology for prevalence estimation for adults is published in final notice form in the Federal Register Volume 64, Number 121, June 24, 1999. The methodology provides a calibrated point estimate of the 12-month number of persons who have Serious Mental Illness, age 18 and older in Illinois. This does not include persons who are homeless and institutionalized. The prevalence estimate provided by CMHS is 5.4%. Based on the adult population for Illinois, it is estimated that in FY2010 there were 523,752 adults with serious mental illnesses residing in Illinois. Information on the number of persons served in FY2011 is derived from the Uniform Reporting System (URS) Tables 2A and 2B, which is currently being prepared. National Outcome Measures (NOMs)/Performance Indicators with quantitative targets related to increased access to services are described in the Performance Indicators Section. The number of individuals with Serious Mental Illnesses (DMH eligible population) reported as receiving services from DMH-funded agencies in FY2010 was 120,196, approximately 94.7% of the total number of adults receiving services (126,883). When viewed in conjunction with the prevalence rate estimates provided above, DMH is purchasing services for approximately 24% of the adult population who needs mental health services. Of course, some individuals in need of services, may be receiving those services from providers who do not contract with DMH for service delivery and who consequently do not report these services.

Children and Adolescents
For an estimate of Children and Adolescents with Serious Emotional Disturbance, Illinois has used the 7% estimate provided in the CMHS notice in the Federal Register, Volume 63, Number 137, July 17, 1998 based on the midpoint of the number estimated at the lower limit of a level of functioning of 50 (LOF=50) and the number estimated at the upper limit of that level of functioning (LOF=50 to 60). The figure has been updated by CMHS using 2009 census information to 110,105 or 7% of the population of children and adolescents aged 9 to 17 based on a 17.8% (FY2008) poverty rate. The number of youth with Serious Emotional Disturbance (eligible population) reported served in FY 2010 was 34,581, approximately 96.2% of the total served (36,242). FY 2011 data will be provided in the Implementation Report. When viewed in conjunction with the prevalence rate estimates provided above, DMH is purchasing services for approximately 32% of the child/adolescent population that needs mental health services. As with the adult estimates, some individuals in need of services, may be receiving those services from providers who do not contract with DMH for service delivery and who consequently do not report these services.
Addressing Unmet Needs and Critical Service Gaps
Although not all unmet needs and service gaps can be addressed due to resource issues and other factors, the DMH has addressed some of these needs as explicated in the next section and as elucidated in the priorities, goals and objectives that are described.
### II: Planning Steps

#### Table 2 Step 3: Prioritize State Planning Activities

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<table>
<thead>
<tr>
<th>Number</th>
<th>State Priority Title</th>
<th>State Priority Detailed Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Adults - Assurance of an effective array of clinical and support services</td>
<td>Assurance of an effective array of clinical and support services for persons enrolled in Medicaid and services which are essential for ongoing clinical care and support of individuals with serious mental illnesses who are not enrolled in Medicaid during this period of fiscal constraint.</td>
</tr>
<tr>
<td>2</td>
<td>Adults - Promote Provision of Evidence Based Practices</td>
<td>Promote Evidence Based Practices for individuals for whom DMH purchases services within the context of service benefit packages established by DMH for the Medicaid and non-Medicaid populations in need of mental health services.</td>
</tr>
<tr>
<td>3</td>
<td>Adults and Children/Adolescents - Bi-directional Integration of Primary Health Care and Behavioral Health Care</td>
<td>Bi-directional Integration of Primary Health Care and Behavioral Health Care</td>
</tr>
<tr>
<td>4</td>
<td>Adults - Advancement of the recovery vision</td>
<td>Advancement of the recovery vision including Wellness Recovery Action Planning, expansion of the scope and quality of consumer and family participation, and promotion of the utilization of the Certified Recovery Support Specialist (CRSS) credential.</td>
</tr>
<tr>
<td>5</td>
<td>Adults - Address the mental health needs of individuals who are homeless, and individuals who live in rural areas, and those who are elderly</td>
<td>Maintain and improve the provision of mental health services to persons who are homeless (including ex-offenders and veterans), to persons who reside in rural areas, and to elderly persons. (Criterion 4)</td>
</tr>
</tbody>
</table>

Start Year: 2012
End Year: 2013
<table>
<thead>
<tr>
<th></th>
<th>Child and Adolescent - Enhancement of collaborative efforts with state and local partners to address the mental health needs of youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Enhancement of collaborative efforts with state and local partners to address the mental health needs of youth in the juvenile justice system, students in public schools, and the implementation of early interventions for families of young children.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Child and Adolescent - Encourage and facilitate the use of the Public Health Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Encourage and facilitate the use of the Public Health Model in the delivery of Mental Health services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Child and Adolescent - Advancement and expansion of the use of video-conferencing and Tele-psychiatry</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>Advancement and expansion of the use of video-conferencing and Tele-psychiatry in clinical work in rural areas and partnering with universities and other stakeholders in planning initiatives to better align service delivery for children and adolescents in rural areas.</td>
</tr>
<tr>
<td></td>
<td>Address the Mental Health needs of children/adolescents who are homeless and those who reside in rural areas.</td>
</tr>
</tbody>
</table>
## II: Planning Steps

### Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators

**Start Year:**

<table>
<thead>
<tr>
<th>Start Year</th>
<th>2012</th>
</tr>
</thead>
</table>

**End Year:**

<table>
<thead>
<tr>
<th>End Year</th>
<th>2013</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Priority</th>
<th>Goal</th>
<th>Strategy</th>
<th>Performance Indicator</th>
<th>Description of Collecting and Measuring Changes in Performance Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Ensure that the following services are available: These services include: Mental health assessment, Treatment plan development, review and modification; Assertive community treatment, case management, community support (individual, group and residential), crisis intervention, mental health intensive outpatient, psychosocial rehabilitation, psychotropic medication administration, monitoring and training,</td>
<td>DMH funded providers by contract must submit demographic, clinical information and claims data for all individuals receiving services funded using DMH dollars. The DMH provides data specifications to assure</td>
<td></td>
</tr>
</tbody>
</table>
### Adults - Assurance of an effective array of clinical and support services

Continue to assure that a comprehensive array of community-based services are available to adults in need of mental health services (Criterion I).

**short-term diagnostic and mental health services, therapy/counseling, assertive community treatment and Oral interpretation and sign language.**

- Work with system partners to provide supportive services including Educational Services, Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA), Substance Abuse Services (through DASA), Services for Co Occurring Mental Health Disorder and Substance Abuse, Medical and Dental Services (through HFS for individuals who are Medicaid eligible, and through Community Integrated Living Arrangements.

Number of adults who are (a) Medicaid eligible or (b) non-Medicaid eligible who receive mental health services.

Data is submitted directly to the DMH information system which is operated by the DMH’s Administrative Services Organization (ASO). Claims data, which is submitted to the state Medicaid agency Healthcare and Family Services (HFS), is returned to the ASO after processing where it is stored with registration information in the DMH data warehouse. This information is used as a basis for developing reports and for analytic purposes, and is the basis for reporting the data used to populate the majority of the URS tables. Data will be collected by fiscal year to compare change across years.

### Adults - Promote Provision of Evidence Based Practices

Promote Evidence Based Practices for individuals for whom DMH purchases services within the context of service benefit packages established by DMH for the Medicaid and non-Medicaid populations in need of mental health services.

**During FY2012 and FY2013, maintain the implementation of Evidence Based Supportive Employment.**

Number of consumers receiving supported employment in FY2012 and FY2013. (National Outcome Measure)

Data for this indicator are generated through a special web-based database created specifically for the DMH SE initiative. Fidelity and outcomes data are submitted to the DMH SE coordinator. As always, DMH has developed specifications for reporting that DMH funded providers must use when submitting data. DMH only reports data for teams that have been found to exhibit fidelity to the evidenced based practice model.
**Adults - Promote Provision of Evidence Based Practices**

Promote Evidence Based Practices for individuals for whom DMH purchases services within the context of service benefit packages established by DMH for the Medicaid and non-Medicaid populations in need of mental health services.

**FY2012-FY2013, continue provision of Assertive Community Treatment that meets national fidelity model requirements.**

**Number of persons with SMI receiving Assertive Community Treatment in FY 2012 and FY 2013 (National Outcome Measure)**

DMH funded providers by contract must submit demographic, clinical information and claims data for all individuals receiving services funded using DMH dollars. The DMH provides data specifications to assure consistency of reporting. Registration data is submitted directly to the DMH information system which is operated by the DMH’s Administrative Services Organization (ASO). Claims data, which is submitted to the state Medicaid agency Healthcare and Family Services (HFS), is returned to the ASO after processing where it is stored with registration information in the DMH data warehouse. This information is used as a basis for developing reports and for analytic purposes, and is the basis for reporting the data used to populate the majority of the URS tables. Data will be collected by fiscal year to compare change across years.

---

**Number of persons with SMI receiving Assertive Community Treatment in FY 2012 and FY 2013 (National Outcome Measure)**

By the end of FY 2013, through the provision of rental subsidies, continue implementation of a statewide permanent supportive housing initiative which targets an additional 300 consumers acquiring decent, safe, and affordable housing and support services in a manner consistent with the national standards for this evidence based practice.

**Number of consumers who acquire appropriate permanent supportive housing in FY 2012 and 2013. (National Outcome Measure)**

Individuals receiving permanent supported housing were not previously required to be registered for mental health treatment services. Therefore, it was necessary to create a special database to track access to and receipt of permanent supportive housing. The data for this indicator will be generated from permanent supportive housing applications which are stored in the special database, as well as a special PSH outcomes database.
| Adults and Children/Adolescents - Bi-directional Integration of Primary Health Care and Behavioral Health Care |
| Work with system partners to identify next steps in planning for bi-directional integration of primary health and behavioral health care |
| 1. Review evaluations of bi-directional healthcare summit held in June 2011. 2. Meet with system partners to continue planning efforts for bi-directional integration of primary health and behavioral health care |
| Follow-up meeting with system partners to continue planning efforts. |
| Minutes of meetings held with system partners. |

| Adults - Advancement of the recovery vision |
| Establish a comprehensive system of care based upon principles of Recovery/Resilience in which consumers are knowledgeable and empowered to participate and provide direction at all levels of the system |
| Educate consumers of mental health services in leadership, personal responsibility and self-advocacy, through participation in regional Recovery Conferences. |
| Number of regional Recovery Conferences held each year. |
| Document each regional recovery conference event. Aggregate data across regions by year to enable comparisons across years. |

| Adults - Advancement of the recovery vision |
| Establish a comprehensive system of care based upon principles of Recovery/Resilience in which consumers are knowledgeable and empowered to participate and provide direction at all levels of the system |
| Enhance the recovery orientation of mental health services through continuing education of certified WRAP Facilitators. |
| Number of regional WRAP continuing education/refresher trainings conducted each year |
| Each training event will be documented when held. Data will be aggregated by fiscal year for comparison across years. |
### Adults - Advancement of the recovery vision

Based upon principles of Recovery/Resilience in which consumers are knowledgeable and empowered to participate and provide direction at all levels of the system.

**Conduct a series of statewide teleconferences designed to disseminate important information to consumers across the State.**

- **Number of statewide teleconferences held each year**

- **Document each teleconference event and aggregate by year for comparison across years.**

### Adults - Advancement of the recovery vision

Establish a comprehensive system of care based upon principles of Recovery/Resilience in which consumers are knowledgeable and empowered to participate and provide direction at all levels of the system.

**Support the role of Certified Recovery Support Specialists and their deployment statewide by hosting webinars for providers to help increase agencies’ understanding of the role, value, function, and advantages of hiring CRSS professionals and by providing competency training events for individuals interested in obtaining the CRSS credential.**

- **Number of training events held each year to increase stakeholder understanding of the CRSS credential and to increase competency in CRSS domains.**

- **Document each training event and aggregate by year for comparison across years.**

### Adults and Children/Adolescents - Advancement of the use of data to support decision-making.

Use Quantitative data to assess access to care and perception of treatment outcomes to provide data for decision support. (Criterion 2)

**Assess access to care by tracking the number of individuals who received treatment partitioned by race, gender and age.**

- **Number of adults and number of children/adolescents receiving services from DMH-funded community-based providers.**

DMH funded providers by contract must submit demographic, clinical information and claims data for all individuals receiving services funded using DMH dollars. The DMH provides data specifications to assure consistency of reporting. Registration data is submitted directly to the DMH information system which is operated by the DMH’s Administrative Services Organization (ASO). Claims data, which is submitted to the state Medicaid agency Healthcare and Family Services (HFS), is returned to the ASO after processing where it is stored with registration information in the DMH data warehouse. This information is used as a basis for developing reports and for analytic purposes, and is the basis for reporting the...
<table>
<thead>
<tr>
<th>Adults and Children/Adolescents</th>
<th>Use Quantitative data to assess access to care and perception of treatment outcomes to provide data for decision support. (Criterion 2)</th>
<th>Conduct a consumer survey to assess perception of care to determine the extent to which consumers and caregivers report positive outcomes that are attributable to treatment received.</th>
<th>Percentage of : a) adults consumers and b) caregivers of youth reporting positively about outcomes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults - Maintain a comprehensive system to serve the forensic needs of court-involved consumers</td>
<td>Maintain a system of care to address the mental health needs of consumers with criminal justice involvement.</td>
<td>Maintain and monitor linkage to community services for individuals with serious mental illness released from Illinois jails</td>
<td>Percentage of eligible individuals released from Jail who are linked with community-based services.</td>
</tr>
<tr>
<td>Adults/Child and Adolescent - Planning, within budgetary constraints, to address the needs of uninsured and underinsured consumers</td>
<td>Identify resources to Purchase Mental Health Services for Uninsured and Underinsured Consumers</td>
<td>Use financial resources from the state general revenue fund, Federal Fund Participation (FFP) and grants as a basis to fund the purchase of mental health services. Enhance human resources of public through continued support of public/academic linkages, mental health and law enforcement</td>
<td>No indicators for this goal</td>
</tr>
</tbody>
</table>

The DMH will utilize the MHSIP Adult Consumer Perception of Care Survey and the Youth Services Survey for Families to collect this data. This year, a random stratified sample of adults receiving treatment in June 2011 is being selected for the survey. This sample will be disseminated via mail in October 2011 with a goal of all data collected by early November. Similarly a random stratified sample of caregivers of children and adolescents receiving services in June 2011 is also being selected to receive the survey. This method will be used for the surveys for FY2012 and FY2013. The indicator values will be compared with data collected in succeeding years.

A daily cross match of individuals receiving mental health services with individuals in jails in selected jurisdictions is used to identify individuals participating in the jail data linkage project. Data will be collected to track the number of individuals who are linked with community based mental health service providers. Data will be aggregated across the year for comparison with data from succeeding years.

No indicators are identified for this goal.
training and training

and coordination of

providers of emergency

and disaster services.

Child and Adolescent

Assurance of an

effective array of

clinical and support

and adolescents

services for children

need of mental

health services

(Criterion I).

Continue to assure

that a

comprehensive

array of community

based services are

available to children and support

adolescents in need of mental

health services

(Criterion I).

Ensure that the

following services are

available: These services

include:

Mental health

assessment, Treatment

plan development,

review and modification;

Screening Assessment,

and Support Services

(SASS), case

management, community

support (individual,

group and residential),

mental health intensive,

management, and

screening.

Number of youth who

are a) Medicaid or b)

non-Medicaid eligible

who receive mental

health services

(Criterion I).

DMH funded providers by contract must

submit demographic, clinical information and

claims data for all individuals receiving

services funded using DMH dollars. The DMH

Claims data, which is submitted to the state

agency, Healthcare and Family

Services (HFS), is returned to the ASO after

processing where it is stored with

registration information in the DMH data

warehouse. This information is used as a

basis for developing reports and for analytic

purposes, and is the basis for reporting the

data used to populate the majority of the

URS tables. Data will be collected by fiscal

year to compare change across years.
### Medical and Dental Services (through HFS for youth who are Medicaid eligible), screening, assessment and support services (SASS), and Wraparound Services.

<table>
<thead>
<tr>
<th>Child and Adolescent - Advancement of family-driven care</th>
<th>Establish a system of care that is family driven and emphasizes services that are evidence-based.</th>
<th>Facilitate parent-to-parent support through the use of Family Resource Developers in system of care grants.</th>
<th>Number of Family Resource Developers hired in System of Care grant-funded programs.</th>
<th>The number of parents hired as system family resource developers for system of care grants will be aggregated across the year for comparison with data collected for subsequent years.</th>
</tr>
</thead>
</table>

| Child and Adolescent - Advancement of family-driven care | Establish a system of care that is family driven and emphasizes services that are evidence-based. | In FY2012 and FY2013 advance Family Driven Care in Illinois by certification of parent providers as Family Partner Professionals | The number of individuals who are credentialed as CFPPs by the end of each fiscal year | The number of parents certified as Family Partner Professionals will be aggregated across the year for comparison with data collected for subsequent years. |

| Child and Adolescent - Enhancement of collaborative efforts with state and local partners to address the mental health needs of youth | Integrate services for children and adolescents across service systems and across the developmental stages from early childhood through young adulthood. (Criterion 3 - Juvenile Justice) | In 2012/FY2013, increase the number of youth receiving services through the Mental Health Juvenile Justice Initiative (MHJJ) | Number of youth served by the MHJJ program statewide | Aggregate the number of youth receiving services from the mental health juvenile justice program across the year that will be compared with data from subsequent years. |

| Child and Adolescent - Enhancement of collaborative efforts with state and local partners to address the mental health needs of youth | Integrate services for children and adolescents across service systems and the developmental stages from early childhood through young adulthood. (Criterion 3 - Schools) | Provide technical assistance and implementation support to educators, parents, organizations and other state agencies on the coordination of the Illinois Interconnected Systems Model of School Based Mental Health. | Number of Technical Assistance events in each fiscal year | Aggregate data on the number of technical assistance events held across the fiscal years for comparison with subsequent years. |

