

Illinois

UNIFORM APPLICATION FY 2008 - STATE PLAN

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

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Center for Mental Health Services
Division of State and Community Systems Development

Introduction:

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

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

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0168.

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Illinois

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FACE SHEET

FISCAL YEAR/S COVERED BY THE PLAN

X **FY2008** **FY 2008-2009** **FY 2008-2010**

STATE NAME: Illinois

DUNS #: 06919071

I. AGENCY TO RECEIVE GRANT

AGENCY: Illinois Department of Human Services

ORGANIZATIONAL UNIT: Division of Mental Health

STREET ADDRESS: 160 North LaSalle Street, 10th Floor

CITY: Chicago

STATE: IL

ZIP: 60601

TELEPHONE: 312-814-4948

FAX: 312-814-2964

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: Carol L. Adams, Ph.D TITLE: Secretary

AGENCY: Illinois Department of Human Services

ORGANIZATIONAL UNIT:

STREET ADDRESS: 401 South Clinton Street

CITY: Chicago

STATE: IL

ZIP CODE: 60601

TELEPHONE: 312-793-1533

FAX:

III. STATE FISCAL YEAR

FROM: 07/01/2007

TO: 06/30/2008

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: Mary E. Smith, Ph.D. TITLE: Chief, Strategic Planning, Evaluation, Decision Support

AGENCY: Illinois Department of Human Services

ORGANIZATIONAL UNIT: Division of Mental Health

STREET ADDRESS: 160 Noeth LaSalle Street, 10th Floor

CITY: Chicago

STATE: IL

ZIP: 60601

TELEPHONE: 312-814-4948

FAX: 312-814-2964

EMAIL: MaryE.Smith@illinois.gov

Illinois

Executive Summary

Please respond by writing an Executive Summary of your current year's application.

**ILLINOIS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH
FY 2008 MENTAL HEALTH BLOCK GRANT APPLICATION**

EXECUTIVE SUMMARY

The Illinois Department of Human Services-Division of Mental Health (DMH) is responsible for managing and purchasing a comprehensive array of services that provide effective treatments to people most in need of publicly funded mental health care. The policies and practices of the DMH focus on fostering coordination and integration of services provided by DMH funded community agencies, private hospitals, and state hospitals across Illinois. The DMH has implemented a wide range of initiatives to increase coordination with other state agencies whose services are accessed by individuals receiving mental health services. The FY2008 Mental Health Block Grant Plan reflects these coordination efforts as well as an emphasis on developing and directing care which is consumer and family driven. During the last year, the DMH has undertaken a number of efforts to continue the transformation of the mental health service delivery system in Illinois to one that is recovery-oriented. These efforts include an expanded focus on planning and implementation of evidenced-based practices, continued planning for the transition to a fee-for-service system from a primarily grant-based funding system, and increasing consumer and family involvement in planning and implementation activities. A wide array of stakeholders representing consumers, family members of individuals with mental illnesses, advocates and public service agencies purchasing or providing treatment to individuals with mental illnesses have participated in these efforts. The anticipated outcome of these efforts is the continued enhancement of activities that support the recovery-orientation of the mental health system, and consumers and their families.

There continue to be significant fiscal challenges to the mental health service system in FY 2008. Illinois, like many other states, experienced a serious economic downturn that began in 2001, and although there has not been an increase in funding, the Division has worked diligently to increase revenue from Medicaid and to seek grant funding to support programmatic efforts.

During FY 2008, the efforts of the DMH remain focused on: (1) planning efforts to continue transformation of the Illinois Mental Health service delivery system, (2) sustaining the significant accomplishments of recent years, (3) continuing the development of the public mental health service system through joint planning, coordination and implementation efforts, (4) emphasizing consumer education, recovery-orientation and enhanced consumer and family involvement in planning and evaluation activities, and (5) continuing development and initiation of strategies to expand access to evidence-based practices. The format of this FY 2008 plan reflects these themes, and is synchronized with the overall planning process of the DMH.

Plan Organization

As the Illinois Mental Health Authority, the DMH is responsible for public mental health services for both children and adults. The previous organization of the plan reflected this service integration. The FY 2008 plan has been re-organized to reflect the SAMHSA CMHS format which calls for two separate plans---one for adults and one for children. Each Criterion contains separate sections for adult services and child services. This organization is reflected in the Narrative, as well as in the performance indicators that relate to the plan.

The following are highlights of this year's application and plan:

- Use of block grant dollars to promote consumer-to-consumer outreach and mentoring,
- Continuing development of housing services, including a new supported housing initiative
- The continuing investment of block grant dollars to increase and improve psychiatric leadership and services
- The use of block grant funds to support crisis services
- Enhancing mental health services for children and adolescents through a range of pilot projects in services to transitioning youth, telepsychiatry in rural areas, early intervention and early childhood consultation.
- Continuing to develop strategies to increase access to evidence-based practices
- Established linkages with jails, juvenile detention facilities, and the Courts
- Providing training and consultation to community-based staff serving children and adolescents in Evidence-Informed Practices
- Working collaboratively in consultation with schools to expand early intervention and prevention in mental health, and
- Initiatives for elderly persons in rural areas that are aimed at providing consultation and promoting the integration of mental health services in meeting the needs of older adults.

Mental Health System Performance Indicators

The FY2008 plan contains Illinois-specific performance indicators, as well as indicators relating to the SAMHSA CMHS National Outcome Measures (NOMS). The system performance indicators are described and clearly referenced in the plan narrative so that the reader may cross-reference them, or simply review them as a set. The Illinois specific indicators are used to monitor the impact of the mental health services that are purchased on behalf of mental health consumers. These indicators include information that is collected and reported as part of the CMHS Uniform Reporting System. This ability to track values of indicators across time has assisted in identifying issues that need to be addressed within the public mental health service system serving as a basis for planning. Additional indicators are added as required to meet the priorities of mental health system development.