Continue to
<table>
<thead>
<tr>
<th>Child and Adolescent - Promotion of Evidence-Informed Practices</th>
<th><strong>Advance the implementation of evidence-informed practices in the child and adolescent service system through FY2013</strong></th>
<th><strong>Implement video-based training methodologies and develop additional evidence-based content in an effort to increase and improve statewide EIP training.</strong></th>
<th>The number of training events (including video-based) held to advance evidence-informed practices.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In FY2012 and FY2013, fully establish and implement the Reaching Out to Help initiative which is a 3-tiered public health model.</strong> Tier 1 consists of universal health promotion/prevention activities which target an entire population to promote and enhance emotional wellness by increasing developmentally appropriate mental health skills. Tier 2 is early intervention targeting children at greater risk of developing risky behaviors and mental health concerns. Tier 3 are treatment activities targeting children identified as having significant mental health concerns that require referral and linkage to clinical mental health treatment. Develop a baseline for measurement of outcomes and the implementation of local systems of care for the Reaching Out to Help Initiative.</td>
<td>Each training event will be documented and the data aggregated across the year for comparison with subsequent years of data.</td>
<td>The number of children and adolescents participating in Tier 1, Tier 2 and Tier 3 in FY 2012 and 2013.</td>
<td>Aggregate the number of children/adolescents participating in Tiers 1, 2 and 3 of the &quot;Reaching Out to Help&quot; Initiative across the year for comparison with subsequent years of data.</td>
</tr>
<tr>
<td>Initiative.</td>
<td>Advance and expand the use of video-conferencing and Tele-psychiatry in clinical work and partner with universities and other stakeholders to plan initiatives to better align service delivery for children and adolescents in rural areas. Through FY2013, continue to implement Tele-psychiatry services in seven rural sites in Illinois and, contingent upon funding opportunities, plan for further expansion of the program. Number of youth living in rural areas receiving services through tele-psychiatry. Aggregate data on the number of individuals receiving data across the year for comparison with subsequent years of data.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
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<td>---</td>
</tr>
<tr>
<td>Child and Adolescent - Advancement and expansion of the use of video-conferencing and Tele-psychiatry</td>
<td>Address the Mental Health needs of children/adolescents who are homeless and those who reside in rural areas. Maintain and increase provision of mental health services to families and children who are homeless and to those who reside in rural areas. (Criterion 4)</td>
<td>Track the number of youth with serious emotional disturbances who are homeless and receiving mental health services. Number of individuals who are homeless and who are receiving services. (NOM - Increased stability in housing)</td>
<td>DMH funded providers by contract must submit demographic, clinical information and claims data for all individuals receiving services funded using DMH dollars. The DMH provides data specifications to assure consistency of reporting. Registration data is submitted directly to the DMH information system which is operated by the DMH’s Administrative Services Organization (ASO). Claims data, which is submitted to the state Medicaid agency Healthcare and Family Services (HFS), is returned to the ASO after processing where it is stored with registration information in the DMH data warehouse. This information is used as a basis for developing reports and for analytic purposes, and is the basis for reporting the data.</td>
</tr>
</tbody>
</table>

**Footnotes:**
### Table 4 Services Purchased Using Reimbursement Strategy

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<table>
<thead>
<tr>
<th>Reimbursement Strategy</th>
<th>Services Purchased Using the Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grant/contract reimbursement</td>
<td>The Illinois plan for the expenditure of the FY 2012 and FY 2013 Community Mental Health Services Block Grant for adults and children/adolescents is primarily directed at providing psychiatric leadership services across the state with a small amount allocated for special projects. The psychiatric leadership services include training and supervision of clinical staff as well as the provision of some services. The funding allocation is consistent with the State Mental Health Plan. Approximately 26% of block grant funds are allocated to C&amp;A Services.</td>
</tr>
</tbody>
</table>

**Footnotes:**
### Table 5: Projected Expenditures for Treatment and Recovery Supports

#### Start Year: 2012  
#### End Year: 2013

<table>
<thead>
<tr>
<th>Category</th>
<th>Service/Activity Example</th>
<th>Estimated Percent of Funds Distributed</th>
</tr>
</thead>
</table>
| Healthcare Home/Physical Health | - General and specialized outpatient medical services  
- Acute Primary Care  
- General Health Screens, Tests and Immunization  
- Comprehensive Care Management  
- Care coordination and health promotion  
- Comprehensive transitional care  
- Individual and Family Support  
- Referral to Community Services | N/A |
| Engagement Services             | - Assessment  
- Specialized Evaluation (Psychological and neurological)  
- Services planning (includes crisis planning)  
- Consumer/Family Education  
- Outreach | N/A |
| Outpatient Services             | - Individual evidence-based therapies  
- Group therapy  
- Family therapy  
- Multi-family therapy  
- Consultation to Caregivers | N/A |
| Medication Services             | - Medication management  
- Pharmacotherapy (including MAT)  
- Laboratory services | N/A |
| Community Support (Rehabilitative) | - Parent/Caregiver Support  
- Skill building (social, daily living, cognitive)  
- Case management  
- Behavior management  
- Supported employment  
- Permanent supported housing  
- Recovery housing  
- Therapeutic mentoring  
- Traditional healing services | N/A |
| Recovery Supports               | - Peer Support  
- Recovery Support Coaching  
- Recovery Support Center Services  
- Supports for Self Directed Care | N/A |
| Other Supports (Habilitative)   | - Personal care  
- Homemaker  
- Respite  
- Supported Education  
- Transportation  
- Assisted living services | N/A |
<table>
<thead>
<tr>
<th>Recreational services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interactive Communication Technology Devices</td>
</tr>
<tr>
<td>Trained behavioral health interpreters</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intensive Support Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance abuse intensive outpatient services</td>
</tr>
<tr>
<td>Partial hospitalization</td>
</tr>
<tr>
<td>Assertive community treatment</td>
</tr>
<tr>
<td>Intensive home based treatment</td>
</tr>
<tr>
<td>Multi-systemic therapy</td>
</tr>
<tr>
<td>Intensive case management</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out-of-Home Residential Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis residential/stabilization</td>
</tr>
<tr>
<td>Clinically Managed 24-Hour Care</td>
</tr>
<tr>
<td>Clinically Managed Medium Intensity Care</td>
</tr>
<tr>
<td>Adult Mental Health Residential</td>
</tr>
<tr>
<td>Adult Substance Abuse Residential</td>
</tr>
<tr>
<td>Children's Mental Health Residential Services</td>
</tr>
<tr>
<td>Youth Substance Abuse Residential Services</td>
</tr>
<tr>
<td>Therapeutic Foster Care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Acute Intensive Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile crisis services</td>
</tr>
<tr>
<td>Medically Monitored Intensive Inpatient</td>
</tr>
<tr>
<td>Peer based crisis services</td>
</tr>
<tr>
<td>Urgent care services</td>
</tr>
<tr>
<td>23 hour crisis stabilization services</td>
</tr>
<tr>
<td>24/7 crisis hotline services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prevention (Including Promotion)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening, Brief Intervention and Referral to Treatment</td>
</tr>
<tr>
<td>Brief Motivational Interviews</td>
</tr>
<tr>
<td>Screening and Brief Intervention for Tobacco Cessation</td>
</tr>
<tr>
<td>Parent Training</td>
</tr>
<tr>
<td>Facilitated Referrals</td>
</tr>
<tr>
<td>Relapse Prevention /Wellness Recovery Support</td>
</tr>
<tr>
<td>Warm line</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>System improvement activities</th>
</tr>
</thead>
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<table>
<thead>
<tr>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;75%</td>
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</tbody>
</table>

**Footnotes:**
## III: Use of Block Grant Dollars for Block Grant Activities

### Table 6 Primary Prevention Planned Expenditures Checklist

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<table>
<thead>
<tr>
<th>Strategy</th>
<th>IOM Target</th>
<th>Block Grant FY 2012</th>
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</table>

**Footnotes:**
### III: Use of Block Grant Dollars for Block Grant Activities

#### Table 7 Projected State Agency Expenditure Report

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<table>
<thead>
<tr>
<th>Activity</th>
<th>A. Block Grant</th>
<th>B. Medicaid (Federal, State, and Local)</th>
<th>C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)</th>
<th>D. State Funds</th>
<th>E. Local Funds (excluding local Medicaid)</th>
<th>F. Other</th>
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<tr>
<td>5. State Hospital</td>
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<tr>
<td>8. Administration (Excluding Program and Provider Level)</td>
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<td>10. Subtotal (Rows 5, 6, 7, and 8)</td>
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<td>11. Total</td>
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**Footnotes:**
### III: Use of Block Grant Dollars for Block Grant Activities

**Table 8 Resource Development Planned Expenditures Checklist**

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<tr>
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</table>

**Footnotes:**
IV: Narrative Plan

D. Activities that Support Individuals in Directing the Services

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Narrative Question:

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following:

- Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s).
- What services for individuals and their support systems are self-directed?
- What participant-directed options do you have in your State?
- What percentage of individuals funded through the SMHA or SSA self direct their care?
- What supports does your State offer to assist individuals to self direct their care?

Footnotes:
D. Activities that Support Individuals in Directing the Services

Implementation of self-directed care in its fullest sense remains a goal in Illinois. Over the years there have been several programs which provided participant directed options to very limited recipient groups with specified funds. In one instance recipients were chosen out of a pool of qualified applicants by lottery. Flexible funding for SASS programs allowed families of children and adolescents with Serious Emotional Disorders to request and receive supports needed beyond the traditional mental health services, but this funding ended with the budget crisis in 2010. The current economic climate of the State is not allowing for the allocation of funds directly to consumers nor the infrastructure required to carry out the tasks associated with self-directed care. However, current recovery oriented and consumer education efforts are orienting and positioning consumers and clinical providers toward person centered planning and consumer /family self-directed care:

- A significant step in this direction has been the establishment of the Wellness Recovery Action Plan (WRAP) model in Illinois. 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. The WRAP curriculum was also modified to address the needs of youth and has been piloted in several agencies in various parts of the State including Chicago, central Illinois, and southeastern Illinois.

- Consumer education activities, credentialing processes for recovered consumers and for parents of children with SED, and the consumer to consumer/parent to parent supports are all designed to inform and enhance the abilities of consumers and families to be more directive about the services they receive and to participate more effectively in monitoring, advocacy, and policy leadership activities. Current efforts are described in Section II. (See the Adult Plan and the Child Plan for further detail.)

- Illinois has developed 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: (1) Choosing culturally and linguistically competent supports, services, and providers; (2) Setting goals; (3)Designing, implementing and evaluating programs; (4) Monitoring outcomes; and (5) Partnering in funding decisions. A commission on Family Driven Care was established in FY2010. Regional surveys have been conducted to gain information on identified mental health needs, family and provider satisfaction with the services available, and the extent to which the system is responsive to the needs and issues encountered by families of youth with serious emotional disturbances. The Commission and activities to increase family voice and directedness in the care of children is continuing. (See Section II- Child Services Plan)
Family and youth partners are active in all aspects of Illinois System of Care projects, including planning, governance, care coordination, administration and evaluation. SOC services are delivered through individualized, comprehensive plans of care, guided by strengths and needs the youth and family, supported by trained family advocates, and coordinated by a single care manager to achieve goals across all life domains and child-serving systems.
Narrative Question:

Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should to complete the service utilization Table 5 in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

- List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
  - Provider characteristics
  - Client enrollment, demographics, and characteristics
  - Admission, assessment, and discharge
  - Services provided, including type, amount, and individual service provider
  - Prescription drug utilization
- As applicable, for each of these systems, please answer the following:
  - For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
  - Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
  - Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
  - Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
  - Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
- As applicable, please answer the following:
  - Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
  - Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?
  - Does your State’s IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?
  - Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
  - Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

In addition to the questions above, please provide any information regarding your State’s current efforts to assist providers with developing and using Electronic Health Records.

**Footnotes:**
E. Data and Information Technology

IT Systems Maintained by the Division of Mental Health

The DMH utilizes data to support decision making in a wide variety of areas including utilization management, quality improvement activities, resource allocation and planning efforts. As such, data is frequently analyzed and interpreted and utilized for these purposes throughout the year. Information is disseminated to a wide variety of entities in different formats that have been designed to be user-friendly. Through the use of quantitative measures of organizational functioning, comparisons can be made against a standard over extended time or between organizational units. Target levels for the performance indicators provide focus for evaluation and planning.

Two primary data systems are used to collect administrative data for individuals receiving DMH funded services. Each system and the type of information recorded and reported is displayed in the table below.

<table>
<thead>
<tr>
<th>Type of Information</th>
<th>Information System Used to Collect Data</th>
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</thead>
<tbody>
<tr>
<td>Provider Characteristics</td>
<td>DMH ASO Information System; DHS Contracting System</td>
</tr>
<tr>
<td>Consumer Enrollment, Demographics and Characteristics</td>
<td>DMH ASO Information System</td>
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<td>Admission, Assessment and Discharge</td>
<td>DHS/DMH MIS – Clinical Inpatient System</td>
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<tr>
<td>Services Provided</td>
<td>DMH ASO Information System</td>
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<tr>
<td>Prescription Drug Utilization</td>
<td>DHS/DMH MIS – Clinical Inpatient System – State Operated Hospital Services Only</td>
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</tbody>
</table>

DMH/ASO Community Reporting System
DMH worked with its Administrative Services Organization (ASO) the Illinois Mental Health Collaborative for Access and Choice to design and develop a comprehensive information system that “went live” in September of 2008. Community mental health agencies are required to use data standards and specifications developed by DMH and the Collaborative as the basis for submitting data. Since, the initial implementation of the system, DMH has made several modifications to enhance data collection requirements and to permit collection of data that is compatible with Uniform Reporting System requirements as developed under the State Infrastructure Grants (DIGs).

DMH funded community providers are contractually required to register all individuals funded with any DMH dollars in the DMH/ASO Community Reporting Information System. Until June 30, 2011, claims for all services were also submitted to this system. However as of July 1, 2011, legislation now requires all claims to be submitted directly to the Illinois Medicaid agency Healthcare and Family Services MMIS. Processing of claims is subject to business rules established by DMH, thus the linkage between registrations of individuals for services and claims submission has been retained. DMH reporting standards require full reporting of consumer and service data by community providers.
DMH State Hospital Reporting
The DMH operates nine state hospitals and one facility for persons who are sexually violent. DMH state hospital staff are required to record and report data using a system developed by the DHS. This system, which is known as the Clinical Inpatient System (CIS), is used to collect demographic, clinical and service data.

Data Warehouse
DMH has worked with the Collaborative to develop a data warehouse which is maintained by the Collaborative. The warehouse stores data related to eligibility, registration, billing/services information, a provider database, and service authorization in one place. DMH now has unprecedented access to this data.

Unique Identifiers and Federal Data Standards
Since FY2006 all individuals seeking mental health services have been assigned unique ID numbers referred to as RINS. RINS are also being assigned to consumers who access services under other Divisions within DHS, as well as to individuals receiving services through the Child Welfare System and Corrections. The use of RINS has improved tracking of services received by consumers across state systems, as well as increasing accuracy in the un-duplication of consumers receiving services in the mental health system. The extent to which each of the two DMH information systems incorporate unique provider and consumer identifiers is described in the table below.

<table>
<thead>
<tr>
<th>Unique Identifiers/Federal Standard Status</th>
<th>DMH ASO MIS</th>
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<td>Use of CPT/HCPS</td>
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<tr>
<td>Medicaid data used to routinely used to produce reports</td>
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</table>

Linkage between the DMH Information Systems and the State Medicaid MMIS
The use of unique provider and consumer identifiers provides the ability for DMH to work with the state Medicaid agency Healthcare and Family Services to aggregate Medicaid and non-Medicaid claims at the level of the provider.

Illinois has developed a health information exchange strategic plan. Efforts in this arena have been delegated to the state Medicaid agency HFS. The vision and mission of Illinois’ efforts to develop a statewide HIE are incorporated in the recently enacted Illinois Health Information and Technology Act2, which states “The State of Illinois has an interest in encouraging the adoption
of a health information system to improve the safety, quality and value of health care, to protect and keep health information secure, and to use the health information exchange system to advance and meet population health goals. The Plan also outlines Illinois’ current and future strategies to leverage existing EHR capacity, investment and broad stakeholder commitment to advance the HIE goals in Illinois. The Illinois Plan may be found at the following website address: http://www.hie.illinois.gov/assets/hiesop.pdf

The goals of the Illinois HIE Strategic and Operational Plan, which are aligned with those of the Illinois State Health Improvement Plan, State Medicaid program, and EHR Incentive Program, are to:

• Improve health care quality and outcomes
• Improve patient safety
• Enhance public health and disease surveillance
• Control the cost of health care
• Reduce health disparities

The objectives related to these overarching goals are to:
• Protect the privacy and security of identifiable health information
• Promote the adoption and Meaningful Use of EHR
• Facilitate quality reporting and measurement
• Encourage information technology-enabled care delivery
• Develop a statewide HIE

The Illinois HIE initiative will employ the following strategies to achieve its goals and objectives:

• Increase EHR adoption through implementation of the Medicaid EHR Incentive Program, support for the Medicare EHR Incentive Program and participation in other programs that encourage practitioners and hospitals to adopt EHR
• Facilitate secure exchange of EHR by developing statewide HIE infrastructure in accordance with evolving national standards and protocols and all applicable state and federal laws
• Increase the use of e-prescribing by increasing awareness of the benefits to both patients and providers and removing existing barriers to use of e-prescribing technology
• Increase the electronic transmission of structured laboratory results by supporting interoperable standards and removing barriers to the sharing of data
• Increase the sharing of patient care summaries by aligning programs and payment mechanisms to encourage and incent this activity
• Increase awareness and public support for the use of EHR through a communications plan that delivers accurate and complete information about EHR and HIE in culturally-relevant formats
• Increase broadband deployment through coordinated activities with the Illinois Broadband Deployment Council and participation in the federal Broadband Opportunities Program
• Provide focused resources for safety net providers and their patients by identifying additional technical resources for EHR adoption and supporting workforce development programs to retrain existing workers in the transition from a paper to an EHR environment
• Develop a plan for financial sustainability of the statewide HIE by calculating a value model for each entity that will participate in the statewide HIE and devising a revenue model that distributes costs reasonably and fairly

Illinois has received a planning grant to create statewide health information exchange, however mental health has not been an active participant in planning around the exchange of mental health related data.
IV: Narrative Plan

F. Quality Improvement Reporting
Page 43 of the Application Guidance

Narrative Question:

SAMHSA expects States to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The State's CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.

Footnotes:
Quality Improvement Reporting

Quality Improvement Mission and Vision
The Division of Mental Health Quality Management Committee serves as the primary point of contact for communication and planning in respect to Quality Assurance and Continuous Quality Improvement. The Quality Management Committee works with Division staff to assess the degree to which the Division meets requirements; recommends actions to bring the Division into compliance with requirements, and recommends actions that will improve the Division’s ability to meet its requirement.

The core values and concepts of continuous quality improvement include continuous assessment of key activities with an eye toward improving processes and outcomes, consumer service and focus, decisions based on facts, data and analysis, employee involvement/empowerment and teamwork. The Quality Management Committee partners with the various units within the Division to ensure that stated needs, issues and concerns are addressed. The Quality Management Committee reviews and provides advice related to various quality improvement work products and engages in problem-solving to resolve issues and risk where needed. The Committee lends support to units within the Division to ensure successful implementation of continuous quality improvement efforts and ensure quality of service delivery.

Quality Reviews, Standards and Provider Audit Requirements
Quality standards and provider audit requirements are defined by Illinois Administrative Code (Title 19, Part 507). Quality improvement and program and financial decision-making rely on relevant, accurate data and insightful planning based on reliable data sources. A necessary and important ingredient of any system established to support management and program improvement activities is a system of monitoring and accreditation. The system for monitoring community providers includes the following activities:

- **Certification Reviews**: Performed by the DHS Bureau of Accreditation, Licensure, and Certification (BALC). These reviews verify that the sites and services of providers are meeting standards for Medicaid certification. These reviews are performed at least every 3 years, more often if significant findings are discovered in an earlier review.

- **Clinical Practice and Guidance Reviews**: Provided annually as a DHS/DMH collaborative effort to guide providers in meeting best-practice standards, including recovery principles.

- **Fidelity Reviews**: A review by DHS/DMH providing feedback to providers on fidelity to specific service definitions, with the goal of ensuring that providers are maintaining fidelity and identifying areas that need improvement.

- **Post-payment Reviews**: A review of Medicaid and Non-MCO services following payment of services billed examining documentation, including medical necessity
for such services. This review is provided by the Collaborative. Findings resulting in a request for recoupment are subject to an appeals process.

Monitoring reviews are followed by an exit conference in which results are shared with managers of the programs reviewed. The DMH regional staff respective to the provider reviewed and other DMH staff also receive monitoring review results. Tools and protocols regarding reviews are available on the DMH Web site. Agencies with identified deficits are expected to develop corrective action plans which are then monitored by DMH regional staff.

**Performance Measurement**

Data is used for monitoring and the results are shared with a range of stakeholders. National Outcome Measures (NOMs) and other performance data are incorporated into the DMH quality improvement plan as reports reflecting the performance of the total system are produced. When there are challenges meeting performance targets, a more specific and detailed analysis of data elements and processes is performed to determine the causes of the problem. Determining the problem then leads to finding a solution. A similar process is used to address situations wherein performance targets are routinely exceeded.

The DMH regularly produces reports reflecting service trends, system performance, and financial status. The use of surveys reflecting views of consumers and caregivers is an important element in improving services and service delivery. Survey results are available on the DMH Web site. The system also includes a Web site address for inquiries regarding conferences, presentations, training, registration, financial issues, monitoring tools, and clinical issues, among them utilization management.

The Division has developed a number of state specific indicators and measures that are regularly monitored and reviewed. The National Outcome Measures have been incorporated into this process. Many of these indicators and measures are described in the priorities, goals and indicators section of this application.
G. Consultation With Tribes
Page 43 of the Application Guidance

IV: Narrative Plan

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to engage in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have Tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, SAMHSA views consultation as a government to government interaction and should be distinguished from input provided by individual Tribal members or services provided for Tribal members whether on or off Tribal lands. Therefore, the interaction should include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description should indicate how concerns of the Tribes were addressed in the State Block Grant plan(s). States shall not require any Tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for Tribal members on Tribal lands.

Footnotes:
Consultation with Tribes

This section is not applicable. Illinois has no Tribal reservations within its boundaries. Primary health care, community health and mental health services are provided to medically underserved members of federally recognized American Indian Tribes and family members residing in the City of Chicago area by the American Indian Health Service of Chicago, Inc. This agency, incorporated in 1975, operates as a non-profit charitable organization and is not funded through DMH. Further information may be obtained from the agency’s Website at www.aihschicago.org.
IV: Narrative Plan

H. Service Management Strategies
Page 44 of the Application Guidance

Narrative Question:

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

In the space below, please describe:

1. The processes that your State will employ over the next planning period to identify trends in over/underutilization of SABG or MHBG funded services
2. The strategies that your State will deploy to address these utilization issues
3. The intended results of your State's utilization management strategies
4. The resources needed to implement utilization management strategies
5. The proposed timeframes for implementing these strategies

Footnotes:
Service Management Strategies

To ensure quality services and compliance with standards in the Illinois Medicaid Rule, DMH has developed and implemented a Utilization Management (UM) Program. Specifically, this is the vehicle through which DHS/DMH ensures that individuals being served receive the services best suited to support their recovery needs and preferences, that cost-effective services are provided in the most appropriate treatment setting, and are consistent with medical necessity criteria and evidence-based practices. By implementing the UM Program, DHS/DMH strives to achieve a balance between the needs, preferences, and well-being of persons in need of mental health services, demonstrated medical necessity, and the resources available to serve their needs. The DHS/DMH UM Program was developed in collaboration with the Department of Healthcare and Family Services, the State Medicaid agency.

The UM program is based on the following principles:
- Utilization Management is a dynamic, quality improvement process that can evolve and change as additional data, new research, and other new information become available.
- Utilization Management must be based on data.
- Individuals accessing services should have a consistent threshold of medical necessity statewide.
- Utilization Management should strive to minimize administrative costs where possible.
- Authorization must be clinically focused and conducted by qualified staff.
- Utilization Management should primarily focus on outliers by identifying patterns of underutilization and overutilization and focusing clinical review and management protocols on outliers to ensure that service utilization patterns are appropriate to the recovery needs of the individuals being served.

DMH is employing a “Thresholds Model” in Utilization Management for the following services: therapy/counseling, psychosocial rehabilitation and community support group. DHS/DMH requires clinical review and authorization when the number of services received by an individual exceeds the 75th percentile as compared to all users of that service statewide. The thresholds for each service were established on the basis of an analysis of FY2009 utilization data. In other words, authorization is only required on outliers. This means that at least 75% of existing consumers are not expected to require authorization for their services because their utilization, based on historical patterns, will not exceed the clinical review threshold. Thresholds are the same for adults and children/adolescents and are calculated by provider and consumer per fiscal year. An example of a current threshold is that authorization is required to continue to provide Therapy Counseling to a specific individual beyond 10 hours in a specific fiscal year. Providers are required to obtain authorization prior to receiving reimbursement for services delivered to consumers beyond the specified thresholds. Authorization for reimbursement is made based upon the medical necessity of the consumers.
The DMH has required pre-authorization of Assertive Community Treatment and Community Support Team services for a number of years.

**Utilization Management for Services Purchased Using Block Funds**

Currently, MHBG dollars are largely directed to psychiatric leadership for which utilization thresholds have not been established. Methodology is in place to track the allocation of funds for this service and providers are required to submit reporting for some activities associated with this service. DMH is working to improve and enhance the mechanisms that are in place to better track data associated with psychiatric leadership services. As DMH continues to plan for and adapt to the changing fiscal and service environment, there may be some necessary shifting and reallocation of block grant funds within the appropriate guidelines established by SAMHSA.
An important change to the administration of the MHBG and SABG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X%. The state could use this indicator for their dashboard.

In addition, SAMHSA will identify several national indicators to supplement the state specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.

Plan Year: 

<table>
<thead>
<tr>
<th>Priority</th>
<th>Performance Indicator</th>
<th>Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults - Assurance of an effective array of clinical and support services</td>
<td>Number of adults who are (a) Medicaid eligible or (b) non-Medicaid eligible who receive mental health services</td>
<td>€</td>
</tr>
<tr>
<td>Adults - Promote Provision of Evidence Based Practices</td>
<td>Number of consumers receiving supported employment in FY2012 and FY2013. (National Outcome Measure)</td>
<td>€</td>
</tr>
<tr>
<td>Adults - Promote Provision of Evidence Based Practices</td>
<td>Number of persons with SMI receiving Assertive Community Treatment in FY 2012 and FY 2013 (National Outcome Measure)</td>
<td>€</td>
</tr>
<tr>
<td>Adults - Promote Provision of Evidence Based Practices</td>
<td>Number of consumers who acquire appropriate permanent supportive housing in FY 2012 and 2013. (National Outcome Measure)</td>
<td>€</td>
</tr>
<tr>
<td>Adults and Children/Adolescents- Bi-directional Integration of Primary Health Care and Behavioral Health Care</td>
<td>Follow-up meeting with system partners to continue planning efforts.</td>
<td>€</td>
</tr>
<tr>
<td>Adults - Advancement of the recovery vision</td>
<td>Number of regional Recovery Conferences held each year.</td>
<td>€</td>
</tr>
<tr>
<td>Adults - Advancement of the recovery vision</td>
<td>Number of regional WRAP continuing education/refresher trainings conducted each year</td>
<td>€</td>
</tr>
<tr>
<td>Adults - Advancement of the recovery vision</td>
<td>Number of statewide teleconferences held each year</td>
<td>€</td>
</tr>
<tr>
<td>Adults - Advancement of the recovery vision</td>
<td>Number of training events held each year to increase stakeholder understanding of the CRSS credential and to increase competency in CRSS domains.</td>
<td>€</td>
</tr>
<tr>
<td>Adults and Children/Adolescents - Advancement of the use of data to support decision-making</td>
<td>Number of adults and number of children/adolescents receiving services from DMH-funded community-based providers.</td>
<td>€</td>
</tr>
<tr>
<td>Adults and Children/Adolescents - Advancement of the use of data to support decision-making</td>
<td>Percentage of : a) adults consumers and b) caregivers of youth reporting positively about outcomes.</td>
<td>€</td>
</tr>
<tr>
<td>Adults - Maintain a comprehensive system to serve the forensic needs of court-involved consumers</td>
<td>Percentage of eligible individuals released from jail who are linked with community-based services.</td>
<td>€</td>
</tr>
<tr>
<td>Adults/Child and Adolescent - Planning, within budgetary constraints, to address the needs of uninsured and underinsured consumers</td>
<td>No indicators for this goal</td>
<td>€</td>
</tr>
<tr>
<td><strong>Child and Adolescent - Assurance of an effective array of clinical and support services for children and adolescents</strong></td>
<td>Number of youth who are a) Medicaid or b) non-Medicaid eligible who receive mental health services</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Child and Adolescent - Advancement of family-driven care</strong></td>
<td>Number of Family Resource Developers hired in System of Care grant-funded programs.</td>
<td></td>
</tr>
<tr>
<td><strong>Child and Adolescent - Advancement of family-driven care</strong></td>
<td>The number of individuals who are credentialed as CFPPs by the end of each fiscal year</td>
<td></td>
</tr>
<tr>
<td><strong>Child and Adolescent - Enhancement of collaborative efforts with state and local partners to address the mental health needs of youth</strong></td>
<td>Number of youth served by the MHJJ program statewide</td>
<td></td>
</tr>
<tr>
<td><strong>Child and Adolescent - Enhancement of collaborative efforts with state and local partners to address the mental health needs of youth</strong></td>
<td>Number of Technical Assistance events in each fiscal year</td>
<td></td>
</tr>
<tr>
<td><strong>Child and Adolescent - Promotion of Evidence-Informed Practices</strong></td>
<td>The number of training events (including video-based) held to advance evidence-informed practices.</td>
<td></td>
</tr>
<tr>
<td><strong>Child and Adolescent - Encourage and facilitate the use of the Public Health Model</strong></td>
<td>The number of children and adolescents participating in Tier 1, Tier 2 and Tier 3 in FY 2012 and 2013.</td>
<td></td>
</tr>
<tr>
<td><strong>Child and Adolescent - Advancement and expansion of the use of video-conferencing and Tele-psychiatry</strong></td>
<td>Number of youth living in rural areas receiving services through tele-psychiatry.</td>
<td></td>
</tr>
<tr>
<td><strong>Address the Mental Health needs of children/adolescents who are homeless and those who reside in rural areas.</strong></td>
<td>Number of individuals who are homeless and who are receiving services. (NOM - Increased stability in housing)</td>
<td></td>
</tr>
</tbody>
</table>

**Footnotes:**
I. State Dashboard

Illinois has already developed a state dashboard that will easily be adapted as needed for federal block grant requirements. During FY2010, recognizing that the current economic environment requires that information be available quickly in a user-friendly format to assist and support decision making and planning efforts, Illinois DMH engaged in a cutting edge project to develop a tool to provide staff with rapid access to information and key performance indicators that could be used for monitoring, evaluation and decision support. The end result of this initiative was two web-based Dashboards which received recognition at the national level for their innovative style and design.

The Dashboard needed to be user-friendly and intuitive, and it needed to provide information at the level of an individual provider as well as summary information at the regional and state level for comparison purposes. The initiative evolved through three phases: Phase I focused on key indicators for fiscal monitoring, Phase 2 focused on clinical and population descriptive measures and indicators, and Phase 3 on the “story board” presentation. The key performance indicators and measures incorporated in the dashboards reflect areas of ongoing priority for the Division, including some of the National Outcome Measures of SAMHSA and the values expressed in the New Freedom Commission Report. Data elements include penetration rates, race, ethnicity, age, living situation and criminal justice involvement of individuals receiving services and a wide range of fiscal measures such as percent of contract earned, percent of claims adjudicated as Medicaid, and quality-related indicators. Many of the indicators that are identified by priority are included in the Dashboard that has been developed. The Dashboards are intended for regional staff, contract managers, clinical managers and executive staff at the DMH. It enables them to access data quickly and easily to guide decisions relating to access, utilization, and quality at the provider, regional and state levels. The Illinois Mental Health Collaborative is responsible for programming the Dashboard and maintaining the data warehouse for DMH. A screenshot of the two Dashboards are included in the Block Grant as attachments.
**IV: Narrative Plan**

**J. Suicide Prevention**

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**Narrative Question:**

In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America's service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State's suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

**Footnotes:**
Suicide Prevention Planning
In Illinois, more than 1,000 persons die by suicide each year and suicide fluctuates yearly between being the second or third leading cause of death for adolescents. Interest, organized efforts, and advocacy for suicide prevention in Illinois resulted in legislative action. In 2004, the Suicide Prevention, Education and Treatment Act (PA093-0907) was passed by the General Assembly and signed by the Governor directing the Illinois Department of Public Health (IDPH) to appoint the Illinois Suicide Prevention Strategic Planning Committee composed of representation of statewide organizations and local agencies that focus on the prevention of suicide and support services to survivors. To unify planning and suicide prevention efforts, an alliance was formed between a coalition of stakeholders and the strategic planning committee that was recognized in law by the General Assembly in 2008. The mission of the Illinois Suicide Prevention Alliance (the Alliance) as stated in the law is “to reduce suicide and its stigma throughout Illinois by collaboratively working with concerned stakeholders from the public and private sectors to increase awareness and education, provide opportunities to develop individual and organizational capacity in addressing suicide prevention, and advocate for access to treatment.” DMH is a member of the Alliance and actively participated in the development of the 2007 Illinois Suicide Prevention Strategic Plan. The Plan is attached to this Application. It may also be accessed at:
http://www.idph.state.il.us/about/chronic/Suicide_Prevention_Plan_Jan-08.pdf
The Alliance and DPH are required to provide an annual report to the General Assembly. The 2010 Annual Report is still in the draft stage and undergoing internal review. The 2009 Annual Report which was completed in June 2010 is attached as an update.

In reference to military personnel and their families, representatives from the Veteran’s Administration programs in Illinois have been active stakeholders and have attended Alliance meetings for the past several years. At its recent meeting, the Alliance approved amending its By-Laws to add a military/VA representative to its membership.
IV: Narrative Plan

K. Technical Assistance Needs

Page 46 of the Application Guidance

Narrative Question:
Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. The State should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

Footnotes:
K. Technical Assistance Needs
Illinois has recently identified technical assistance needs in the following areas:
- Integration of mental health in healthcare reform efforts
- Workforce development and cost effective models of staff education.
- Managed Care impact on mental health services, especially around integrated models versus carve out models.

Although not so much technical assistance as advocacy, we also urge SAMHSA to continue efforts to include mental health in national conversations with regard to health information exchange and health information technology. In terms of exchange of information, it would be helpful for SAMHSA:
- To convene forums for sharing of information by states and other entities around health care reform, health information exchange and workforce development. These forums could be convened through Webinars or through on-site forums to encourage in-depth conversation.
- Incorporate the many products, resources developed over the years by the states to support work in the arena of data collection, outcomes and other performance measures.

Active advocacy by SAMHSA is needed to both obtain funding in order to assist State Mental Health Authorities (SMHAs) in health information exchange activities as well as to include SMHAs in health information planning activities at the state and federal levels. Resources that would be helpful to Illinois include:
- Grants, Contracts and other fiscal supports to support the work of the DMH given that the mental health budget has been drastically reduced and some services are no longer available.
- Infrastructure dollars to support health care reform and health information exchange activities.
- Flexibility to fund some services/programs identified as a priority by the state.

Dollars and resources are urgently needed to undertake the above activities. Mental Health must have greater visibility!
IV: Narrative Plan

L. Involvement of Individuals and Families
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Narrative Question:

The State must support and help strengthen existing consumer and family networks, recovery organizations and community peer advocacy organizations in expanding self advocacy, self-help programs, support networks, and recovery-oriented services. There are many activities that State SMHAs and SSAs can undertake to engage these individuals and families. In the space below, States should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the State mental health and substance abuse treatment system. In completing this response, State should consider the following questions:

• How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coachers and or peer specialists)?
• Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?
• Does the State sponsor meetings that specifically identify individual and family members’ issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
• How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?
• How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Footnotes:
**L. Involvement of Individuals and Families**

The provision of mental health care that is consumer and family driven is an important priority of the Illinois Division of Mental Health. This priority is consistent with the current emphasis on involving consumers and families in orienting the mental health system towards recovery, and to improve access to, and accountability for mental health services. A variety of initiatives are being implemented to support consumer participation.

*On the Mental Health Planning Advisory Council*

A concerted effort has been made to ensure that consumers and family members play an important role in planning for mental health services. Representation by consumers and parents of children with serious emotional disturbances has increased. Consumers and/or family members co-chair the MHPAC, as well as all MHPAC sub-committees.

*WRAP Initiative.*

The Wellness Recovery Action Plan (WRAP) model is well established in Illinois. Through WRAP classes in community agencies and the introduction of the principles of WRAP at consumer forums and conferences, thousands of consumers throughout the state have benefited from receiving orientation and education in the principles and components of this evidence-based practice in recovery-oriented services. Since the inception of the Wellness Recovery Action Plan (WRAP) Initiative in Illinois, more than 300 individuals (including consumers currently receiving services) have received Certificates of Achievement as WRAP Facilitators, through their completion of a 40-hour intensive course. Refresher/Continuing Education courses are held in each region bi-annually for Certified WRAP Facilitators. Six regional WRAP refresher trainings were conducted between July 1, 2010 and April 30, 2011. The average number of participants per session was 15.

*Regional Recovery Conferences*

Consumer education is provided through a variety of venues in the state. DMH Recovery Support Specialists work with stakeholders to design, plan and convene annual recovery conferences in each DMH region. These conferences often have a well-known and/or national speaker who delivers the keynote address and who sets the "tone of recovery" for the conference. Two regional consumer conferences were held between July 1, 2010 and April 30, 2011. More than 500 consumers, family members, providers, DMH and other state agency staff attended these conferences.

Consumer participation objectives for FY 2012/2013 support the DMH priority for furthering work on the recovery vision in Illinois, by encouraging consumers and family members to participate in decision-making and service planning. Some of these objectives are continuations of efforts initiated in prior fiscal years.

*Consumer Education and Support Initiative.*

Dissemination of accurate information regarding services for consumers is the primary focus of the Consumer Education and Support Initiative. 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. In FY2011, eight statewide consumer education calls have been held between July 1, 2010 and April 30, 2011. There was an average of 480 participants for each consumer education teleconference. These calls provided a forum for discussion of service information, performance data, new developments, and emerging issues to promote consumers’ awareness and knowledge.

**Recovery oriented training**

In addition to the regional recovery conferences and statewide consumer education calls, recovery oriented training sessions were held in a variety of venues for all interested stakeholders in FY2011. Audiences for these sessions 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. Recovery oriented training events and presentations will continue in FY2012 and FY2013.

**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 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 credential became available through the ICB beginning in July of 2007.

As a means of disseminating information regarding the credential, the DHS/DMH developed a brochure entitled “Employing Persons with the CRSS Credential” and the ICB provided staff presence at regional recovery conferences to distribute information and respond to questions. DMH staff and the Mental Health Collaborative for Access and Choice designed a study guide for use by individuals seeking to obtain their certification that was published online in November 2009.

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In FY2011, the Office of Recovery Support Services continued 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

In FY2012, the DMH Office of Recovery Services is planning to host webinars for providers to help increase agencies’ understanding of the role, value, function, and advantages of hiring CRSS professionals with the aim of increasing the number of agencies hiring CRSS professionals in FY2013.