Attachment A

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2008

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.]

Section 1911:

- Subject to Section 1916, the State¹ 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.

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].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2008, 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).

21. The term State shall hereafter be understood to include Territories.

(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.

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.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:

(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and

(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;

(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;

(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and

(D) the families of such adults or families of children with emotional disturbance.

- (2) A condition under subsection (a) for a Council is that:
- (A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
 - (B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

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.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) 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.

Section 1916:

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

- (1) to provide inpatient services;
- (2) to make cash payments to intended recipients of health services;
- (3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
- (4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
- (5) to provide financial assistance to any entity other than a public or nonprofit entity.

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

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.

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:

- (1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
 - (2) the recipients of amounts provided in the grant.
- (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:
- (1) make copies of the reports and audits described in this section available for public inspection within the State; and
 - (2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

- (a) The State will:
- (1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
 - (B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
 - (2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
 - (3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section
- (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.

~~XXXXXX~~

Carol L. Adams, Ph.D, Secretary, Illinois Dept of Human Services

Date

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 sub-grantees 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 workplace 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 to 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), (c), (d), (e), and (f).

For purposes of paragraph (e) 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
 Department of Health and Human Services
 200 Independence Avenue, S.W., Room 517-D
 Washington, D.C. 20201

3. CERTIFICATION 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 under-

signed, 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 statements or claims 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, day care, 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.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Secretary, Department of Human Services	
APPLICANT ORGANIZATION Illinois Department of Human Services/Division of Mental Health		DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action: <input type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	2. Status of Federal Action <input type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	3. Report Type: <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change For Material Change Only: Year _____ Quarter _____ date of last report _____
4. Name and Address of Reporting Entity: Prime _____ Subawardee _____ Tier _____, if known: Congressional District, if known: _____		5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, if known: _____
6. Federal Department/Agency:	7. Federal Program Name/Description: CFDA Number, if applicable: _____	
8. Federal Action Number, if known:	9. Award Amount, if known: \$ _____	
10. a. Name and Address of Lobbying Entity <i>(if individual, last name, first name, MI):</i>	b. Individuals Performing Services <i>(including address if different from No. 10a.)</i> <i>(last name, first name, MI):</i>	
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____	
Federal Use Only:		Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity 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 a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., "RFP-DE-90-001."
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.
10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

(b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No.0348-0046. Public reporting burden for this collection of information is estimated to average 10 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 (0348-0046), Washington, DC 20503.

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. 91-616), 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.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

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 National Environmental Policy 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 Clear 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. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
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, re- gulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Secretary, Department of Human Services	
APPLICANT ORGANIZATION Illinois Department of Human Services/Division of Mental Health		DATE SUBMITTED

II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

States are required to provide systems of integrated services for children with serious emotional disturbances (SED). Each year the State shall expend not less than the calculated amount for FY 1994.

Data Reported by:

State FY X

Federal FY _____

State Expenditures for Mental Health Services

Calculated FY 1994	Actual FY 2006	Estimate/Actual FY 2007
<u>\$24,236,971</u>	<u>\$73,557,677</u>	<u>\$84,822,489</u>

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

III. MAINTENANCE OF EFFORT(MOE) REPORT

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained 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.

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

States are required to submit State expenditures in the following format:

MOE information reported by:

State FY X

Federal FY _____

State Expenditures for Mental Health Services

Actual FY 2005	Actual FY 2006	Actual/Estimate FY 2007
<u>\$402,042,280</u>	<u>\$414,287,972</u>	<u>\$428,645,083</u>

MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

TABLE 1.**List of Planning Council Members**

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Anselmo, Frank	Others(not state employees or providers)	Community Behavioral Health Assn	3085 Stevenson Drive Springfield,IL 62703 PH:217-585-1600 FAX:	
Barnes, Kimberly	Family Members of Children with SED		P.O. Box 185 Shawneetown,IL 62984 PH:618-269-3670 FAX:	
Boyd, Cheryl	Providers		Franklin Williamson Human Services 902 West Main Street West Frankfort,IL 62896 PH:618-937-6483 FAX:	
Burchell, Juana	State Employees	Education	100 North 1st Street Springfield,IL 62777 PH:217-782-5589 FAX:	
Connor, Ray	Family Members of Children with SED		3 Creekside Lane Barrington,IL 60010 PH:847-426-3692 FAX:	
Cooke, Andrea	Consumers/Survivors/Ex-patients(C/S/X)		3061 Euclid Lane Richton park,IL PH:788-288-4550 FAX:	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Daxenbichler, Cindy	Family Members of Children with SED		1301 Sommerset Street Pekin,IL 61554 PH:309-642-1080 FAX:	
Day, John	Providers	Mental Health Assn of Illinois	3716 West Brighton Peoria,IL 61615 PH:309-691-7755 FAX:	
Denson, Linda	Consumers/Survivors/Ex-patients(C/S/X)	Sankofa Organization of Il	7619 Parnell Avenue Chicago,IL 60660 PH:312-636-4051 FAX:	
Durkin, Eileen	Providers	Victor C Newmann Assn	5547 North Ravenswood Chicago,IL 60660 PH:773-506-3024 FAX:	
Eagleton-Helmy, Heather	Others(not state employees or providers)	Illinois Assn of Rehabilitation Facilities	206 soth 6th Street Springfield,IL 62701 PH:217-753-1190 FAX:	
Ford-Whitsett Smith, Pamela	Consumers/Survivors/Ex-patients(C/S/X)		9 south Kedzie Chicago,IL 60612 PH:772-711-7900 FAX:	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Frazier, Sondra	Family Members of Children with SED		6957 South Jeffrey Blvd Chicago,IL 60649 PH:773-274-2150 FAX:	
Friedman, Fred	Consumers/Survivors/Ex-patients(C/S/X)		6513 North Sacramento Chicago,IL 60645 PH:773-274-2150 FAX:	
Garnett, Frederica	Providers	Delta Center	1400 Commercial Avenue Cairo,IL 62914 PH:618-734-2665 FAX:	
Hanko, Stephanie	State Employees	Medicaid	201 South Grand Ave East (covers Social Srvs) 3rd floor Springfield,IL 62914 PH:217-557-1031 FAX:	
Heyrman, Mark	Others(not state employees or providers)	University of Chicago	6020 South University Avenue Chicago,IL 60537 PH:773-753-4440 FAX:	
Hopkins, Dennis	Providers	Iroquois Mental Health Center	323 West Mulberry Street Watseka,IL 60970 PH:815-432-5241 FAX:	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Irving, Anne	Others(not state employees or providers)	AFSCME	29 North Wacker Drive, Suite 800 Dhicago,IL 60601 PH:312-641-6060 FAX:	
James, Brian	Consumers/Survivors/Ex-patients(C/S/X)		210 Avenue C Danville,IL 61832 PH: FAX:	
Knaebe, Diana	Providers	Heritage Behavioral Health Center	P.O. Box 710 151 North Main Street Decatur,IL 62525 PH:217-420-4702 FAX:	
Koeliker, Marsha	Others(not state employees or providers)	Equip for Equality	20 North Michigan Avenue, Suite 300 Chicago,IL 60602 PH: FAX:	
Kopera, Anthony	Providers	Community Counseling Centers of Chicago	4740 North Clark Street Chicago,IL 60640 PH:773-769-02-5 FAX:	
Larson, Nanette	Consumers/Survivors/Ex-patients(C/S/X)	State Rep - Consumer Affairs	5407 North University Avenue Chicago,IL 60640 PH:309-693-5228 FAX:	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Lindahl, Ted	Family Members of Children with SED		McHenry County Mental Health Board 620 Dakota Street Crystal Lake,IL 60012 PH:815-455-2828 FAX:	
Martinez, Daniel B	Providers		Lutheran Social Services 4840 West Byron Street Chicago,IL 60641 PH:773-282-7800 FAX:	
May, Jann	Consumers/Survivors/Ex-patients(C/S/X)		2615 Edwards Street Alton,IL 62002 PH:618-462-2331 FAX:	
Mercer, Orville	Providers	Chestnut Health Care Systems	\$50 Northgate Industrial Drive, Route 3 Granite city,IL 62040 PH:618-877-4420 FAX:	
Moffett, Regina	Consumers/Survivors/Ex-patients(C/S/X)		661 East 69th Street, Unit 607 Chicago,IL 60637 PH: FAX:	
Nance, Mike	Consumers/Survivors/Ex-patients(C/S/X)		365 East Waggoner St Decatur,IL 62526 PH: FAX:	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Navarro, Wendy	State Employees	Criminal Justice	30 W200 Ferry Road Warrenville,IL PH:60555 FAX:815-284-6611	
Nehrborn, Caryn	Consumers/Survivors/Ex-patients(C/S/X)		1126 Healthcare Drive, Unit 104 Mt. Carroll,IL 61053 PH:815-284-6611 FAX:	
Nolen, Kim	Family Members of Children with SED		1825 Oak Lane Rd Flossmoor,IL 60422 PH:708-798-2820 FAX:	
Novk, Joseph	Providers	North West Community Hospital	800 West Central Road Arlington Heights,IL 60005 PH:847-618-4075 FAX:	
O'Shea, Lynn	Providers	Association for Individual Development	309 West New Indian Trail Court Aurora,IL 60506 PH:630-966-4001 FAX:	
Oulvey, Gene	State Employees	Vocational Rehabilitation	618 E Washington, 3rd Floor Springfield,IL PH:62794 FAX:217-785-7636	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Pannell, Wende	Family Members of Children with SED		733 N May Aurora,IL 60506 PH:630-801-1669 FAX:	
Peterson, Anne	Consumers/Survivors/Ex-patients(C/S/X)		226 Lincoln Parkway Crystal Lake ,IL 60014 PH:815-455-1391 FAX:	
Pluta, William	State Employees	Housing	Illinois Housing Development Authority 401 North Michigan Avenue, suite 900 Chicago,IL 60611 PH:312-836-5354 FAX:	
Schneider, Beth	Consumers/Survivors/Ex-patients(C/S/X)		8234 Kilpatrick Skokie,IL 60076 PH:847-674-4045 FAX:	
Shustotzlu, John	Providers	Pillars	333 North LaGrange Road LaGrange Park,IL 60076 PH:708-698-5500 FAX:	
Sorrells, Anita	Family Members of Children with SED		2009 Windsor Street Pekin,IL 61554 PH:309-346-1643 FAX:	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
St.Clair, Cathy	Consumers/Survivors/Ex-patients(C/S/X)		6301 North Sheridan Road #8D Chicago, IL 60660 PH:773 FAX:	
Thomas, Lisa	Family Members of Children with SED		1775 Kings Gate Lane Crystal Lake, IL 60014 PH:815-455-5396 FAX:	
Troee, Thomas	Consumers/Survivors/Ex-patients(C/S/X)		8421 Nortj Selkirk Peoria, IL 61615 PH:309-689-0739 FAX:	
Virgil, Linda	Family Members of adults with SMI		1434 Greendell Decatur, IL 62562 PH:217-877-1569 FAX:	
Vyverberg, Robert	State Employees	Mental Health	5407 North University Peoria, IL 61614 PH:309-693-5228 FAX:	
Ware, Frank	Providers	Janet Wattles Mental Health Center	526 West State Street Rockford, IL 61101 PH:815-968-9300 FAX:	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Weissman, Sidney	State Employees	Other	676 St. Clair, Suite 1760 Chicago,IL 60611 PH: FAX:	
Wells, Don P	Consumers/Survivors/Ex-patients(C/S/X)		9524 Robinson Lane Mapleton,IL 61547 PH:309-697-0090 FAX:	
Zych, Gilbert	Providers	Lyons Township Mental Health Commission	6404 Joliet Road Countryside,IL 60525 PH:708-352-2992 FAX:	

TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	51	
Consumers/Survivors/Ex-patients(C/S/X)	15	
Family Members of Children with SED	9	
Family Members of adults with SMI	1	
Vacancies(C/S/X and Family Members)	1	
Others(not state employees or providers)	5	
TOTAL C/S/X, Family Members and Others	30	58.82%
State Employees	7	
Providers	14	
Vacancies	1	
TOTAL State Employees and Providers	21	41.18%

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State Employee and Provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services. 4) Totals and Percentages do not include vacancies.

Illinois

Planning Council Charge, Role and Activities

State Mental Health Planning Councils are required to perform certain duties. If available, a charter or a narrative summarizing the duties of the Planning Council should be included. This section should also specify the policies and procedures for the selection of council members, their terms, the conduct of meetings, and a report of the Planning Council's efforts and related duties as mandated by law:

reviewing plans and submitting to the State any recommendations for modification
serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems,
monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State.

the role of the Planning Council in improving mental health services within the State.

In addition to the duties mandated by law, States should include a brief description of the role of the Planning Council in the State's transformation activities that are described in Part C, Section II and Section III.

**PART B – ADMINISTRATIVE REQUIREMENTS, FISCAL PLANNING
ASSUMPTIONS AND SPECIAL GUIDANCE**

IV. State Mental Health Planning Councils

1. The IMHPAC bylaws include the role and purpose of the Council as well as the membership requirements.

By-Laws of the Illinois Mental Health Planning and Advisory Council (IMHPAC)

ARTICLE I - NAME

The name of this unincorporated association shall be the Illinois Mental Health Planning and Advisory Council (the “Council”).

ARTICLE II - PURPOSE

The purposes of the Council shall be: (1) to exchange information and develop, evaluate and communicate ideas about mental health planning, (2) to review and make recommendations regarding the Federal Mental Health Services Block Grant plan for mental health services in the State of Illinois, (3) to advise the Illinois Department of Human Services Division of Mental Health and other departments, divisions and agencies of state government concerning proposed and adopted plans affecting mental health services provided or coordinated by the state and the implementation thereof, (4) to monitor, review and evaluate the allocation and adequacy of mental health services in Illinois and to advise the Illinois state government concerning the need for and quality of services and programs for adults with mental illness and children and adolescents with serious emotional disturbances, and (5) to develop and take advocacy positions concerning legislation and regulations affecting mental health.

ARTICLE III - MEMBERSHIP

Section 1. Qualifications

Council membership composition shall follow the guidelines set forth in P.L. 102-321 and any subsequent federal regulation. The Council shall have at least 45 and no more than 55 members. Less than 50% of the members shall be state employees or employed by any entity which provides mental health services.

Section 2. Election of Members

(a) No later than October 1st of each year, the Council Development Committee shall notify the Council in writing of the names of Council members whose terms will expire on December 31st. This notice shall include the geographic location of each Council member whose term will expire, whether that member represents a service provider, persons with a mental illness, family members of persons with mental illness, family members of children or adolescents with a serious emotional disturbance or a specific state agency. The Committee shall solicit nominees from the Council, mental health service providers and organizations representing service providers, organizations which represent or are advocates for persons with mental illness or their relatives.

(b) The Committee shall request that the Division of Mental Health designate a representative to be a member of the Council and that the Division of Mental Health solicit representatives from the Division of Rehabilitation Services, the Department of Corrections, the Housing Development Authority, the Department of Public Aid, and the State Board of Education. The Committee shall request that a union representing persons employed by the Division of Mental Health shall designate a representative.

(c) The Committee shall nominate a slate of proposed new members to be elected during the Fall meeting of the Council. Such slate shall include the persons designated pursuant to paragraph (b) of this Section. The Committee shall ensure that the slate and the membership of the Council as a whole are comprised in a manner so that:

- (i) members are chosen in compliance with all applicable federal laws and regulations and these bylaws;
- (ii) each region of the state is adequately represented;
- (iii) the ratio of parents of children and adolescents with serious emotional disturbances to the other members of the Council is sufficient to provide adequate representation to such parents; and,
- (iv) there is diversity in the racial, gender, ethnic and geographic composition of the Council as a whole.

(d) The Council shall vote for the entire slate of proposed new members as a group. Any member of the Council may by motion propose an alternative slate of new members provided such slate complies with the provisions in subsection (c) of this Section and provided such motion is seconded by a member of the Council. The members of the slate which receives the most votes shall be considered elected to the Council.

(e) The Committee may appoint a new member when, during the course of any year, a vacancy occurs. Whenever one or more new members are appointed by the Committee, the Committee shall promptly advise the full Council in writing of the appointment.