**Family Participation**

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- Support the establishment of Family Resource Developers, parents and caregivers of children with SED in the role of assisting families within Screening Assessment and Support Services (SASS) programs by providing training for FRD’s, and monthly FRD regional meetings.
- Employ Family Consumer Specialists (FCS) as C & A staff members of DMH in each region of the state. All five of the DMH regions now have a Family Consumer Specialist actively involved.
- Increase family participation in Regional Planning Councils, and the IMHPAC. The Child and Adolescent sub-committee of the Illinois Mental Health Planning and Advisory Council has been successfully co-chaired by a parent who exhibits strong leadership and advocacy skills and a community mental health agency director. This committee has become increasingly influential within the IMHPAC.
- Partner with and provide technical assistance and logistical support to the ICG parent group that is concerned with the enhancement of the quality of services in the Individual Care Grant (ICG) program and continues to be a robust voice in developing child services in Illinois.
- Require that Family Resource Developers are members of teams that provide services to youth and their families.
**Family Resource Developers**
DMH has required that Family Resource Developers (FRDs) be hired in SASS agencies. Increasing value has been placed on the expertise FRDs bring to the SASS teams and their support role has expanded. Monthly meetings are held for the FRDs in order to provide education, resource development and support for the positions.

**Family Driven Care**
Illinois was one of six states that received a SAMHSA award in 2009 that paid expenses to participate in a policy academy focused on Family Driven Care. This project 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. The project has involved surveys of families and providers, development of a multi-agency Family Driven Care Commission, and the beginning development of a state recognized certification for parent providers. The Family Driven Care Commission led the development of the Certified Family Partner Professional (CFPP) credential. The CFPP will assist in ensuring the quality of care that is provided to client families by peer parents in many of the child-serving systems. Certification will be accomplished through a mandatory training and experience protocol and the successful completion of a written examination. The goal for this credential is that it will be recognized in Illinois Medicaid Rule (Rule 132), and CFPP’s will be authorized to provide services at the Mental Health Practitioner (MHP) level. The expectation is that moving the system to truly family driven care will require ongoing effort for several years.

**Parent /Caregiver Education**
Family Consumer Specialists host monthly statewide ‘Parent Empowerment Calls’ to provide parents with information that will allow them to more effectively drive and evaluate their children’s care and the system at large. Consumer conferences for parents on evidence-based practices are scheduled, and education campaigns for families on the use of outcome measures are being developed. To support the discussion, the EBP committee has designed a brochure on Evidence Informed Practice for parents in order to help families know what to ask for and expect regarding care for their children.
L. Involvement of Individuals and Families

The provision of mental health care that is consumer and family driven is an important priority of the Illinois Division of Mental Health. This priority is consistent with the current emphasis on involving consumers and families in orienting the mental health system towards recovery, and to improve access to, and accountability for mental health services. A variety of initiatives are being implemented to support consumer participation.

On the Mental Health Planning Advisory Council

A concerted effort has been made to ensure that consumers and family members play an important role in planning for mental health services. Representation by consumers and parents of children with serious emotional disturbances has increased. Consumers and/or family members co-chair the MHPAC, as well as all MHPAC sub-committees.

WRAP Initiative.

The Wellness Recovery Action Plan (WRAP) model is well established in Illinois. Through WRAP classes in community agencies and the introduction of the principles of WRAP at consumer forums and conferences, thousands of consumers throughout the state have benefited from receiving orientation and education in the principles and components of this evidence-based practice in recovery-oriented services. Since the inception of the Wellness Recovery Action Plan (WRAP) Initiative in Illinois, more than 300 individuals (including consumers currently receiving services) have received Certificates of Achievement as WRAP Facilitators, through their completion of a 40-hour intensive course. Refresher/Continuing Education courses are held in each region bi-annually for Certified WRAP Facilitators. Six regional WRAP refresher trainings were conducted between July 1, 2010 and April 30, 2011. The average number of participants per session was 15.

Regional Recovery Conferences

Consumer education is provided through a variety of venues in the state. DMH Recovery Support Specialists work with stakeholders to design, plan and convene annual recovery conferences in each DMH region. These conferences often have a well-known and/or national speaker who delivers the keynote address and who sets the "tone of recovery" for the conference. Two regional consumer conferences were held between July 1, 2010 and April 30, 2011. More than 500 consumers, family members, providers, DMH and other state agency staff attended these conferences.

Consumer participation objectives for FY 2012/2013 support the DMH priority for furthering work on the recovery vision in Illinois, by encouraging consumers and family members to participate in decision-making and service planning. Some of these objectives are continuations of efforts initiated in prior fiscal years.

Consumer Education and Support Initiative.

Dissemination of accurate information regarding services for consumers is the primary focus of the Consumer Education and Support Initiative. 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. In FY2011, eight statewide consumer education calls have been held between July 1, 2010 and April 30, 2011. There was an average of 480 participants for each consumer education teleconference. These calls provided a forum for discussion of service information, performance data, new developments, and emerging issues to promote consumers’ awareness and knowledge.

Recovery oriented training

In addition to the regional recovery conferences and statewide consumer education calls, recovery oriented training sessions were held in a variety of venues for all interested stakeholders in FY2011. Audiences for these sessions 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. Recovery oriented training events and presentations will continue in FY2012 and FY2013.

Certified Recovery Support Specialist (CRSS)

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IV: Narrative Plan

M. Use of Technology
Page 47 of the Application Guidance

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care services. ICTs are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, etherapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, case manager support and guidance, telemedicine. In the space below, please describe:

a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?
b. What specific applications of ICTs does the State plan to promote over the next two years?
c. What incentives is the State planning to put in place to encourage their use?
d. What support systems does the State plan to provide to encourage their use?
e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?
g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

Footnotes: 

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M. Use of Technology

*Interactive Communication Technologies*
Communication Technologies have been very valuable in conducting the day to day business of the Division of Mental Health and in providing a medium for conducting stakeholder meetings and furthering training and education.

- **Video conferencing** business meetings between offices of DMH (Springfield, Chicago, and Regional Offices) has become commonplace.

- **Meetings of the Illinois Planning and Advisory Council** are conducted interactively through video conferencing between Springfield and Chicago with telephone conference inclusion for members unable to reach either location. Council Committees meet by video-conferencing from multiple locations in the State as well as bringing individuals in by telephone. The Child & Adolescent Committee, for example, conducts a two hour bi-monthly interactive meeting with over 100 members participating from all parts of the State.

- **Consumer Education and Parent Empowerment Call-Ins** have been of inestimable value in informing consumers and parents across the State about current issues in the system, clinical developments, and resource information. In FY2010, eleven consumer call-ins were conducted with 300 to 700 participants in each call and seven parent empowerment call-ins garnered at least 180 participants for each call.

- **Monthly Teleconferences in the areas of Utilization Management, Assertive Community Treatment and Information Technology** have been used as a cost-effective means to provide technical assistance to the network of providers with whom DMH contracts.

DMH worked with the Mental Health Collaborative for Access and Choice (the Collaborative), its contracted Administrative Services Organization, to develop and maintain two innovative Websites which can be easily accessed by consumers and providers.

- The **WRAP Locator** provides current information to consumers on the Wellness and Recovery Action Plan classes located everywhere in the State thereby allowing consumers to choose a convenient location and a desirable format. WRAP facilitators are accommodated in entering the information about WRAP classes scheduled to begin or ongoing classes which are of interest.

- **Referral Connect** is available to both consumers and providers and allows them to search for a mental health provider based on location and type of service provided. There are two versions of ReferralConnect that are accessible. The first is a version that maintains listings of more than 50,000 providers and offers the ability to search for services throughout Illinois and across the United States. The second version is Illinois-specific containing more detailed information about specific service availability and type of service.
In rural areas where there are shortages of psychiatrists, especially child psychiatry, Tele-psychiatry has been a very valuable tool to provide and improve the quality of clinical work (See Objective C4.1). Public Act 95-16 (July, 2007) permits rural Medicaid patients in Illinois to receive treatment through Tele-psychiatry - primarily videoconferencing - to provide psychiatric care to offset the long distances and limited access to transportation that make it difficult for rural persons to obtain adequate mental healthcare.

The efforts described above are generally expected to continue over the next year.

*Use of Interactive Technology to Support the Integration of Mental Health Services and Addiction Treatment with Primary Care and Emergency Medicine*

As discussed in another section of the Block Grant plan, the DMH in partnership with other DHS Divisions and state agencies convened a bi-directional healthcare summit in June 2011. Interactive technology was used effectively to promote this effort. The day-long summit itself was available via webcast providing an opportunity for a large and diverse audience to participate. Additionally videos of the presentations are posted on the DHS/DMH website, as well as written materials produced for and from the Summit. It is expected that these efforts will continue as the DMH moves forward with system partners on this important initiative.

*Health Information Technology*

The Governor’s Office has appointed the state Medicaid Authority, Healthcare and Family Services, as the lead agency for the state with regard to health information technology and health information exchange. On July 27, 2010, Governor Pat Quinn signed a bill into law to create a secure framework for the sharing of electronic health information in Illinois. The new law created the Health Information Exchange and Technology Act and established a state authority to operate the Illinois Health Information Exchange (HIE). House Bill 6441 creates the framework necessary for providers and insurers to share health records electronically. The HIE will provide health care providers with a secure system to access a patient’s comprehensive medical history, avoid duplicate tests and procedures, and assure the accuracy of prescription drugs and other medical orders.

The new law creates the Health Information Exchange Authority to establish and operate the HIE and foster the widespread adoption of electronic records and participation in the HIE. The legislation also creates an eight-member board to govern the authority. The directors of the Illinois Departments of Healthcare and Family Services, Public Health, and Insurance and the Secretary of the Illinois Department of Human Services, or their designees, and a designee of the Office of the Governor, serve as ex-officio members of the Authority. The Division of Mental Health, as the SMHA, does not, however, have a major role in this initiative.

As mental health/behavioral health is not currently an eligible recipient of dollars to support activities related to Health Information Exchange, or to assist in developing Electronic Health Records, there are simply no dollars available to assist in undertaking
these important tasks during a time of unprecedented cuts to the state mental health budget. In effect, mental health is being left out of an extremely critical conversation and has not been given an opportunity to play an active role in larger state health information activities. As a result, there has been little opportunity to ensure that mental health/behavioral health needs and requirements are addressed. Although DMH staff have worked for many years on developing data standards, data definitions, and performance measures that could greatly support work in this arena, this work is not being incorporated into health information exchange activities. For example, over the last few years, DMH has been working with a very small, nearly non-existent budget, to begin planning around electronic health record development and implementation for the nine state psychiatric hospitals that it operates. If the infrastructure is not put into place and funds are not available to develop EHRs for this system, the state may very well have HIE activities occurring with private entities, but the state hospitals will not be able to participate in these activities.

**Barriers to Promoting Interactive Communication Technology**

Although DMH has been able to promote Interactive Communication Technology in many venues as described above, the primary barrier to expanding this effort into other arenas rest with the lack of availability of resources to do so. At present, the DMH does not intend to use ICTS to collect data for program evaluation at provider and client levels. In terms of data collection and measures to judge the use and effectiveness of ICTs that are used, DMH may consider addressing these issues
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The success of a State's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(ies); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The State Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into contact with the criminal and juvenile justice systems; promote strategies for appropriate diversion and alternatives to incarceration; provide screening and treatment; and implement transition services for those individuals reentering the community.
- The State Education Agency examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe; supported in their social-emotional development; exposed to initiatives that target risk and protective actors for mental and substance use disorders; and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The State Child Welfare/Human Services Department, in response to State Child and Family Services Reviews, working with local child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.
N. Support of State Partners

Adult Services
DMH exerts ongoing leadership through system integration initiatives, competence development, consumer development and continuous quality improvement. Emphasis is on developing systems integration at the statewide level that parallels the relationships that community mental health centers develop at the local level.

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

Division of Human Capital Development (DHCD) The DHCD oversees programs that help clients to achieve self-sufficiency including employment and training services, child care and family services, and financial support services. This Division serves over one million DHS customers each month through income supports such as: cash assistance, food stamps, medical programs, employment and training programs, help with child care, emergency assistance, refugee and immigration services, homeless services, and specialized social services. DHCD has six regional and 106 local Family Community Resource Centers that serve as the first point of contact for many IDHS clients. These offices offer direct transitional services and a link to employers and key community organizations.

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

DMH and the Division of Alcoholism and Substance Abuse (DASA) have collaborated for many years to address services for individuals with co-occurring disorders. Initiatives have included the establishment of consortiums comprised of mental health and substance abuse providers to collaborate on treatment provision, cross-training of providers from both service systems focusing on integrated treatment, and the funding of an institute to provide training to service providers across the state.
The Division of Developmental Disabilities (DDD) provides respite care, developmental training, and family support services to help individuals with developmental disabilities to become independent. Services are provided through residential facilities and programs that help disabled individuals live at home or in a community living center. DMH and DDD share leadership tasks in addressing the needs of persons with Autistic Spectrum disorders (ASD) and joint efforts are ongoing to resolve service issues for those consumers who have been dually diagnosed with a developmental disability and a mental disorder.

The Division of Rehabilitation Services (DRS) oversees programs serving persons with disabilities that include vocational training, home services, educational services, advocacy, information and referral. Also provided are a variety of services for persons who are blind, visually impaired, deaf or hard of hearing.

DMH and DRS are partnering to increase the access of persons with serious mental illnesses to vocational rehabilitation services and to improve the coordination of psychiatric and vocational services. DMH, DRS, and DASA have worked collaboratively with the Illinois Certification Board (ICB) to develop the Illinois Model for Certified Recovery Support Specialist (CRSS) that defines baseline criteria for CRSS professionals and provides a professional certification that is competency based. DMH and DRS continue to jointly assess their service systems to determine what gaps exist locally and emphasize technical assistance for needed program modifications.

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

**Mental Health and the Justice System**

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

- Illinois Department of Corrections
- Illinois Department of Juvenile Justice (Established in FY2006)
- Administrative Offices of the Illinois Courts
- Illinois Criminal Justice Authority
- Illinois State Police
- Illinois Sheriff’s Association
- Cook County Department of Corrections
- County Jails and Juvenile Detention Centers (statewide)
- Local law enforcement agencies and organizations (statewide)

IDHS/DMH has assumed a leadership role in the development of significant statewide initiatives for justice-involved individuals with mental illness and has been instrumental in developing integrated processes of identification, reentry linkage, and service delivery between the criminal justice, mental health and substance abuse networks, and recovery support services, such as housing and employment. These efforts have laid the groundwork for a more comprehensive and effective diversion approach based on leveraging existing successful intervention models, enhancement of capacity, and increased availability of clinically appropriate services.
These two initiatives demonstrate partnering support and an increasing clinical role in serving individuals with mental illnesses who have been adjudicated in the criminal courts:

The Jail Data Link Project is a pilot program between the Cook County Department of Corrections (CCDOC) and the mental health system begun in FY2000 has now expanded to other sites around the state. The initial program effort was implemented through Thresholds, a community mental health center, and was designed to serve adults diagnosed with serious mental illnesses who are detained at CCDOC (pre-trial). The project received a Gold Award from the American Psychiatric Association. A key aspect of this project was the development of a database for the daily exchange of information between Cook County Jail and the community mental health provider. This initiative is more fully described in Section II (Adult Plan-Goal 1).

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

Law Enforcement and Crisis Intervention Training

The DMH regularly collaborates with law enforcement agencies and emergency services at general hospitals to facilitate appropriate and effective psychiatric intervention to persons who are in crisis. Each DMH Region is committed to working on improving relationships through cross-training events for law enforcement officers and mental health staff of community agencies. DMH has worked collaboratively with a number of law enforcement agencies to provide training targeting police officers that interface with individuals with mental illnesses.

Illinois Housing Development Authority

The availability of safe, decent, and affordable housing is a necessary component of a comprehensive community support system. DMH has worked at forging dialogue and partnerships with the Illinois Housing Development Authority (IHDA), a group with a legislative mandate to oversee and advise on Housing in Illinois, which includes the broader spectrum of state government in its membership, as well as local housing authorities, housing developers and other finance entities.

Illinois Department on Aging

The DMH works closely with the Illinois Department on Aging (DOA) to increase training opportunities in the geriatric field, to improve the quality and accessibility of services for elderly persons with mental illness, and to enhance networking, collaboration and coordination of programs and services in provider networks. Training, consultation
and technical assistance have been provided in the area of mental health and aging as well as promotion of public awareness of geriatric mental health concerns.

Child Services

Collaboration with the IDHS Division of Community Health and Prevention

The Division of Community Health and Prevention (DCHP) service purview encompasses community health services, family and youth development, violence prevention and intervention, and addiction prevention. The DCHP includes: Maternal and Child Health Services, Comprehensive Services for Youth, Substance Abuse Prevention, the Teen REACH Program, and Violence Prevention and Education Services. Collaboration, cross training, and consultation between DMH and DCHP has continued:

- A statewide perinatal mental health consultation service has been established for providers to use when a screening indicates that a pregnant or postpartum woman may be suffering from depression. This service is accessed by a toll free number and provides consultation with psychiatrists specializing in women’s health issues, information about medications that may be used in the management of perinatal depression during and/or after pregnancy, and referral and linkage to available mental health resources. This program was formed in collaboration with DCHP, HFS (Illinois Healthcare and Family Services), and DMH.

- Early Intervention Services provided through DCHP for children under three years of age who are experiencing delays in one or more of the following areas: cognitive development; physical development; language and speech development; psycho-social development; and self-help skills. Evaluations and assessments are provided at no cost to families. Families with eligible children receive an Individualized Family Service Plan (IFSP) listing the services and support that must be made available to the family. DMH Child and Adolescent Services is supporting this program through efforts to increase community mental health provider capacity to serve any mental health needs of the children identified through these screenings; capacity-building programs include collaboration in the Illinois’ Children’s Mental Health Partnership’s Early Childhood Consultation project providing early childhood mental health consultants to participating community mental health agencies, and the addition this year of the Devereaux Early Childhood Assessment tools to the DMH Child and Adolescent Services web-based outcomes system for children ages 0-5 served in the community mental health services system.

- Project LAUNCH: DCHP and DMH Child and Adolescent Services leadership are serving as Co-Principal Investigators for this SAMHSA-awarded, 5 year grant program focusing on the healthy developmental needs of children ages 0-8 years. The project has both a statewide and a local component and currently both statewide and local scans are being conducted to assess needs and resources available to children and their caretakers in this important age range. Following these scans, both statewide and local strategic plans are to be developed with the Technical Assistance provided by SAMHSA regarding resources and services needs of this population and their caretakers. The local component of the project
provides services to this population and their caretakers, including mental health consultants based in the local community and are available to multiple child caring providers there.

**Mental Health Services Provided for Youth Through Other State Agencies**

An overview of mental health services to youth and families in Illinois would be incomplete without the acknowledgement of the programs provided through state departments other than DHS. Screening Assessment and Support Services (SASS) are services provided by the Department of Children & Family Services (DCFS) for children who are under the guardianship of the Department. The Department of Health and Family Services (DHFS) funds SASS services for children enrolled in Medicaid. The Illinois Children’s Mental Health Partnership (ICMHP) has partnered with DMH in providing a range of pilot projects affording services including early intervention, for youth transitioning from DMH funded 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. ICMHP directly manages a mental health consultation program for children under the age of 5. The Illinois State Board of Education (ISBE) provides mental health services through school districts for children who need them in the school setting. The Department of Juvenile Justice (DJJJ) employs mental health professionals who provide services in that Department’s Youth Centers. Within DHS, the Comprehensive Community-Based Youth Services Program (CCBYS) provides mental health services to youth ages 10-17 who are at risk of involvement in the child welfare and/or juvenile justice system. The program has a statutory mandate to provide short-term crisis intervention services to youth who have run away from home or whose parents will not allow them to return to their home; or who are generally beyond the control of their parents. By law, the program must be available in every area of the state, 24 hours a day.

**Juvenile Justice**

The DMH has a Juvenile Forensic Program that develops treatment programs for forensic youth who are court-ordered into mental health care (i.e. unfit to stand trial or not guilty by reason of insanity). The Juvenile Forensic Program oversees the DMH Mental Health Juvenile Justice Initiative (MHJJ), which links minors in juvenile detention centers who have a major mental illness and sometimes co-occurring substance abuse problems to comprehensive community-based care. MHJJ began as a pilot program in FY2000 and expanded statewide by the end of FY2002. MHJJ is available at all the detention centers in Illinois. (See Section II-B Child Plan-Goal 3)

**Illinois State Board of Education (ISBE)**

The DMH has pursued the Positive Behavioral Interventions and Supports (PBIS) model of collaboration between education and mental health through work on our States’ current three System of Care Grants and through collaborative efforts with the Children's’ Mental Health Partnership. The Division of Mental Health is currently funding six school-based Mental Health programs in collaboration with ISBE and the Illinois Children’s Mental Health Partnership, and these have been successful in implementing the three-tiered model of schools-based mental health and development collaborations, helping not only
students in all three tiers of the model, but schools staff such as teachers, and parents as well. Work is continuing to expand the education/mental health partnership of these schools and mental health programs. (See Section II-B Child Plan-Goal 3)

**Child Welfare**

DMH continues to work closely with Department of Children & Family Services, the child welfare agency, on a number of initiatives related to the mental health needs of children in the child welfare system including the Screening, Assessment, and Support Services (SASS) Program, which is an interagency collaboration between DMH, DCFS, and HFS (Healthcare and Family Services). This SASS program provides 24/7 access to children, youth, and their families in crisis in the State and is accessed through a 1-800 CARES line number statewide.
IV: Narrative Plan

O. State Behavioral Health Advisory Council
Page 49 of the Application Guidance

Narrative Question:

Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State.

Please complete the following forms regarding the membership of your State's advisory council. The first form is a list of the Advisory Council for your State. The second form is a description of each member of the behavioral health advisory council.

Footnotes:
The Illinois Mental Health Planning and Advisory Council

Description of Role and Activities
The Illinois Mental Health Planning and Advisory Council (IMHPAC) advises the DMH on mental health issues. The Advisory Council is a body of 53 members, which includes consumers and representatives from public and private organizations that plan, operate, and advocate for mental health and support services for persons with serious mental illness. Established in 1992, the Advisory Council’s participation in the analysis of Illinois' mental health system has yielded a significant public/private partnership that focused on restructuring public mental health services in Illinois and guided the development of a strategic plan for consumer-responsive, community-based, and cost-effective service delivery. The Council approved a set of By Laws at the end of FY2002 and has revised them as needed.

Each DMH Community Comprehensive Service Region (CCSR) is represented on the Council. Providers, consumers, family members and parents of children with SED who are members of the Council may also act in an advisory capacity in the Regions. State employees representing principal state agencies with respect to mental health, education, criminal justice, vocational rehabilitation, housing, and a variety of social services as well as representatives of organizations that are significant stakeholders and advocates are full members of the Council. Expansion of the Council membership to encompass behavioral health including representation of the Alcoholism and Substance Abuse community of providers and consumers, representation of primary health care, and representation of the Health Information Exchange Authority in FY2012 and FY2013 is currently being discussed.

The Advisory Council currently has several sub-committees including an Executive Committee, Planning Advisory Committee, and Substantive Committees. The Substantive Committees include: Adult Inpatient, Child and Adolescent Services, and Adult Community Services. Other committees may be appointed as needed. The Council as a whole meets six times a year to review new developments, monitor the progress of initiatives, and discuss problematic issues in the mental health service system. Each subcommittee also meets at least six times a year, during alternating months of the full council meeting. Each subcommittee is co-chaired by a consumer or family member and a provider or other council member. The Council advises DMH on its policies and plans and advocates for improvements in the mental health system. The Council has identified critical funding needs in the public mental health service system, and members of the Council, privately and through their affiliations developed a Mental Health Summit to lobby for additional funding. The focus, coordination, and organization of their efforts have been instrumental in bringing mental health issues to public and legislative attention, founding an infrastructure for further advocacy, and participating in DMH efforts to generate more revenue for community mental health services.

The activities of monitoring, reviewing and evaluating the allocation and adequacy of mental health services within the state are an integral component of developing the state plan. The Planning Committee of the Advisory Council meets regularly with DMH staff to develop and review the state plan. Members of the IMHPAC participate in statewide planning meetings convened by the Division of Mental Health. Based on feedback provided by a wide range of stakeholders, key priorities for the mental health service
delivery system are identified. These priorities include expanding work in the areas of: recovery, implementation of evidence-based practices, permanent supportive housing, children’s mental health issues and mental health and justice system involvement.
# IV: Narrative Plan

## Table 11 List of Advisory Council Members

Pages 51 and 52 of the Application Guidance

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<tr>
<th>Start Year</th>
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<tr>
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<tr>
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</tr>
<tr>
<td>Lora Thomas</td>
<td>Others (Not State employees or providers)</td>
<td>NAMI Illinois</td>
<td>218 W. Lawrence</td>
<td><a href="mailto:Thomas.lora@sbcglobal.net">Thomas.lora@sbcglobal.net</a></td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Springfield, IL 62704</td>
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<tr>
<td>Christine Walker</td>
<td>Family Members of Individuals in Recovery (from Mental Illness and Addictions)</td>
<td>Lyons Township Mental Health Commission</td>
<td>6404 Joliet Road</td>
<td><a href="mailto:ltmhc@lyonsts.com">ltmhc@lyonsts.com</a></td>
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<tr>
<td>Melinda Willenborg</td>
<td>Family Members of Individuals in Recovery (from Mental Illness and Addictions)</td>
<td>Lyons Township Mental Health Commission</td>
<td>157 County Road 700 North</td>
<td><a href="mailto:mindywillenborg@yahoo.com">mindywillenborg@yahoo.com</a></td>
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<tr>
<td>Robert Vyverberg, ED.D</td>
<td>State Employees</td>
<td>DHS Division of Mental Health</td>
<td>5407 N. University St.</td>
<td><a href="mailto:Robert.Vyverberg@illinois.gov">Robert.Vyverberg@illinois.gov</a></td>
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<tr>
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<tr>
<td>Gilbert Zych</td>
<td>Others (Not State employees or providers)</td>
<td>Lyons Township Mental Health Commission</td>
<td>6404 Joliet Road</td>
<td><a href="mailto:ltmhc@lyonsts.com">ltmhc@lyonsts.com</a></td>
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<td>Countryside, IL 60525</td>
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**Footnotes:**

Council Co-Chair
## IV: Narrative Plan

### Table 12 Behavioral Health Advisory Council Composition by Type of Member

Pages 52 and 52 of the Application Guidance

<table>
<thead>
<tr>
<th>Type of Membership</th>
<th>Number</th>
<th>Percentage</th>
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<tr>
<td><strong>Total Membership</strong></td>
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<tr>
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<td>Vacancies (Individuals and Family Members)</td>
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<tr>
<td><strong>Total Individuals in Recovery, Family Members &amp; Others</strong></td>
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<tr>
<td><strong>Total State Employees &amp; Providers</strong></td>
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<td>36.17%</td>
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</tbody>
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### Footnotes:

OMB No. 0930-0168  Approved: 07/19/2011  Expires: 07/31/2014  Page 119 of 184
Narrative Question:

SAMHSA statute requires that, as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State plan. States should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. In the section below, States should describe their efforts and procedures to obtain public comment on the plan in this section.
The development of the state mental health block grant plan is made available for public comment in multiple ways. (1) The Illinois Mental Health Planning and Advisory Council (MHPAC) includes consumers of mental health services and family members who also participate in a range of advocacy groups such as the Mental Health Summit, the Mental Health Association and the Illinois Alliance for the Mentally Ill. Council members regularly consult with their respective advocacy groups during the development of the state plan. (2) All Council meetings are open to the public. Council meeting dates are set up a year in advance to facilitate participation. Persons with an interest in the state plan may attend meetings at which the plan is discussed and provide feedback and comments. (3) The Planning Committee of the MHPAC reviewed the FY2012/2013 Block Grant Plan during its development and requested comment and input from all members of the Council. This year, the Committee requested specific feedback on the Council with regard to unmet needs. Developments and issues in Block Grant Planning have also been discussed at all IMHPAC meetings in the past year. (4) A Notice requesting public comment and a working draft of the Plan was posted on the DHS Website on August 26, 2011. (5) The final state block grant application and proposed plan will be posted on the web site for the Division of Mental Health (www.dhs.state.il.us) in September. The public can access this DHS DMH Internet site. Interested parties have been instructed to contact Dr. Mary E. Smith to provide comment. Contact information is provided on the website. Detailed comments that have been provided thus far are on file at the DMH. Additional comments submitted after the final draft of the plan is posted will be reviewed by the MHPAC planning committee.

The Illinois Mental Health Planning Advisory Council (MHPAC) has delegated detailed work on the Mental Health Block Grant Application to the MHPAC Planning Committee which is comprised of consumers, a parent of a child with SED, providers, advocates, and is staffed by the mental health block grant planner. This committee meets every other month for three hours during which a variety of topics are discussed including block grant objectives, performance measures and indicators and service initiatives. Members of the planning committee make special presentations to the full MHPAC Council on various components of the plan to ensure that all members understand the content of the plan.
TOOLS OF THE TRADE: DASHBOARDS FOR DECISION SUPPORT

Mary E. Smith, PhD; Dorothy D. Efring, MPH; Illinois Department of Human Services, Division of Mental Health

Overview

Illinois Mental Health Collaborative staff are responsible for programming the Dashboard and for maintaining a data warehouse for DMH. The fiscal Dashboard has been "live" since 2000, the clinical dashboard is its final stage of evolution and is expected to be rolled out in August 2010. The Dashboards are intended for regional, contract managers, clinical managers and executive staff at the DMH. It enables them to access data quickly and easily to guide decision-making relating to access, utilization and quality at the provider, regional and state levels.

Fiscal Dashboard

There are four tabs that comprise this dashboard and one is shown here. The tab focuses on "Earned Contract Percent" and shows where paid claims stand in relation to annual provider contracts. Contract managers use this to support interventions at the provider level to maintain continuity of services.

Clinical Dashboard - Welcome Tab

The welcome tab displays an interactive map of Illinois with three key service indicators: number of individuals served and percent of visits outside of the office for ACT and Community Support. It will provide a quick synopsis of regional activity. All data in the clinical dashboard is currently being validated and should be regarded as demonstration data.

ACT & Community Support Indicators Tab

This tab is used to monitor key performance indicators for ACT and Community Support. ACT Indicator #1: Percent of approved and paid claims that occurred at a frequency of 3 or more times per week per consumer of ACT services who had a claim that week. ACT Indicator #2: Percent of approved and paid claims that occurred outside of the provider’s office by week. CS Indicator #1: Percent of approved and paid claims that occurred outside of the provider’s office by week.

Service Mix Tab

Information on the service mix displays amount and type of services provided to consumers broken out by the state, regional and provider level. While an appropriate mix of services has not been officially defined by DMH, utilization management (UM) policies are being established for some services such as Psychosocial Rehabilitation (PSR) and therapy/counseling. Monitoring this mix is important for decision making at the state level because it will give an indication of the impact of service changes by provider once UM policies are implemented.

Background

The Illinois DMH Division of Mental Health (DMH) is responsible for oversight of the public mental health system, policy formulation and review, planning, services evaluation, purchases of services and allocation of funds. The DMH is organized into five Comprehensive Community Service Regions (CCSRs). Through these Regions, the DMH operates nine state hospitals and contracts with 149 community-based outpatient rehabilitation agencies across the state.

The Regions are charged with the responsibility for managing care, developing the capacity and expertise of providers, monitoring service provision and increasing the quality and the quantity of participation from persons who receive mental health services. Two Regions are located in the Chicago Metropolitan area and surrounding suburbs, and three Regions cover the central, southern and metro-east southern (East St. Louis region) areas of the State. Administratively, each Region has an Executive Director, a lead Clinical Director, a lead Recovery Services Development Specialist, and a Coordinator of Forensic Services.

The DMH purchases services for more than 150,000 adults and children in need for mental illnesses and emotional disorders annually. As the DMH, the Division works to assure that individuals receive efficient and effective services that support the development of resilience and to support individuals’ recovery so they can participate fully in a life in the community.

Target Adult (TA) or Target Child (TC): consumers who have serious mental illnesses based on a combination of diagnosis, functioning impairment and or a history of disability. The DMH has a policy that encourages providers to give priority access to this group.

Eligible denotes individuals who do not meet the criteria of target but are eligible for services.

#define definitions

### Definitions

**Target Adult (TA)** or **Target Child (TC)**: consumers who have serious mental illnesses based on a combination of diagnosis, functioning impairment and/or a history of disability. The DMH has a policy that encourages providers to give priority access to this group.

**Eligible** denotes individuals who do not meet the criteria of target but are eligible for services.

**Assessment Community Treatment (ACT)**: is an evidence based practice performed by a multi-disciplinary team to help those with significant functional impairments from serious mental illnesses for whom regular outpatient services are not sufficient to maintain their lives in the community.

**Community Support (CS)**: is a recovery and resiliency oriented, community based rehabilitation and outreach service for adults and youth.

Acknowledgements and Contact Information

Special Thanks to: Michael Berry, Illinois Mental Health Collaborative/Value Options

Attribution: Purrington, C.B. 2006. Advice on designing scientific posters. dorothy.elfring@illinois.gov

Poster Presented at the 2010 National Mental Health Block Grant and Data Conference and the State Data Infrastructure Grantee Conference 2010

June 23-25, 2010

Template provided by: "posters4research.com"
### Illinois Suicide Statistics

- More than 1,000 Illinoisans die by suicide each year.
- Firearms are the leading method of suicide.
- Persons 70 years of age and older have the highest suicide rate.
- Males complete suicide 4.4 times the rate of females. Females attempt suicide 45 percent more than males.
The problem of suicide in Illinois challenges everyone: communities, educators, advocates, clergy, public health professionals, hospital personnel, health care providers, prevention specialists, law enforcement, physicians, mental health professionals and policy-makers. Efforts by the Illinois Department of Public Health (Department) to address the problem and to reduce the number of suicides and lessen its stigma across Illinois began nine years ago.

The initial statewide effort to address suicide in Illinois began in 2001 with the establishment of the Illinois Suicide Prevention Coalition by the Department. The coalition held meetings from 2001 through 2003 with the initial purpose of developing a state plan for suicide prevention. The initial plan was completed in 2003 and included recommendations for establishing a comprehensive approach to suicide prevention which included survivors, families, suicide service providers, state agencies and community advocates.

In 2004, the Illinois General Assembly passed the Suicide Prevention, Education and Treatment Act (Public Act 093-0907). Public Act 093-0907 (http://www.ilga.gov) required the Illinois Department of Public Health to establish a Suicide Prevention Strategic Planning Committee and set out requirements for the appointment of members. To unify planning work and advance suicide prevention efforts in Illinois, an alliance was created between the Illinois Suicide Prevention Strategic Planning Committee and the Illinois Suicide Prevention Coalition in 2007. The committee represented statewide organizations and state agencies that focus on the prevention of suicide and the improvement of mental health treatment, along with others that provide suicide prevention or survivor support services. The committee was charged to: 1) develop the Illinois Suicide Prevention Strategic Plan; 2) incorporate recommendations for a public awareness media campaign, education initiatives and pilot programs to provide training and direct service into the plan; and, 3) provide an annual report to the General Assembly. In 2007 legislation was passed officially changing the name of the committee to the Illinois Suicide Prevention Alliance (the alliance) and was signed into law on January 1, 2008. The report narrative captures the 2009 work of the Department and its advisory board, the Illinois Suicide Prevention Alliance, along with other state suicide prevention efforts.
The alliance met five times during 2009 (January 14, March 12, May 19, September 15 and November 13). Highlights of the work accomplished in 2009 are:

- Completed and distributed 2008 Suicide Prevention Report.
- Completed the document, State Agency Review and Initial Recommendations Report: Recommendations of policy and program changes to support suicide prevention.
- Promoted increased awareness of education about suicide and suicide prevention efforts.
- Promoted development of organizational capacity in addressing suicide prevention.

The alliance activities and recommendations regarding education, awareness, training and organizational capacity were done in conjunction with funds provided to Mental Health America of Illinois through a grant. Because of the interconnected nature of the activities of the alliance and the grant projects, detailed summaries of the grant activities are incorporated into this report.

A. Education and Training Efforts
Activities addressing education and training focused on building the capacity of professionals and community members to gain knowledge and skills for suicide prevention. The efforts were incorporated into the grant deliverables of the Mental Health America grant and developed in collaboration with the Education and Training work group of the alliance. Specific 2009 accomplishments include:

- A two-day Core Competency Training was held for nine community-based teams to develop local projects that support suicide prevention education efforts.
- Fifty people were trained from nine different teams from across Illinois, with coverage of the following counties and local cities – Bureau, Cook, DeKalb, DuPage, Grundy, Kane, Kendall, McHenry, Madison, Marshall, Monroe, Peoria, Randolph, St. Clair, Saline, Stark, Tazewell and White counties; Orland Park, Orland Hills and Orland Township and the Metropolitan Chicago area.
- Local projects focused on improving identification and treatment of suicidal behavior by utilizing existing services and improving service referrals and timely support to suicidal individuals.

Work in this area in the upcoming 2010 year will focus on building an additional 15-20 effective coalitions / partnerships that support local efforts through core competency training and technical assistance to develop and implement a nine-month initiative to support each team’s plan.

Schools are key stakeholders in the prevention of suicide among young people.
- Through the Mental Health America project, seven mini-grants were awarded to school districts and local non-profits to introduce or expand suicide prevention efforts. Impact was made in the following areas: suicide prevention curricula,
increase in-school mental health support, professional development and programs to educate students, parents/other caregivers.

- Through the mini-grants, 500 school and community professionals were trained in the following counties: Adams, Champaign, Cook (including Chicago metropolitan and suburbs), Macon, Whiteside and Winnebago.

The Illinois Department of Human Services Division of Mental Health (DMH) was selected as a training participant under the Mental Health America grant and participated in the following accomplishments:

- A partnership with the Division of Mental Health was designed to enhance capacity of the network of mental health service providers to identify and evaluate clients who were at risk. After assessment, providers were encouraged to manage risk in collaboration with the client and/or their family.
- National trainers from the QPR (Question, Persuade and Refer) Institute for Suicide Prevention conducted five trainings geographically spread throughout the five DMH Regions.
- Twenty-five professionals, including five DMH staff, became certified QPR instructors so they can continue to train others throughout Illinois.
- More than 100 participants from northern, central and southern Illinois participated in QPR Institute’s Suicide Risk Detection, Risk Assessment and Risk Management Course. This course provided an overview of:
  - suicide risk factors in clinical settings
  - epidemiology of suicide
  - detecting suicidal thoughts and feelings
  - risk factors and their assessment
  - completing the QPRT Suicide Risk management Inventory
  - understanding para-suicidal behavior
  - managing an at-risk patient over time
  - and clinical and legal considerations

Additional training services under the grant were provided to the Illinois Department on Aging network of service providers who work with Illinois’ aging population. Suicide prevention service provider agencies provided prevention education speakers and trainings at three statewide conferences held in March and April 2009:

- The Case Management Supervisor's Conference featured a presentation on Depression, Suicide and Suicide Prevention Assessment for Certified Community Care Programs; the targeted audience was case managers and supervisors, nursing home administrators and licensed social/clinical social workers.
- The second presentation was on Suicide Prevention in Nursing Homes for State Ombudsmen at the Long Term Care Ombudsman Statewide Training-Resident Advocate.
- A keynote address at the Mental Health and Aging Conference addressed suicide risk in the elderly. A breakout presentation session detailing the Illinois Suicide Prevention Alliance and state plan educated mental health professionals, licensed social/clinical social workers, aging network professionals and nursing home administrators.
Additionally, a number of training videos and educational resources were purchased by the Department on Aging for continued professional development throughout its network.