Section 3. Terms

Members shall be elected to serve a three-year term. No member shall serve more than three consecutive terms. However, there shall be no limit to the number of terms served by a representative chosen by the Division of Mental Health, the Division of Rehabilitation Services, the Department of Corrections, the Housing Development Authority, the Department of Public Aid, the State Board of Education or a union representing persons employed by the Division-Office of Mental Health.

Section 4. Compensation

The members of the Council shall serve without pay, but the Council may authorize or recommend the payment of reasonable and necessary expenses incurred by the members in the performance of their duties. By vote of the Council in which consumers shall not participate, the Council may authorize compensation for consumers for their participation in the work of the Council and its committees to the extent that such consumers are not otherwise compensated for this work.

Section 5. Removal of Members

A member may be removed by the Council whenever in its judgment the best interests of the Council would be served thereby. Whenever a member has failed to attend at least 50% of the regularly scheduled meetings in any calendar year, the Council Development Committee shall notify the Council and the member of that fact. If the committee determines that good cause does not exist for the failure of the member to attend Council meetings, the Committee shall move that the member be removed. Removal may occur only at a properly called meeting of the Council, after at least thirty days written notice to the person proposed to be removed and to the Council. No member may be removed unless at least two thirds of the members present vote to remove a member. Any member may resign at any time by giving written notice to the Council.

ARTICLE IV--MEETINGS

Section 1. Timing and location

Regular meetings of the Council shall be held at least four times each year. The dates of the regular meetings shall be determined at the beginning of each year and a written schedule of the meetings shall be provided to each member. The Council may decide to meet more frequently. At least two meetings each year shall be held in Cook County and at least two meetings each years shall be held in Sangamon County. Special meetings of the Council may be called at any time by the co-chairs or by a written request to either of the co-chairs from 25% of the members. Members may participate in Council meetings through video-conferencing or other similar technologies if such technologies are available.

Section 2. Notice

The co-chairs may call for a special meeting of the Council by mailing an agenda to all of the members at least 7 days prior to any such meeting, and not more than 60 days prior to any such meeting.

Section 3. Quorum

A quorum of the Council shall exist if one third or more of the total members as of the day prior to the meeting are present. A majority of the members present is required for any action of the Council.

Section 4. Powers

The Council shall have all of the powers vested in it by virtue of these Bylaws, together with any other reasonable and necessary powers to carry out the purposes of the Council. The Council may commit the Council, but not the State of Illinois or the Division of Mental Health or any member, concerning any matter within the purpose of the Council.

Section 5. Open Meetings

All meetings of the Council shall be open to the public. The Council shall take reasonable steps to insure that persons and organizations with an interest in the mental health system in Illinois are notified of the time and location of all meetings, including, if possible listing such meetings on the websites of relevant government agencies. A reasonable period shall be set aside at all meetings of the Council for members of the public to address the Council. Members of the public shall be permitted to propose “new business” for the next meeting of the Council. Subject to veto by the Council, such new business shall be placed on the next Council meeting agenda.

Section 6. Alternates; Abstention

There shall be no proxies for meetings of the Council. A member of the Council may designate an alternative to attend Council meetings when such member is unable to attend, but such an alternative shall not be entitled to vote.

Section 7. Rules of Order

In all procedural matters not governed by these Bylaws, the Council shall be bound by the provisions of *Robert's Rules of Order, Newly Revised* (1990). But the Council may, by the vote of two-thirds of a quorum of the Council present at a meeting of the Council, suspend any provision of these Bylaws or of *Robert's Rules*, at any time, whether or not such suspension is on the agenda.

Section 8. Participation of the Division of Mental Health/Youth and Geriatric Advisory Councils

The co-chairs of the Council shall request that the Division of Mental Health designate such representatives as may be appropriate to attend meetings of the Council and its committees. Whenever issues relating to the delivery of mental health services to aged persons or to children or adolescents are to be discussed, the Division of Mental Health shall take reasonable steps to obtain the presence at Council meetings of one or more members of the Geriatric Advisory Council or Youth Advisory Council as it deems appropriate.

ARTICLE V - OFFICERS

Section 1. Terms

The officers of the Council shall consist of one co-chair who is a service provider, one co-chair who is a primary or secondary consumer, a secretary and a treasurer. Each officer shall serve for two years unless such person ceases to be qualified to serve as an officer. Each officer shall hold office until his or her successor shall have been duly elected by the Council.

Section 2. Nominations

The Council Development Committee shall solicit nominations for officer positions from the Council and from the Division of Mental Health. The Committee shall choose at least one person for each office. Nominees receiving a plurality vote of the Committee for the available vacancies shall be declared elected. Each position shall be voted on separately.

Section 3. Duties of Co-Chairs

The co-chairs shall be the parliamentary chairs of the Council. It shall be the duty of the co-chairs to preside over all meetings of the Council, and, subject to the control of the Council, to supervise and control all of the business affairs of the Council. The co-chairs shall be *ex-officio* members of all committees. The co-chairs shall see that all motions and resolutions of the Council are carried into effect.

Section 4. Duties of Treasurer

The Treasurer shall be responsible for accounting for any funds allocated or obtained for the use of the Council, subject to the oversight of the Finance Committee.

Section 5. Duties of Secretary

The Secretary shall be responsible for insuring that minutes of each Council meeting are prepared and provided to the Council and for maintaining such other Council records as the Council or the co-chairs may direct.