B. Public Awareness Efforts
Public awareness efforts conducted through the Mental Health America grant focused on increasing public awareness of suicide prevention and decreasing stigma around suicide and mental health and were developed in conjunction with the public awareness work group of the alliance.

Accomplishments:
- Began development and finalized plans for implementation of a public awareness campaign to reduce the stigma of suicide, increase awareness of risk factors, including mental illnesses and promote linkage to human services for at-risk individuals.
- Engaged with Market M public relations and marketing firm to develop a statewide suicide prevention public awareness campaign, “It Only Takes One,” including a draft of a suicide prevention Web site.
  - Finalized the “It Only Takes One” public awareness campaign.
  - Phase one goals were achieved with a campaign logo, Web site, collateral materials and an implementation plan to launch statewide events.

C. Community Outreach Efforts
Community outreach efforts conducted through the Mental Health America grant focused on increasing the number of partners and collaborations across Illinois to assist with the implementation of suicide prevention efforts on the local level.

Accomplishments:
- Developed and distributed Suicide Prevention Month activities during September 2008 and Mental Health Month during May 2009, to organizations in communities throughout Illinois.
- Suicide prevention coordinators at local veteran affairs hospitals were actively recruited into alliance activities.
- An application for youth suicide prevention activities was submitted by the Department to the Substance Abuse and Mental Health Services Administration.
- Participated in the development of the State Injury Indicator’s Report by the U.S. Centers for Disease Control and Prevention. The report is a surveillance effort to identify trends and gain a broader picture of the burden of injuries across the nation. The report is anticipated to be released in 2010.
D. Data Collection and Analysis Efforts
Data collection and analysis efforts focus on increasing the quality and availability of statewide and community data for planning, surveillance and evaluation of suicide. Mini-grants were made available from the Mental Health America project to address these areas.

Accomplishments:
- Under the Mental Health American grant, sub-contractor funds were provided to the Center for Prevention Research and Development (CPRD) University of Illinois, Urbana-Champaign, to develop research-based evaluation methods to use as a guide in replicating outcome-based suicide prevention programming. CPRD conducted a comprehensive evaluation of the nine local coalitions involved in the Suicide Prevention Resource Center’s (SPRC) two-day Core Competency Training and the local suicide prevention projects that were implemented during 2009. The following components were evaluated: 1) community mobilization factors, 2) planning methods and processes, 3) successful programs, policies and practices implementation and 4) outcomes and preliminary indicators of success. Data collection and review included: archival and program document review, coalition member survey, project director interview, site focus groups and in-person interviews. Quarterly reports on the evaluation project were provided throughout the year and a summary report was completed by CPRD in July 2009.
- Also under the MHA grant, a sub-contract award with evaluators from the Children’s Safety Network: Economics and Data Analysis Resource Center of Pacific Institute for Research and Evaluation (PIRE) to evaluate Illinois’ current sources of suicide data and recommend improvements in data collection. PIRE conducted interviews with Illinois data coordinators and reviewed data sources that included: Youth Risk Behavior Surveys, Child Death Review, Hospital Discharge Data, WISQARS, Community Mental Health Centers, Crisis Centers/Hotlines, State Mental Health Departments, State Substance Abuse Departments and the SCRIPTS- Child Data Lab Project. The final assessment to be completed in 2010 will identify data gaps and needs, along with recommendations to guide future development of Illinois suicide data.
EXAMPLES OF SUICIDE PREVENTION EFFORTS BY PARTNER AGENCIES

Illinois Council Against Handgun Violence (ICHV), Chicago
- Displayed on a billboard on I-55 near Bloomington the fact that homes with guns experience greater rates of suicide than home without guns.
- Presented the compelling connection between guns in the home and the increased risk of suicide at more than 40 speaking engagements throughout Illinois.
- Updated a suicide and guns fact sheet and distributed thousands throughout the state as well as posted on the ICHV Web site.
- Featured Stan Lewy, an Illinois leader in suicide prevention efforts, in an ICHV “Insights” piece that was distributed via e-mail to members and posted on the ICHV Web site.
- Thomas Mannard, ICHV executive director was interviewed on WBBM radio’s “At Issue” program in October to discuss the connection between guns and suicide.

LifeSavers Training Corporation, Carbondale
- A Suicide Prevention Conference at John A. Logan College was attended by nearly 150 professional and lay people.
- Organized candlelight vigils for World Suicide Prevention Day in 10 communities in southern Illinois.
- Conducted three LifeSavers Training Retreats attended by 210 trainees, group leaders, advisors and trainers.
- Conducted LifeSavers Advisors Retreat, along with a Board Retreat, to address suicide prevention in schools.
- Provided a number of community- based presentations on signs and symptoms of suicide tailored for psychology and health departments at Southern Illinois University at Carbondale, NAMI Jackson County, Nurses Conference and the Illinois Counselor Association.
- Facilitated monthly grief support group for people who lost someone to suicide.
- Published articles on local Suicide Prevention, Suicide Survivor’s Day and related issues for "The Southern Illinoisan."

South Elgin High School, Elgin
- Conducted a research project that measured the attitudes of 173 students on the topic of suicide and depression at South Elgin High School.
- Addressed 500 teens (in about 20 classrooms) for two consecutive days on the topic of suicide and depression at South Elgin High School.
- Presented a post-vention protocol to 60 school social workers at a professional conference.
- Spoke to a community group of about 100 concerned adults in St. Charles in the wake of a suicide.
- Addressed suicide prevention efforts to many groups, reaching between 800 and 900 people who learned about depression and suicide prevention.
Blessing Hospital, Quincy

- Fourteen presentations on "Teen Depression and Suicide" educated public health students from Quincy Senior High School and Notre Dame High School in Quincy.
- Mailed a letter and a Blessing Hospital brochure on “Suicide Guide to Warning Signs and Suicide Prevention Resources” to area churches in recognition of Suicide Prevention Week.
- Conducted National Depression Screenings in area churches with the assistance of volunteer counselors and the Blessing-Reiman School of Nursing.

In the area of community outreach, the Department also had accomplishments that were conducted separately from the Mental Health America Grant. Specifically:

- The Department contracted with Children’s Memorial Hospital, Children’s Data Lab to implement the Illinois Violent Death Reporting System in three counties.
- The Department contracted with the Farm Resource Center to offer outreach crisis intervention.
- Created state level data materials detailing suicides and suicide attempts to demonstrate county suicide rates and responded to data requests.

PROPOSED ACTIVITIES TO BE INCLUDED IN THE 2010 REPORT

Based on the goals and objectives of the Illinois Suicide Prevention Strategic Plan, the alliance made recommendations to the Department on utilization of an additional $350,000 allocated in the state budget to be spent in state fiscal year 2010. The following are seen as potential initiative next steps in fulfilling the goals of the Illinois Suicide Prevention Strategic Plan:

- Develop and evaluate five Model Suicide Prevention Comprehensive Pilot Programs (three year programs) that include prevention, intervention and post-vention to provide replicable, evidenced-based outcomes that can be adapted for communities throughout Illinois.

- Implement a statewide Suicide Prevention, Early Intervention and Training Initiative to:
  1) Develop and enhance the statewide capacity of community gatekeepers through community-based mini-grants to increase suicide prevention and early intervention skills.
  2) Assess the current capacity and network of crisis lines in Illinois.
  3) Enhance professional development abilities in Illinois through a statewide conference on suicide prevention.
  4) Develop and enhance the capacity of health service providers statewide to increase suicide prevention and early intervention skills.
  5) Develop and enhance the capacity of service providers to target suicide prevention and early intervention initiatives among specifically targeted populations, e.g. the aging population in Illinois and traumatized children in the child welfare system.
• Implement the Suicide Prevention Public Awareness Campaign to reduce the stigma of suicide, increase awareness of risk factors, including mental illnesses, and promote linkage to human services for individuals who are at risk.

• Develop and Implement a Suicide Prevention Community Outreach Initiative to build capacity across the state to promote local suicide prevention efforts by building/expanding 20 to 25 new effective and efficient coalitions and partnerships.

• Implement Suicide Prevention School-based Initiatives to support and build the following school-based initiatives:
  1) Professional development related to suicide prevention.
  2) Mini-grants will be provided to school districts to develop and implement suicide prevention initiatives within their curricula, increase in-school mental health support, conduct staff development and educate students and parents/other caregivers.

• Improve Suicide Prevention Data Collection and Analysis to:
  1) Develop and implement the Illinois Violent Death Reporting System (IVDRS) statewide to collect more effective and accurate data on suicide deaths in Illinois.
  2) Work with an epidemiologist to analyze suicide attempt data statewide, train providers on how to collect better data and provide reports on data by county.

• Support Suicide Prevention Evaluation and Research to support research-based evaluation methods and technical assistance; and, to replicate suicide prevention efforts throughout Illinois according to outcome measures.
## ILLINOIS SUICIDE PREVENTION ALLIANCE (ISPA) MEMBERS in 2009

<table>
<thead>
<tr>
<th>Member</th>
<th>Agency</th>
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<tbody>
<tr>
<td>Sergeant Jill Allen</td>
<td>Illinois State Police</td>
</tr>
<tr>
<td>Judy Ashby</td>
<td>LifeSavers Training Corporation</td>
</tr>
<tr>
<td>Wendy Blank</td>
<td>Illinois Department of Corrections</td>
</tr>
<tr>
<td>Amy Brausch</td>
<td>Researcher - Eastern Illinois University</td>
</tr>
<tr>
<td>Sherry Bryant</td>
<td>Survivor</td>
</tr>
<tr>
<td>Reshma Desai</td>
<td>Illinois Violence Prevention Authority</td>
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<tr>
<td>Paul Fleming</td>
<td>Survivor</td>
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<tr>
<td>Dr. Sam Gaines</td>
<td>Illinois Department of Public Health, Division of Emergency</td>
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<td></td>
<td>Medical Services and Highway Safety</td>
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<tr>
<td>Carol Gall (Wozniewski)</td>
<td>Mental Health America of Illinois (Co-chair)</td>
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<tr>
<td>Thomas Mannard</td>
<td>Illinois Council Against Handgun Violence</td>
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<tr>
<td>Becky Markwell</td>
<td>Illinois Higher Education Center</td>
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<td>Jennifer Martin/George Dirks</td>
<td>Illinois Department of Public Health, Injury and Violence</td>
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<td>Prevention Program</td>
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<td>Mary Mayes</td>
<td>Illinois Department on Aging</td>
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<tr>
<td>Christine Mitchell</td>
<td>American Foundation for Suicide Prevention</td>
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<tr>
<td>Jessica O’Leary</td>
<td>Office of the Illinois Attorney General</td>
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<tr>
<td>Marilyn Peebles</td>
<td>Illinois Department of Children and Family Services</td>
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<tr>
<td>Patricia Reedy</td>
<td>Illinois Department of Human Services, Division of Mental Health</td>
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<tr>
<td>Sharneice Snyder</td>
<td>Jason Foundation at Streamwood Behavioral Health Systems</td>
</tr>
<tr>
<td>Glenn Steinhausen</td>
<td>Illinois State Board of Education (Co-chair)</td>
</tr>
<tr>
<td>Shannon Sullivan</td>
<td>Illinois Safe Schools Alliance</td>
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<tr>
<td>Lora Thomas</td>
<td>NAMI Illinois - National Alliance on Mental Illness</td>
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<tr>
<td>Stephanie Weber</td>
<td>Suicide Prevention Services</td>
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Illinois Department of Public Health
Suicides by County
1997-2006 Aggregated

Suicides by County
- 61 or More (25)
- 29 to 60 (25)
- 16 to 28 (26)
- 4 to 15 (26)

Statewide deaths due to suicide from 1997-2006 was 10,463.

Source: Illinois Department of Public Health, Center for Health Statistics
Illinois Department of Public Health
Suicide Rate per 100,000
2002-2006 Aggregated

Suicide Rate per 100,000
- 15.4 to 20.2 (7)
- 11.6 to 15.3 (18)
- 9.1 to 11.5 (21)
- 4.8 to 9.0 (21)

Note: Counties in white had less than 10 deaths during the time period. A rate would not meet standards of reliability and precision.

Statewide aggregate rate for 2002-2006 was 8.3 per 100,000.

Source: Illinois Department of Public Health, Center for Health Statistics
Motor vehicle related deaths account for 21 percent of total injury deaths. It is unknown how many of these are intentional crashes, yet it is assumed that a portion are suicides.
Illinois Suicide Data

Average Annual Suicide Rates by Age Group and Sex, Illinois, 2005-2007

Source: Illinois Department of Public Health, Center for Health Statistics

Average Annual Suicide Rates by Race Category and Sex, Illinois, 2005-2007

Source: Illinois Department of Public Health, Center for Health Statistics
Illinois Suicide and Homicide Data

Trend in Suicide and Homicide, Illinois 1999-2007

Source: Illinois Department of Public Health, Center for Health Statistics

Illinois Suicide and Homicide Data

Self-inflicted and Assault-related Injury Hospital Discharges, Illinois Residents, 2000-2008

Source: Illinois Department of Public Health, Division of Patient Safety and Quality

(* Note the increase in 2008 primarily reflects increased reporting of E-codes. The percentage of E-codes reported statewide for injury cases in 2007 and years prior was 55 percent. For 2008, it was 85 percent.)

Page 15
Hospital Discharge Data

and

Youth Risk Behavior Survey Results
Illinois Hospital Discharge Data by Age and Sex

Source: Illinois Department of Public Health, Division of Patient Safety and Quality

(* Note the increase in 2008 primarily reflects increased reporting of E-codes. The percentage of E-codes reported statewide for injury cases in 2007 and years prior was 55 percent. For 2008, it was 85 percent.)
The total number of self-inflicted injury hospitalizations in 2007 was 6,309.

The total number of self-inflicted injury hospitalizations in 2008 was 9,584.

(* Note the increase in 2008 primarily reflects increased reporting of E-codes. The percentage of E-codes reported statewide for injury cases in 2007 and years prior was 55 percent. For 2008 it was 85 percent.)
Illinois Hospital Discharge Data by Type and Sex

Self-inflicted Injury Discharge by Type/Sex, Illinois Residents, 2006-2008

Source: Illinois Department of Public Health, Division of Patient Safety and Quality

Self-inflicted Injury Discharges by Type and Age, Illinois Residents, 2006

Source: Illinois Department of Public Health, Division of Patient Safety and Quality
Self-inflicted Injury Discharges by Type and Age, Illinois Residents, 2007

Source: Illinois Department of Public Health, Division of Patient Safety and Quality

(* Note the increase in 2008 primarily reflects increased reporting of E-codes. The percentage of E-codes reported statewide for injury cases in 2007 and years prior was 55 percent. For 2008, it was 85 percent. )
## 2009 Youth Risk Behavior Survey Results

### Illinois High School Survey
Summary Table - Weighted Data

QN23: Percentage of students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percent</td>
<td>95% Confidence Interval</td>
<td>N</td>
</tr>
<tr>
<td>Total</td>
<td>27.2</td>
<td>(23.1 - 31.7)</td>
<td>1,749</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 or younger</td>
<td>26.5</td>
<td>(22.3 - 31.2)</td>
<td>582</td>
</tr>
<tr>
<td>16 or 17</td>
<td>26.9</td>
<td>(21.5 - 33.1)</td>
<td>894</td>
</tr>
<tr>
<td>18 or older</td>
<td>26.5</td>
<td>(23.6 - 36.1)</td>
<td>260</td>
</tr>
<tr>
<td>Grade</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9th</td>
<td>26.6</td>
<td>(21.7 - 30.6)</td>
<td>477</td>
</tr>
<tr>
<td>10th</td>
<td>29.6</td>
<td>(19.8 - 41.8)</td>
<td>412</td>
</tr>
<tr>
<td>11th</td>
<td>25.6</td>
<td>(21.1 - 30.7)</td>
<td>447</td>
</tr>
<tr>
<td>12th</td>
<td>27.5</td>
<td>(23.5 - 31.9)</td>
<td>396</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black*</td>
<td>27.1</td>
<td>(21.8 - 33.1)</td>
<td>294</td>
</tr>
<tr>
<td>Hispanic/ Latino</td>
<td>29.3</td>
<td>(22.3 - 37.4)</td>
<td>287</td>
</tr>
<tr>
<td>White*</td>
<td>26.2</td>
<td>(20.6 - 32.6)</td>
<td>1,069</td>
</tr>
<tr>
<td>All other races</td>
<td>-</td>
<td>-</td>
<td>82</td>
</tr>
<tr>
<td>Multiple races</td>
<td>-</td>
<td>-</td>
<td>75</td>
</tr>
</tbody>
</table>

Note: There were 9 students who were excluded from the analysis for QN23.
N = Number of students.
*Non-Hispanic.
- = Less than 100 students in the subgroup.
# 2009 Youth Risk Behavior Survey Results

## Illinois High School Survey
### Summary Table - Weighted Data

**QN24: Percentage of students who seriously considered attempting suicide during the past 12 months**

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percentage</td>
<td>95% confidence interval</td>
<td>N</td>
</tr>
<tr>
<td>Total</td>
<td>14.9 (12.9 - 17.1)</td>
<td></td>
<td>1,754</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 or younger</td>
<td>16.0 (12.3 - 20.7)</td>
<td></td>
<td>583</td>
</tr>
<tr>
<td>16 or 17</td>
<td>13.9 (11.3 - 16.9)</td>
<td></td>
<td>898</td>
</tr>
<tr>
<td>18 or older</td>
<td>15.6 (11.4 - 20.9)</td>
<td></td>
<td>268</td>
</tr>
<tr>
<td>Grade</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9th</td>
<td>13.2 (9.7 - 17.8)</td>
<td></td>
<td>478</td>
</tr>
<tr>
<td>10th</td>
<td>16.8 (13.0 - 21.4)</td>
<td></td>
<td>414</td>
</tr>
<tr>
<td>11th</td>
<td>13.5 (10.6 - 17.4)</td>
<td></td>
<td>448</td>
</tr>
<tr>
<td>12th</td>
<td>15.2 (11.7 - 19.5)</td>
<td></td>
<td>396</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black*</td>
<td>16.1 (9.9 - 24.9)</td>
<td></td>
<td>204</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>14.0 (8.4 - 22.3)</td>
<td></td>
<td>287</td>
</tr>
<tr>
<td>White*</td>
<td>14.5 (11.7 - 17.8)</td>
<td></td>
<td>1,073</td>
</tr>
<tr>
<td>All other races</td>
<td>-</td>
<td></td>
<td>82</td>
</tr>
<tr>
<td>Multiple races</td>
<td>-</td>
<td></td>
<td>75</td>
</tr>
</tbody>
</table>

Note: There were 4 students who were excluded from the analysis for QN24.