Section 6. Removal

An officer may be removed by the Council whenever in its judgment the best interests of the Council would be served thereby, but such removal shall be without prejudice to such officer's position as a member. Removal may occur only at a properly called meeting of the Council, after at least thirty days notice to the person proposed to be removed. Any officer may resign at any time by giving written notice to the Council.

Section 7. Vacancy

A vacancy shall exist whenever an officer is removed, resigns, dies, or ceases to be a member of the Council.

Section 8. Agenda

After consultation with the Associate Director of the Division of Mental Health and the members of the Executive Committee, to the extent feasible, the co-chairs shall set the agenda for meetings of the Council and recommend action to the Council and shall insure that a copy of the agenda is mailed to the members of the Council at least seven days prior to any meeting of the Council.

ARTICLE VI - COMMITTEES

Section 1. Appointments

Except for the Council Development Committee and the Executive Committee, the co-chairs, in consultation with the Council, shall appoint all chairs and members of all committees of the Council. The co-chairs may include an additional consumer to maintain a balance of representation on the executive committee. Every member of the Council shall serve on at least one committee, except as may be determined by the co-chairs. Persons who are not members of the Council, including employees of the Division of Mental Health, may serve as members of any standing committee except for the Council Development and Executive Committees. The co-chairs may appoint one or more adolescent consumers to committees of the Council other than the Council Development and Executive Committee. The majority of the members of each committee shall be members of the Council.

Section 2. Executive Committee

There shall be an Executive Committee comprised of the co-chairs of the Council, the treasurer, the secretary and the chair of each standing committee. The Executive Committee may make any decision concerning the affairs of the Council in the interim between properly called meetings of the Council. However, any such action shall be reported to the Council at the next meeting thereof. The Executive Committee shall develop an annual budget for the Council and shall monitor the expenditure of Council funds.

Section 3. Standing Committees

The standing committees shall be as follows:

(a) Council Development: This committee shall be comprised of 5 members. One member of the Committee shall be the member of the Council representing the Division of Mental Health. The other members of this committee shall be elected by a vote of the Council at a meeting of the Council to be held prior to June 1st of each year. At least one of the members of the committee elected by the Council shall be a primary consumer. The Executive Committee shall determine the procedures for the conduct of this election and provide written notice of those procedures and of the election itself to the members of the Council at least 30 days prior to the election. This committee shall be responsible for receiving and reviewing applications and nominating members to be members and officers of the Council. This committee shall be responsible: (i) for nominating persons to serve on the council; (ii) for selecting persons to serve as officers of the Council; (iii) for drafting such amendments to the Bylaws as may be needed; (iv) recommending to the Council the removal of any officer or member who is not longer qualified to serve, and, (v) for orienting new Council members. This committee shall also work with the Division of Mental Health to identify state funds to support the work of the Council, may identify and seek other sources of funds, public or private, to support the work of the Council.

(b) Planning. This committee shall review plans provided to the Council by the State pursuant to 42 USC §300x-4(a) and make recommendations to the Council and the Division of Mental Health for modifications to the plans.

(c) Substantive Committees. The council shall establish committees relating to the specific areas of services for persons with mental illnesses. These committees shall be responsible for devising a monitoring plan for their area of oversight; interacting with and advising the relevant state, county and municipal entities which provide services within their area of oversight; and, recommending to the Council advocacy priorities within their area of oversight. The substantive committees shall include:

- (i) Adult inpatient mental health services
- (ii) Adult community mental health services
- (iii) Children and adolescent mental health services
- (iv) Persons with mental illnesses in the criminal justice system
- (v) Any other substantive committees as determined by the Council to be necessary or expedient to carry on the mission of the Council.

Section 4. Powers

The Committees shall have the power and authority to make decisions only as may be specifically assigned by a majority of a quorum of the Council at a properly called

meeting of the Council. Chairs shall be responsible for keeping minutes of committee meetings and for reporting activities to the Council.

Section 5. Other Committees

Other committees may be appointed by the co-chairs as the Council deems necessary or expedient to carry on the business of the Council.

Section 6. Removal

The chair or any member of any committee may be removed for willful misconduct by a majority of a quorum of the Council at any time at a properly called meeting of the Council.

ARTICLE VII--ANTI-DISCRIMINATION

The Council shall not discriminate in any regard with respect to race, creed, color, sex, sexual orientation, marital status, religion, national origin, ancestry, pregnancy, parenthood, custody of a minor child or physical or mental disability.

ARTICLE VIII--AMENDMENT OF BYLAWS

Any member of the Council may propose amendments to these bylaws. These bylaws may be amended by the Council at any time, provided that written notice of such proposed amendment is provided to the Council at least 30 days prior to the meeting at which such amendment is approved and that any amendment is approved by a majority of a quorum of the Council present at such meeting.

3. The Role Of The Illinois Mental Health Planning And Advisory Council (IMHPAC) In Improving Mental Health Services Within The State

Charge, Role and Activities

The Illinois Mental Health Planning and Advisory Council (IMHPAC) advise 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. At the end of FY2002, the Council completed work on drafting a set of By Laws, which were approved. These by-laws were revised in FY 2005.

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.

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, Adult Community Services, Mental Health and Criminal Justice. 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 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, directs committees to communicate with Legislators, DHS administration, and the Office of the Governor in relation to problematic issues, 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.

Evidence of Advisory Council Activities

- As an advocate for adults with SMI and children with SED, and

- Monitoring, reviewing and evaluating the allocation and adequacy of mental health services within the state.

A major focus this year has been the need to generate more revenue for community services and the related project to increase billing Medicaid for services provided by community mental health centers. Members of the MHPAC, including the co-chair, have been closely involved with DMH and other stakeholder groups in developing this process. The President's New Freedom Commission Report and the Surgeon General's Report on Mental Health have been recognized as foundational documents in this ongoing effort.

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 met with DMH staff to develop and review the state plan, as indicated by the letter from the Chairpersons, Dan Martinez and Tom Troe, which have been included in this application. A copy of the letter from the MHPAC co-chairs endorsing the FY 2007 Illinois Mental Health Block Grant Application is also included.

Transformational Activities of the Illinois Mental Health Planning and Advisory Council

During FY 2008, the IMHPAC Planning Committee has identified two specific goals on which it will focus. The first goal is to hold a retreat for members of the MHPAC in September 2007. The purpose of the retreat is: (1) to engage in a planning process to identify priorities on which the Council will focus over the next two to three years; (2) to develop strategies and action steps to address the priorities, and (3) to clarify the organizational structure and communication structure for the MHPAC as a means of improving on-going planning efforts.

A second goal is to conduct a thoughtful and careful review with regard to how Mental Health Block Grant dollars are currently spent and the impact of the services which are purchased with block grant dollars. The Council will work with DMH staff to find funds that can be used to support the priorities that are identified through the Council's planning process. This process will position the Council to be more effective in advocating for improvements to the public mental health service system.

During the past year, members of the IMHPAC have participated 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 have been identified. These priorities include expanding work in the areas of: recovery, implementation of evidence-based practices, supportive permanent housing, children's mental health issues and mental health and justice system involvement.

4. State Mental Health Planning Council Comments and Recommendations

The comments and recommendations of the IMHPAC are reflected in the letters of support that have been submitted.

5. Public Comment on the FY 2008 Illinois Mental Health Block Grant Application

The development of the state mental health block grant plan is made available for public comment in several 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 meeting at which the plan is discussed and provide feedback and comments. (3) The FY 2008 block grant plan was reviewed by the Planning Committee for the Illinois MHPAC during its development on several occasions. A formal meeting to review the plan was held on August 2nd. The Block Plan has also been discussed at all MHPAC meetings in the past year. Notice of the availability of the plan via the web was emailed to all Council members. (4) 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) by September 12, 2007. 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.

Illinois

Public Comments on State Plan

Section 1941 of the Block Grant legislation stipulates 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 will make the mental health plan public in such a manner to facilitate comment from any person (including Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

States should describe their efforts and procedures to obtain public comment on the plan on the plan in this section.

The development of the state mental health block grant plan is made available for public comment in several 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 meeting at which the plan is discussed and provide feedback and comments. (3) The FY 2008 block grant plan was reviewed by the Planning Committee for the Illinois MHPAC during its development on several occasions. A formal meeting to review the plan was held on August 2nd. The Block Plan has also been discussed at all MHPAC meetings in the past year. Notice of the availability of the plan via the web was emailed to all Council members. (4) 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) by September 12, 2007. 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.

Illinois

Adult - Overview of State's Mental Health System

Adult - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

Overview of the State's Mental Health System

The Mental Health System at the State Level

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

It is the vision of the Division of Mental Health that all persons with mental illnesses recover and are able to participate fully in life in the community. Within available fiscal resources, the priority for DMH is to provide access to clinically appropriate, effective and efficient mental health care and treatment for individuals who have serious mental illnesses and who have limited social and economic resources. Planning and budgeting decisions are guided by the basic principle that individuals will receive services in the least restrictive, most clinically appropriate environment, with the best quality of recovery-oriented and evidence-based treatment and care possible. The administrative offices of the Division of Mental Health are based in Springfield and Chicago. Statewide efforts to maintain and improve the system of care are coordinated through the Central Office. Planning and program implementation are accomplished in conjunction with regional administrators. The Central Office is responsible for oversight of the system, policy formulation and review, the operation of nine state hospitals, planning, services evaluation, and allocation of funds. Interagency collaborative efforts and leadership in initiatives such as activities related to transformation, consumer participation/involvement, the promotion of evidence-based practices, the planning of clinical services, forensic services, and child and adolescent services are carried out by statewide administrative staff. There are 70.5 FTE positions in Central Office available to accomplish the manifold tasks required of it.

Illinois

Adult - Summary of Areas Previously Identified by State as Needing Attention

Adult - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

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

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

Consumer Participation and Involvement

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

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

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

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

C&A Services focused on family participation by increasing the availability of family resource developers (FRDs) and the advisory role of youth who utilize or have utilized services. Of the 54 agencies providing SASS services, only three of the agencies have never hired a FRD. There is generally a modest level of turnover in the FRD staff, and at the point that the FY 2007 FRD survey was conducted 41 of 49 reporting agencies (84%)

had FRDs employed. Thirty-one (76%) were FTE positions. Monthly meetings are held for the FRDs in order to provide education, resource development and support for the positions. FRDs from the Federal Systems of Care demonstration grants also attend these meetings. The survey results could not specify the number of positions that were FY 2007 new hires. Some agencies have expanded the support role and are using FRDs to assist with Individual Care Grant application processes and service planning. Each System of Care site has emphasized the importance and hiring of FRDs.

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

Evidence-Based Practices

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

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

Systems Integration

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

Division of Rehabilitation Services' continue its collaboration the 'Brand New Day Initiative' and the provision of Benefits Planning, Assistance and Outreach Project funded by the Social Security Administration. DMH collaborates with the City of Chicago Mayor's Office for Persons with Disabilities on the latter initiative. There is also continuing collaborative work with the Department on Aging on joint training and advocacy programs.