N = Number of students.

*Non-Hispanic.

- = Less than 100 students in the subgroup.
### 2009 YOUTH RISK BEHAVIOR SURVEY RESULTS

**Illinois High School Survey**  
Summary Table - Weighted Data

QN25: Percentage of students who made a plan about how they would attempt suicide during the past 12 months

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Percentage</th>
<th>95% confidence interval</th>
<th>N</th>
<th></th>
<th>Percentage</th>
<th>95% confidence interval</th>
<th>N</th>
<th></th>
<th>Percentage</th>
<th>95% confidence interval</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>11.6</td>
<td>(10.2 - 13.3)</td>
<td>1,741</td>
<td></td>
<td>9.8</td>
<td>(8.0 - 11.6)</td>
<td>387</td>
<td></td>
<td>13.5</td>
<td>(11.4 - 16.0)</td>
<td>347</td>
</tr>
<tr>
<td></td>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>15 or younger</td>
<td>14.4</td>
<td>(11.7 - 18.5)</td>
<td>579</td>
<td></td>
<td>12.5</td>
<td>(8.5 - 17.9)</td>
<td>279</td>
<td></td>
<td>17.1</td>
<td>(13.5 - 21.4)</td>
<td>301</td>
</tr>
<tr>
<td></td>
<td>16 or 17</td>
<td>9.9</td>
<td>(7.9 - 12.2)</td>
<td>881</td>
<td></td>
<td>8.2</td>
<td>(6.5 - 10.4)</td>
<td>462</td>
<td></td>
<td>11.5</td>
<td>(8.5 - 15.5)</td>
<td>428</td>
</tr>
<tr>
<td></td>
<td>18 or older</td>
<td>10.5</td>
<td>(6.9 - 15.7)</td>
<td>266</td>
<td></td>
<td>9.0</td>
<td>(3.4 - 21.6)</td>
<td>148</td>
<td></td>
<td>12.2</td>
<td>(8.6 - 17.0)</td>
<td>116</td>
</tr>
<tr>
<td></td>
<td>Grade</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9th</td>
<td>11.5</td>
<td>(8.1 - 16.1)</td>
<td>476</td>
<td></td>
<td>10.9</td>
<td>(6.7 - 17.4)</td>
<td>222</td>
<td></td>
<td>12.1</td>
<td>(9.0 - 16.2)</td>
<td>254</td>
</tr>
<tr>
<td></td>
<td>10th</td>
<td>14.0</td>
<td>(10.7 - 18.1)</td>
<td>412</td>
<td></td>
<td>8.5</td>
<td>(5.1 - 14.0)</td>
<td>222</td>
<td></td>
<td>19.6</td>
<td>(14.9 - 25.3)</td>
<td>188</td>
</tr>
<tr>
<td></td>
<td>11th</td>
<td>10.5</td>
<td>(8.0 - 13.6)</td>
<td>447</td>
<td></td>
<td>9.5</td>
<td>(6.6 - 13.5)</td>
<td>233</td>
<td></td>
<td>11.6</td>
<td>(7.6 - 17.4)</td>
<td>214</td>
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<tr>
<td></td>
<td>12th</td>
<td>9.7</td>
<td>(6.9 - 13.5)</td>
<td>389</td>
<td></td>
<td>8.7</td>
<td>(3.9 - 18.2)</td>
<td>199</td>
<td></td>
<td>10.7</td>
<td>(6.9 - 16.2)</td>
<td>190</td>
</tr>
<tr>
<td></td>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Black*</td>
<td>14.9</td>
<td>(11.0 - 19.8)</td>
<td>263</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hispanic/Latino</td>
<td>12.9</td>
<td>(8.2 - 19.6)</td>
<td>265</td>
<td></td>
<td>11.5</td>
<td>(5.9 - 21.4)</td>
<td>134</td>
<td></td>
<td>14.2</td>
<td>(5.7 - 31.1)</td>
<td>150</td>
</tr>
<tr>
<td></td>
<td>White*</td>
<td>10.3</td>
<td>(8.4 - 12.0)</td>
<td>1,060</td>
<td></td>
<td>8.0</td>
<td>(6.0 - 10.7)</td>
<td>552</td>
<td></td>
<td>12.2</td>
<td>(9.1 - 16.0)</td>
<td>514</td>
</tr>
<tr>
<td></td>
<td>All other races</td>
<td>-</td>
<td>-</td>
<td>80</td>
<td></td>
<td>-</td>
<td>-</td>
<td>40</td>
<td></td>
<td>-</td>
<td>-</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>Multiple races</td>
<td>-</td>
<td>-</td>
<td>75</td>
<td></td>
<td>-</td>
<td>-</td>
<td>41</td>
<td></td>
<td>-</td>
<td>-</td>
<td>34</td>
</tr>
</tbody>
</table>

Note: There were 17 students who were excluded from the analysis for QN25.  
N = Number of students.  
*Non-Hispanic.  
- = Less than 100 students in the subgroup.
### 2009 YOUTH RISK BEHAVIOR SURVEY RESULTS

#### Illinois High School Survey
Summary Table - Weighted Data

QN26: Percentage of students who actually attempted suicide one or more times during the past 12 months:

<table>
<thead>
<tr>
<th>Age</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>95% CI</td>
<td></td>
<td>95% CI</td>
</tr>
<tr>
<td>Total</td>
<td>8.0</td>
<td>1,528</td>
<td>7.4</td>
</tr>
<tr>
<td></td>
<td>(6.1 - 10.5)</td>
<td>(5.6 - 9.8)</td>
<td>(5.5 - 12.9)</td>
</tr>
<tr>
<td>15 or younger</td>
<td>9.4</td>
<td>512</td>
<td>6.8</td>
</tr>
<tr>
<td></td>
<td>(5.6 - 15.4)</td>
<td>(3.9 - 11.7)</td>
<td>(6.6 - 20.4)</td>
</tr>
<tr>
<td>16 or 17</td>
<td>6.0</td>
<td>786</td>
<td>6.3</td>
</tr>
<tr>
<td></td>
<td>(4.2 - 8.6)</td>
<td>(4.3 - 9.2)</td>
<td>(3.4 - 9.4)</td>
</tr>
<tr>
<td>18 or older</td>
<td>11.8</td>
<td>229</td>
<td>12.6</td>
</tr>
<tr>
<td></td>
<td>(7.5 - 17.9)</td>
<td>(7.9 - 19.7)</td>
<td>(4.7 - 23.2)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Grade</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>95% CI</td>
<td></td>
<td>95% CI</td>
</tr>
<tr>
<td>9th</td>
<td>7.6</td>
<td>415</td>
<td>7.9</td>
</tr>
<tr>
<td></td>
<td>(4.5 - 12.7)</td>
<td>(4.6 - 13.1)</td>
<td>(3.8 - 13.6)</td>
</tr>
<tr>
<td>10th</td>
<td>8.6</td>
<td>363</td>
<td>4.7</td>
</tr>
<tr>
<td></td>
<td>(4.9 - 14.8)</td>
<td>(2.1 - 10.5)</td>
<td>(6.6 - 22.5)</td>
</tr>
<tr>
<td>11th</td>
<td>5.6</td>
<td>396</td>
<td>6.8</td>
</tr>
<tr>
<td></td>
<td>(3.4 - 9.1)</td>
<td>(2.7 - 16.2)</td>
<td>(2.3 - 8.3)</td>
</tr>
<tr>
<td>12th</td>
<td>9.1</td>
<td>342</td>
<td>10.0</td>
</tr>
<tr>
<td></td>
<td>(6.0 - 13.4)</td>
<td>(5.3 - 18.1)</td>
<td>(4.3 - 15.1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td>95% CI</td>
<td></td>
</tr>
<tr>
<td>Black*</td>
<td>11.8</td>
<td>159</td>
</tr>
<tr>
<td></td>
<td>(7.5 - 18.3)</td>
<td></td>
</tr>
<tr>
<td>Hispanic/ Latino</td>
<td>9.9</td>
<td>245</td>
</tr>
<tr>
<td></td>
<td>(4.5 - 20.4)</td>
<td>(2.3 - 18.2)</td>
</tr>
<tr>
<td>White*</td>
<td>6.1</td>
<td>957</td>
</tr>
<tr>
<td></td>
<td>(4.1 - 9.0)</td>
<td>(3.8 - 8.7)</td>
</tr>
<tr>
<td>All other races</td>
<td>-</td>
<td>73</td>
</tr>
<tr>
<td>Multiple races</td>
<td>-</td>
<td>72</td>
</tr>
</tbody>
</table>

Note: There were 230 students who were excluded from the analysis for QN26.
N = Number of students.
*Non-Hispanic.
- = Less than 100 students in the subgroup.
Sexual Orientation, 2009
In 2009, two questions were added to the Illinois YRBS to assess student’s sexual orientation:
- During your life, with whom have you had sexual contact?
- Which of the following best describes you?
  - Heterosexual (straight), Gay or Lesbian, Bisexual, Not sure

![Depressive Feelings and Suicide Related Questions by Sexual Orientation](Image)

<table>
<thead>
<tr>
<th></th>
<th>Heterosexual</th>
<th>versus</th>
<th>GLB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressive Feelings</td>
<td>25.50%</td>
<td></td>
<td>54.30%</td>
</tr>
<tr>
<td>Suicidal Thoughts</td>
<td>13.50%</td>
<td></td>
<td>45.80%</td>
</tr>
<tr>
<td>Suicidal Plans</td>
<td>10.50%</td>
<td></td>
<td>35.30%</td>
</tr>
<tr>
<td>Suicide Attempts</td>
<td>6.50%</td>
<td></td>
<td>33.60%</td>
</tr>
</tbody>
</table>
Copies of this report are available at
http://www.idph.state.il.us/pub_home.htm

Printed by Authority of the State of Illinois
P.O. #3711740  200  7/10
EXECUTIVE SUMMARY

This plan is dedicated to all people in Illinois whose lives have been affected by suicide.

Between 2001 and 2004, the statewide effort to address suicide began, and flourished, with facilitation from the Illinois Department of Public Health. The first meeting of the suicide prevention group was convened in 2002. The main task of the group was to develop a state plan for suicide prevention. By 2003, a rough draft of the plan was completed, which included key recommendations for suicide prevention. Members of the Illinois Suicide Prevention Coalition (ISPC), which is facilitated by the Illinois Department of Public Health (IDPH) and assists IDPH to mobilize agencies and individuals around the issue of suicide prevention, provided specific recommendations on the action steps of the plan and organized workgroups to begin these action steps. ISPC includes a wide range of people from across the state concerned with preventing suicide and suicide attempts.

In 2004, the Suicide Prevention, Education and Treatment Act (Public Act 093-0907) was passed by the Illinois General Assembly and signed into law by Gov. Rod R. Blagojevich. Public Act 093-0907 (http://www.ilga.gov) directed the Illinois Department of Public Health to appoint an advisory board entitled the Illinois Suicide Prevention Strategic Planning Committee. The committee represents statewide organizations and other agencies that focus on the prevention of suicide and the improvement of mental health treatment, or that provide suicide prevention or survivor support services. The committee is charged with the development and implementation of the Illinois Suicide Prevention Strategic Plan. In addition to the strategic plan, it also is charged with implementing: 1) a statewide suicide prevention conference, 2) a media campaign, 3) a public awareness campaign, 4) education initiatives, and, 5) if funds are appropriated, five pilot programs to provide training and direct service.

In 2007, an alliance was formed between the Illinois Suicide Prevention Strategic Planning Committee and the Illinois Suicide Prevention Coalition, unifying the strengths of these groups to continue to advance the plan. The joint mission of this alliance is “to reduce suicide and its stigma throughout Illinois by collaboratively working with concerned stakeholders from the public and private sectors to increase awareness and education, provide opportunities to develop individual and organizational capacity in addressing suicide prevention, and advocate for access to treatment.”

Suicide represents a major national public health problem. Each year -

- More than 1,000 Illinoisans die by suicide.
- A greater number of suicide deaths occur than deaths by homicide, HIV disease or impaired driving. In the years between 1999 and 2002, 5.5 percent more Illinoisans died from suicide than homicide.
- Suicide fluctuates between the second and third leading cause of death for adolescents in Illinois.
- Suicide attempts result in 650,000 emergency department visits and 30,000 deaths nationally.
- It is estimated there are approximately six immediate family members and close friends significantly affected by each suicide death. In many situations, the number of
people affected is far greater. This is especially true when the person who dies by suicide is a young person.

- In addition to the pain of loss by suicide, in Illinois, the annual estimated cost of suicide and medically treated youth suicide attempts is $539 million.

Suicide is recognized as a chronic epidemic. Despite the overwhelming numbers, the tragedy of suicide is hidden by stigma, myth and shame. The stigma surrounding suicide serves to restrict prevention and intervention. Additionally, many people have the mistaken notion that talking about suicide causes it to happen. Today, experts agree that suicide is preventable. We must, as a society, reverse the many years of stigma that continue to keep people from discussing suicide.

Illinois is responding to this problem through the Illinois Suicide Prevention Strategic Plan, which extends the continued national efforts to address suicide. The U.S. Surgeon General's National Strategy for Suicide Prevention, published in 2001 by the U.S. Department of Health and Human Services, stated that the nation will “increase the proportion of states with comprehensive prevention plans by 2005 that (a) coordinate across government agencies, (b) involve the private sector, and (c) support plan development, implementation and evaluation in its communities.”

The recommendations in the plan are comprehensive, complex and ambitious, as they should be. The scope of the suicide problem in Illinois demands the strongest and most professional response/aftercare.

The Illinois Department of Public Health extends its appreciation to those dedicated individuals who contributed time and expertise to the development of the plan. These included survivors, clinicians, professors, youth workers, elder care workers, psychiatrists, educators, researchers, human service personnel, clergy, law enforcement officers, coroners, suicide prevention experts, public health officials, health care providers, firearm safety advocates, violence prevention workers, and families and friends who have lost someone to suicide.

This plan challenges communities, public health professionals and health care providers to educate, inform, and motivate the public to maximize resources to reduce the burden of suicide in this state. Together, we can ensure a better environment and better outcomes for persons with depression and other mental illnesses, and for persons whose life situations have brought seemingly unbearable pain. Quite simply, the plan challenges Illinois to save lives.
The Illinois Suicide Prevention Coalition developed the goals and objectives for the Illinois Suicide Prevention Strategic Plan.

Acknowledgment to those who reviewed the Plan and provided input to its final version:

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Terms and Definitions:

**Prevention**¹ – A strategy or approach that does one of the following: 1) reduces the likelihood of onset of a health problem, 2) delays the onset of health problems or 3) reduces the harm resulting from conditions or behaviors.

- **Primary (universal) prevention** – targets the general population (public education campaigns, media guidelines and school-based suicide prevention programs).

- **Secondary (selective) prevention** – targets groups with a greater risk of becoming suicidal than the general population, often identified through screening mechanisms or by applying suicide prevention activities (gatekeeper training, crisis response/aftercare services, screening and social skills training).

- **Tertiary (indicated) prevention** – targets individuals who exhibit clear signs of suicidal ideation or related emotional distress (case management, hospitalization, medication, support training and crisis response/aftercare services).

**Intervention**¹ – A strategy or approach that is intended to prevent an adverse outcome or to alter the course of an existing condition (such as strengthening social support in a community).

**Crisis response/aftercare (also known as postvention)**¹ – A strategy or approach that is implemented after a crisis or traumatic event has occurred.

**Suicidal ideation**² - Any self-reported thought of engaging in suicide-related behaviors.

**Suicide attempt**² - Potentially self-injurious behavior with non-fatal outcomes, in which the evidence suggests: 1) the injury was self-inflicted, and 2) there was intention to kill one’s self. Suicide attempts do not have to result in an actual injury.

**Suicide**² - A death that results from self-inflicted injury in which there is evidence that the person intended to kill him/herself.

(Note: Non-fatal attempt is a preferable term to using terms such as “unsuccessful” or “failed.” Use of the term suicide is preferable to the phrase “successful suicide.”)

**Gatekeepers**¹ – those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate.

---


ILLINOIS GOALS AND OBJECTIVES

The goals and objectives of this plan reflect the input of public and private organizations and stakeholders concerned with mental health. The plan is designed to reduce suicide through a positive public health approach.

Goal 1:  Ask About Suicide

Educate everyone -- especially all mental health, social service, clergy, law enforcement and school personnel -- to ask about suicidal ideations and intentions.

Short-term Objective 1.1: By 2010, establish a technical assistance group (TAG) to assist all communities in their suicide prevention efforts.

Long-term Objective 1.1: By 2012, offer year-round suicide risk/depression/anxiety health screenings through 200 sites in Illinois; collect and evaluate data from the screening program to identify the most effective interventions.

Long-term Objective 1.2: By 2012, distribute suicide prevention information packets to major professional associations.

Long-term Objective 1.3: By 2012, offer free suicide screening, prevention, intervention and crisis response/aftercare information through the Illinois Department of Public Health, local health departments and health care providers.

Goal 2:  Know Your Neighbor

Encourage networks of relatives, friends, neighbors and members of the faith community to decrease isolation, which is one of the strongest risk factors for suicide.

Short-term Objective 2.1: By 2010, host 100 community-based advisory collaboration committees to address isolation; target rural areas.

Long-term Objective 2.1: By 2012, sustain year-round public service awareness and collaboration activities in 200 communities to decrease isolation, increase neighbor-to-neighbor outreach and identify at-risk persons.
Goal 3: Treatment Works

Advocate for a comprehensive continuum of care for those at highest risk for suicide.

Short-term Objective 3.1: By 2010, broadly disseminate public education materials about current Medicare, Medicaid and private insurance benefits that support mental health services.

Long-term Objective 3.1: By 2012, distribute a report that addresses consumer needs regarding suicide prevention, mental health care and peer-to-peer support.

Goal 4: Ensure Safety to Live and Love

Promote utilization of suicide prevention services for victims of harassment and violence.

Short-term Objective 4.1: By 2010, develop and distribute information on the relationship between harassment, violence and suicide risk through health departments and schools, elementary through higher education.

Long-term Objective 4.1: By 2012, present educational opportunities in 50 different human service settings on the relationship between violence, harassment and suicide risk.

Goal 5 Knowledge is Power

Increase awareness of and competency in suicide prevention and treatment for first responders, educational personnel, heath care providers, clergy, physicians, law enforcement, mental health professionals and social service personnel.

Short-term Objective 5.1: By 2010, offer at least 10 targeted continuing education opportunities on suicide prevention annually, throughout the state.

Long-term Objective 5.1: By 2012, influence higher education institutions to offer coursework on suicide screening, prevention and/or treatment.

Long-term Objective 5.2: By 2012, collaborate with schools to work toward compliance with the self-destructive (suicide) curricula requirements in the Illinois School Code.
Goal 6: Everyone Deserves Care

Increase access to mental health care.

Short-term Objective 6.1: By 2010, establish an advisory council on rural suicide prevention.

Short-term Objective 6.2: By 2010, establish sustainable activities and collaborations to disseminate information about existing public sector health insurance availability and community-based resources.

Long-term Objective 6.1: By 2012, organize and implement legislative advocacy in collaboration with other stakeholders for expanded mental health parity.

Goal 7: Data Counts

Improve suicide-related data collection.

Short-term Objective 7.1: By 2010, identify strengths and weaknesses of Illinois suicide data and the process of data collection.

Long-term Objective 7.1: By 2012, influence key stakeholders to expand Illinois’ participation in the National Violent Death Reporting System.

Goal 8: Suicide is Everyone’s Business

Increase public awareness of the benefits of restricting access to means of suicide.

Short-term Objective 8.1: By 2010, develop and initiate an advocacy campaign about the risks of suicide and preventing access to means of suicide.

Long-term Objective 8.1: By 2012, impact legislation and increase resources for the purpose of restricting means to suicide.
Goal 9: Help Break the Stigma

Reduce the stigma of suicide and increase the public’s awareness that mental health care is a critical part of health care.

Short-term Objective 9.1: By 2010, implement a statewide speaker’s bureau for presentations on suicide prevention.

Long-term Objective 9.1: By 2012, host suicide prevention week activities, town hall meetings, and/or suicide prevention presentations in 100 communities.

Long-term Objective 9.2: By 2012, collaborate with no fewer than 10 major statewide efforts to reduce the stigma of receiving mental health care.

Goal 10: Bank on Saving Lives

Develop sustainable funding sources for implementing suicide prevention, intervention and crisis response/aftercare programs in Illinois and for evaluation of the results in order to save more lives

Short-term Objective 10.1: By 2010, actively expand participation in suicide prevention lobby day advocacy efforts.

Short-term Objective 10.2: By 2010, develop sustainable funding streams for suicide prevention efforts.

Short-term Objective 10:3 By 2010, annually assess the current suicide prevention legislation; develop enhancements as needed.
Next Steps to Advance Suicide Prevention in Illinois

The alliance between the Illinois Suicide Prevention Strategic Planning Committee and the Illinois Suicide Prevention Coalition seeks to develop and enhance comprehensive suicide prevention, early intervention, and crisis response/aftercare programs and services across Illinois, building vital supports across diverse communities.

The following initiatives are recommended next steps in carrying out the goals of the strategic plan:

- **Develop and Evaluate Five Model Suicide Prevention Comprehensive Pilot Programs (three-year programs)** - To develop and evaluate five comprehensive model programs statewide that include suicide prevention, intervention, and crisis response/aftercare in order to provide replicable, evidenced-based outcomes that other communities and service providers can use with adaptations.

- **Implement a Suicide Prevention, Early Intervention and Training Initiative** – To:
  1) Develop and enhance the capacity of community gatekeepers statewide through community-based mini-grants to increase suicide prevention and early intervention skills through local education by experts in the field.
  2) Assess the current capacity and network of crisis lines.
  3) Enhance professional development abilities through a statewide conference on suicide prevention.
  4) Develop and enhance the capacity of health service providers statewide to increase suicide prevention and early intervention skills through local education by experts in the field.
  5) Develop and enhance the capacity of service providers to the aging population on suicide prevention and early intervention skills. To develop and enhance service provider skills to traumatized children in the child welfare system on suicide prevention and early intervention.

- **Implement the Suicide Prevention Public Awareness Campaign** - To develop and implement a public awareness campaign to reduce the stigma of suicide, and increase awareness of risk factors, including mental illnesses, and promote linkage to human services for at-risk individuals.

- **Develop and Implement a Suicide Prevention Community Outreach Initiative** - To build capacity across the state to promote local suicide prevention efforts by building/expanding 20-25 new effective and efficient coalitions and partnerships.

- **Improve and Implement Suicide Prevention School-based Initiatives** - To support and build the following school-based initiatives:
  1) Professional development related to suicide prevention.
  2) Grants to school districts to develop and implement suicide prevention initiatives within their curricula, increase in-school mental health support, conduct staff development, and educate students and parents/other caregivers.
* **Improve Suicide Prevention Data Collection and Analysis** – To:
  1) Develop and implement the Illinois Violent Death Reporting System (IVDRS) statewide in order to collect more effective and accurate data on suicide deaths in Illinois.
  2) Work with an epidemiologist to analyze suicide attempt data statewide, train providers on how to collect better data, and provide reports on data by county.

* **Support Suicide Prevention Evaluation and Research** - To support research-based evaluation methods and technical assistance to plan for replication of suicide prevention efforts in Illinois according to outcome measures.

* **Inventory Suicide Prevention, Intervention and Crisis Response/Aftercare Activities Within State Agencies** – To ensure suicide prevention, intervention and crisis response/aftercare services are implemented throughout the state system through the following activities:
  1) Identify suicide-related activities and programming that has occurred among state agencies.
  2) Identify additional suicide-related activities and programming from state agencies to implement.
  3) Identify avenues for implementing the action steps of the Illinois Suicide Prevention Strategic Plan.
SUICIDE AS A PUBLIC HEALTH PROBLEM

The National Center for Injury Prevention and Control (NCIPC) is working to raise awareness of suicide as a serious public health problem and is focusing on science-based prevention strategies to reduce injuries and deaths due to suicide. The Surgeon General's Call to Action, published in 1999, introduced a blueprint for addressing suicide – Awareness, Intervention and Methodology (AIM). The AIM methodology targets the risks inherent in undetected and under treated substance use and psychiatric disorders.

The public health approach to suicide prevention is a system of collecting data and organizing prevention efforts with a focus on identifying and addressing patterns of suicide and suicide-related behaviors in the population.

PUBLIC HEALTH APPROACH TO PREVENTION

The steps may be sequential, or overlap. For example, the techniques used to define the problem, such as determining the frequency with which a particular problem arises in a community, may be used in assessing the overall effectiveness of prevention programs. Evaluating interventions must be built into implementation, and information gained from evaluations should guide the development of new interventions.

Source: Suicide Prevention Resource Center
SUICIDE IN ILLINOIS: *

Statistics on suicide in Illinois reveal the broad impact of this public health problem. In the pages that follow, data is presented that depict overall trends related to suicide in the state.

Big picture

- More than 1,000 Illinoisans die each year by suicide. This number exceeds the number of deaths by homicide or HIV disease.
- Suicide is the 11th leading cause of death.
- For every adult suicide, there are an estimated 25 to 35 attempted adult suicides.

Race

- Suicide rates are 2.3 times higher for Caucasians than for African Americans.
- In recent years, a concerning trend of increasing suicide rates has been noted among African-American persons.

Gender

- Suicide rates are four times higher for males than females.

Adolescent and Young People

- In any given year, suicide is either the second or third leading cause of death for adolescents. The first leading cause of death is unintentional injury. Additional deaths go unrecognized as suicides.
- Thirteen percent of suicide deaths occur among young people between 15 and 24 years of age.
- More young people – ages 15 to 24 – die by suicide than by cancer and heart disease, COMBINED.
- For every adolescent suicide, there are an estimated 100 adolescent suicide attempts.

Urban vs. Non-Urban Counties

- The suicide rate for non-urban counties is nearly 5.25 percent higher than the rate for urban counties.
Firearms

- Firearm suicide deaths comprise 39 percent of suicides.
- Homes with firearms experience a higher rate of suicide than homes without firearms which explains, in part, the reason why non-urban counties have a 15 percent higher rate of suicide than urban counties, since there is a higher percentage of homes with firearms in non-urban counties.

Cost

- The horrible pain of the loss of a loved one to suicide simply cannot be measured. The estimated annual cost of completed and medically treated youth suicide acts is $539 million (Children Safety Network Economics and Insurance Resource Center, 1999).

**BURDEN OF SUICIDE IN ILLINOIS:**
*Unless otherwise noted, data comes from the Illinois Department of Public Health*

![Total Injury Death by Intent, Illinois, 2005](image)

Some Key Points:

- Motor vehicle related deaths account for 23 percent of total injury deaths. It is unknown how many of these are intentional crashes, yet it is assumed that a portion are suicides.
- In 2005, 1,073 suicides were reported.
- Homicide (14%) actually accounts for a smaller percentage of injury deaths than does suicide (17%).
Some Key Points:

- Male suicide rates are 4.25 times higher than female rates.
- Female suicide rates peak for women in the age group of 45-54 years.
- Male suicide rates are higher in age group 85-plus years.
- Suicide is the third leading cause of death in the age group of 10-34 years after unintentional injuries and homicide.
- Suicide accounts for 10 percent of adolescent deaths.
Some Key Points:

- Self-inflicted injuries, measured by discharges from hospitals for such injuries, are higher for females than for males.

- Self-inflicted injury rates for both males and females are highest in the age group of 15-24 years.

- The highest self-inflicted injury rate is in the age group of 15-24 years.

- One-third of self-inflicted injuries occur in young people in the age group of 15-24 years.

- Three-fourths of self-inflicted injuries occur in the age group of 15-44 years.
Some Key Points:

- Firearms is the number one method of suicide-related deaths.
- Suffocation, hanging and strangulation is the second leading mechanism for suicide-related deaths accounting for 25 percent of total completed suicides.
- Poisoning accounts for 19 percent of total suicides making it the third leading mechanism for suicide-related deaths. In comparison to the chart on the next page, illustrates that poisoning accounts for the leading mechanism for self-inflicted injury hospitalizations.
Some Key Points:

- The total number of self-inflicted injury hospitalizations in 2006 was 6,112.
- Poisoning accounted for 79 percent of total self-inflicted injury hospitalizations.
- Cutting and piercing accounted for 14 percent of self-inflicted injury hospitalizations.
- It is important to remember that the phrase “self-inflicted injury” is not synonymous with suicide. Many people who injure themselves have no desire to die.
Some Key Points:

- In 2005, the suicide rate was 1.25 times the homicide rate.
- In 2003-2005, the homicide rate decreased while the suicide rate increased.
Some Key Points:

- In 1999-2006, self-inflicted injury related hospital discharge rates consistently were higher than assault related hospital discharge rates.
RACIAL AND ETHNIC DIVERSITY AND SUICIDE PREVENTION

The growth of racial and ethnic minority groups in the United States has been well documented. Sadly, medical and mental health care systems are not adequately equipped to treat persons from diverse racial and ethnic backgrounds. Racial and ethnic minorities have more unmet mental health needs than Caucasians.

The Surgeon General has identified several barriers to health for racial and ethnic minorities. These include:

- Cost of care
- Stigma
- Disorganized, fragmented services
- Lack of awareness of cultural issues
- Bias
- Language limitations
- Racism and discrimination

Other authors speak of class-bound values, language bias and culture-bound values. Racially diverse populations face more difficulties and challenges than the majority do, which may stress culturally bound coping skills and increase the risk of developing mental health issues.

---

Some Key Points:

- The white population has the highest overall suicide rate for both males and females.

- Male suicide rates are 4.4 times higher than female rates in the white population; 3.9 times in the black population; and 1.6 times in the Asian and Pacific Islander (API) population.

- Males have higher suicide rates than females, irrespective of race.
COMMUNITY NEEDS ASSESSMENT SURVEY – RESULTS

While preparing this strategic plan, a needs assessment was completed to gain ideas and suggestions about how to prevent suicide among Illinois citizens. Coalition members distributed the survey to state and local partners. The survey also was formatted as an online survey and the survey link was forwarded broadly. All survey results were inputted into a data base and the findings were computed.

Participants included a wide range of community sectors

- Businesses
- Media
- Community-based Organizations
- Parent Organizations
- Counseling/Mental Health Organizations
- Public Organizations
- Faith Communities
- Schools
- Government (local/state) Agencies
- Social Service Agencies
- Legal/Criminal Justice/Juvenile Justice Agencies
- Substance Abuse Prevention Agencies
- Legislative Bodies
- Survivors of Suicide
- Health Care Organizations
- Universities or Colleges

Need for programs

- 82 percent agreed that there is a significant need for suicide prevention programs for the citizens in their communities.
- 58 percent disagreed that people in their communities were receiving the treatment they needed for depression and other mental illnesses.

Question: Do you agree or disagree that the following factors would be barriers to development or implementation of a suicide prevention or intervention program for your community?

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding</td>
<td>81%</td>
<td>5%</td>
</tr>
<tr>
<td>Stigma or fear of mental illness</td>
<td>66.5%</td>
<td>14%</td>
</tr>
<tr>
<td>Lack of staff or volunteers</td>
<td>64.3%</td>
<td>13%</td>
</tr>
<tr>
<td>Lack of technical assistance, training</td>
<td>Agree</td>
<td>Disagree</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>-------</td>
<td>----------</td>
</tr>
<tr>
<td></td>
<td>53.3%</td>
<td>11.6%</td>
</tr>
<tr>
<td>Unmet need for good prevention models</td>
<td>47%</td>
<td>17.5%</td>
</tr>
<tr>
<td>Time constraints</td>
<td>45%</td>
<td>16.2%</td>
</tr>
<tr>
<td>Lack of interest</td>
<td>37%</td>
<td>32%</td>
</tr>
<tr>
<td>Potential negative parent response/aftercaree</td>
<td>34%</td>
<td>29.5%</td>
</tr>
</tbody>
</table>

**Question:** Do you agree or disagree that your community needs the following tools to develop and implement a suicide prevention/intervention plan?

<table>
<thead>
<tr>
<th>Needs</th>
<th>Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding</td>
<td>79.6%</td>
<td>5%</td>
</tr>
<tr>
<td>Community support and participation</td>
<td>77.7%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Staff and volunteers</td>
<td>77%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Information on student reactions</td>
<td>73.4%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Information on parent reactions</td>
<td>72.5%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Consultation with communities that have developed programs</td>
<td>70.3%</td>
<td>7%</td>
</tr>
<tr>
<td>Research reports on program effectiveness</td>
<td>69.7%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Information on how to develop a plan</td>
<td>67.4%</td>
<td>11.3%</td>
</tr>
<tr>
<td>Legal input</td>
<td>66.0%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Technical assistance with evaluation</td>
<td>65.4%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Information on suicidal individuals</td>
<td>65%</td>
<td>9%</td>
</tr>
</tbody>
</table>
REFERENCE TO ISSUE PAPERS

Please note: Issue papers are being developed on a wide range of topics. Interested parties can contact the Illinois Department of Public Health to learn the status of these issue papers.

The following topics will be addressed:

- Access to Care for Persons Insured by Medicare
- Access to Means
- Access to Mental Health Care
- Child Abuse
- Clinical Depression
- College Students
- Cultural Issues Impacting Suicide
- Domestic Violence Related Suicide
- Educating Physicians
- Faith-based Role in Suicide Prevention
- First Responders
- Gender Issues Impacting Suicide
- Incarcerated Population
- Law Enforcement Role in Suicide Prevention
- Military
- Medical Illness
- Mental Illness
- Older Adults
- Role of the Media
- Rural Suicide Prevention and Access to Care
- Sexual Assault
- Sexual Identity
- Students
- Substance Abuse
- Survivors and Crisis Intervention in the Aftermath
- Youth in the Juvenile Justice System
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“Suicide is not chosen; it occurs when pain exceeds resources for dealing with pain.”

— Dr. David Conroy

Sponsored by
Illinois Department of Public Health
In collaboration with
Illinois Suicide Prevention Strategic Planning Committee
and
Illinois Suicide Prevention Coalition

Copies of this plan are available from:
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Printed by Authority of the State of Illinois
(P.O. # 379763 - 200 - 1/08)
IIISG08-268
<table>
<thead>
<tr>
<th>Agency_Name</th>
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<th>Activity_Name</th>
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</tbody>
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$14,764,727
August 30, 2011

Linda Denson, Co-Chair
Illinois Mental Health Planning and Advisory Council
Sankofal Organization of Illinois
P.O. Box 607294
Richton, Illinois 60010

John W. Shustitzky, Ph.D., Co-Chair
Illinois Mental Health Planning and Advisory Council
President and Chief Executive Officer
Pillars
333 North La Grange Road, Suite One
La Grange Park, IL 60526

Dear Ms. Denson and Dr. Shustitzky:

As Co-Chair of the Illinois Mental Health Planning and Advisory Council Planning Committee, I am writing this letter in support of the Illinois 2012 IDHS Division of Mental Health Block Grant Application.

As you are aware, Illinois is experiencing a continuous and deep fiscal crisis, similar to that of many states around the country. While we have reached a short term budget agreement in our state, there is still a lot of uncertainty about the future of services for low income people in Illinois, and especially people who are mentally ill and do not have Medicaid. On-going cash flow delays in payments to social service agencies around the state have caused a few agencies to close and many are being forced to consider what services they will have to end due to the lack of funding and the lack of payments.

There are reports around the state that the state hospitals for mental health are filled and there are patients without Medicaid who simply have no access to urgent care and the on-going care needed for them to remain stabilized in the community. This is a very difficult time for consumers and providers alike.

The bi-monthly meetings of the full Council are a strong vehicle for communication between providers and the Division of Mental Health and there have been several efforts to collaborate on solutions. The Division itself is also experiencing staff cutbacks and is scrambling to make do with existing resources. One positive outcome that has occurred in the past year is the result of a class action lawsuit regarding patients with severe mental illness who are housed in nursing homes. These patients will now be receiving services to assess their needs, their housing and community living goals, and funds will be available to help them transition to a less restricted environment. Several Council member agencies and consumers have been involved in that planning process.

This year’s review process for the Block Grant was a bit cumbersome due to the process changes that were established by SAMHSA with very short notice. The Council has generally been receptive to the proposed changes; the significant involvement of and integration with substance abuse services is viewed as especially welcomed due to the overlap of consumers who have a dual diagnosis.
Despite the timing issue, the committee and the full council had the opportunity to review the initial draft of the document in June. All questions were answered and any suggested changes were considered in the final draft of the document. The Committee recommends the application to the Council and supports the efforts of the Division to be responsive to the requests of SAMHSA for this block grant application process. The Block Grant funds are a critical component to funding services in Illinois.

Sincerely,

Cathy St. Clair
Co-Chair
Planning Committee
August 30, 2011

Barbara Orlando
Grants Management Specialist
Division of Grants Management, OPS, SAMHSA
1 Choke Cherry Road, Room 7-1091
Rockville, Maryland 20857

Dear Ms. Orlando:

As Co-Chairs to the Illinois Mental Health Planning and Advisory Council, and on behalf of that Council, we offer our support for the 2012 Community Mental Health Services Block Grant application being submitted by the Illinois Division of Mental Health, Department of Human Services. This application has been reviewed by our Council’s Planning Committee as well as other members of the Council.

The current financial crisis at the federal, state and local level has made it even more challenging to meet the mental health needs of Illinois residents. We refer you to the attached letter from our Planning Committee Chair, Cathy St. Clair, for more details.

We will continue to address the mental health needs in Illinois by holding IMHPAC meetings bi-monthly. Standing Committees meet during interim months resulting in a process that allows an active role in Block Grant discussion, planning and submission. The membership includes consumers of mental health services, family members and parents of serious emotionally disturbed (SED) children, mental health service providers, advocates, representatives of many agencies and departments of State government and others. Per our By-Laws, consumers and family members comprise a majority of our membership. We have been successful in maintaining a membership that represents all regions of our very large State.

Please feel free to contact either of us if you have any questions or need any additional information.

Sincerely,

Linda Denson
IMHPAC
President and Chief Executive Officer
CEO, Sankofa Organization of Illinois, Inc.
Post Office Box 706294
Chicago, IL 60660-7294
(312) 747-9380

John W. Shustitzky, Ph.D., Co-Chair
Pillars
333 North LaGrange Road
LaGrange Park, IL 60526
(708) 995-3502
(c/o Dorothy Wieneck)