Program Enhancement

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

Service Administration

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

Information Technology

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

Grants

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

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

In FY 2006, a new award was made by SAMHSA to expand System of Care principles and practices to McHenry County, thus providing the opportunity to expand the System

of Care model to other areas in Illinois. The grant was awarded in October, 2005, and the project has shown rapid development. Family CARE stands for Child/Adolescent Recovery Experience and is a \$9 million, six –year federal grant designed to involve families and youth in decision making related to treatment, goal-setting, designing and implementing programs, monitoring outcomes and determining the effectiveness of efforts that promote the well-being of children and youth. The grant is designed to improve access to services for 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. Family Resource Developers have been hired through the grant to assist and support families navigating mental health and education systems. across the county. A variety of committees have been meeting with the aim of involving agencies, clinicians, school administrations, families and youth in designing effective mental health services which build on the strengths of consumers and address cultural and linguistic needs. The Governance Council includes professionals, family members and youth which will ensure that the project is family driven, youth guided, culturally competent, and able to shape policies and strategies to improve mental health care and develop a comprehensive system of care for McHenry County. Staff have been hired and extensive community input was solicited and incorporated into design changes. The team obtained a suicide-prevention grant from another source to provide suicide-prevention training for system of care families, youth, and partners. This project will also focus on promoting Evidence Informed Practices as it continues to develop.

Illinois

Adult - New Developments and Issues

Adult - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

New Developments and Issues Affecting Mental Health Service Delivery

Mental Health Transformation

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

The Fiscal Integrity of the Public Mental Health Service System

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

System Restructuring Initiative (SRI)

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

Administrative Services Organization

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

- Promote recovery, resiliency, and self-determination for consumers through services based on principles of consumer choice, high quality biopsychosocial assessment and individualized treatment planning, and by implementation of consumer communication, maintenance of a consumer handbook, and a measurable commitment to meaningful consumer leadership within daily operations.
- Improve provider clinical and administrative practices in documentation, appropriateness of service provision (including coordination across providers) and valid claims submission.
- Promote best practices through an utilization management program, system-wide quality management processes, implementation of consumer perception of care surveys and complaint/grievance procedures, and ongoing evaluation of all aspects of the work performed.
- Facilitate the development of the provider system, including but not limited to the following: provider relations functions, provider training and technical assistance, publishing and maintaining a provider manual and provider directory, provider contract monitoring, and provider satisfaction surveys.
- Through contract monitoring, service authorizations, and other appropriate mechanisms, ensure that service resources are distributed statewide and within each service region in appropriate proportion to the distribution of the DHS/DMH priority populations and their clinical needs.
- Coordinate and administer all aspects and mechanisms which are necessary to implement and optimize fee-for-service financing while minimizing clinical risk to consumers and promoting financial viability and service capacity of providers. Implement fee-for-service mechanisms in accordance with the DHS/DMH coordination of benefits policy.
- Coordinate and administer all non-fee-for-service financing mechanisms and service reporting and incorporate mechanisms to accommodate any provider pooled loan payments.
- Design and implement consumer enrollment processes and procedures which ensure that DHS/DMH funding is used only for rehabilitative or medically necessary services for DHS/DMH priority populations.
- Design and implement efficient and effective mechanisms for provider claims submission, validation, processing, adjudication, and payment.
- Implement a state-of-the-art management information system (MIS) which supports the preceding objectives through: reliable, valid, and expeditious data transmission among all appropriate federal, state, and local entities;

efficient and accessible data storage/warehousing/access; and HIPAA compliant procedures and processes throughout the system.

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

Anti-Stigma Campaign

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

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

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

Illinois

Adult - Legislative Initiatives and Changes

Adult - Legislative initiatives and changes, if any.

Legislative Initiatives And Changes

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

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

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

Moving from Institution to Community: Leadership in Olmstead Activities

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

Illinois

Adult - Description of Regional Resources

Adult - A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

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

Community services are considered the cornerstone of the mental health delivery system. Services provided and purchased by the DMH are geographically based. The DMH is organized into five Comprehensive Community Service Regions (CCSRs).

Through these Regions, the DMH operates state hospitals and contracts with 151 community mental health providers across the state. The DMH continually seeks input from consumers, family members, advocates, and representatives of public and private organizations through the framework of the Illinois Mental Health Planning and Advisory Council (IMHPAC) to aid in planning efforts. Comprehensive Community Service Regions are charged with the responsibility for managing care, developing the capacity and expertise of providers, monitoring service provision and increasing the quality and the quantity of participation from persons who receive mental health services. Two Regions are located in the Chicago Metropolitan area and surrounding suburbs, and three Regions cover the central, southern and metro-east southern areas of the State. Administratively, each Region has an Executive Director, a lead Clinical Director, a lead Recovery Services Development Specialist, and a Coordinator of Forensic Services. Child and Adolescent Service expertise is provided to Regional staff by statewide C&A Services staff who are centrally located.

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

Illinois

Adult - Description of State Agency's Leadership

Adult - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

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

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

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

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

IDHS Service Areas

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

DMH and the State Welfare Program

In an ongoing effort to address issues that may provide barriers to work readiness, the DMH and the DHCD work together in establishing and managing liaison relationships between local community mental health centers and local IDHS offices. The aim is to identify customers of IDHS who may be in need of mental health services (screening, assessment, and treatment). Statewide, DMH funds eleven community mental health provider agencies with General Revenue Funds (GRF) to provide for a full or half time Qualified Mental Health Professional (QMHP) staff position onsite at eleven designated

IDHS Family Community Resource Centers. Of these, six DHCD offices located in the Metro Chicago area have a full-time QMHP, one has a part-time QMHP, and four offices in downstate Illinois have the presence of a part-time QMHP. Paralleling this co-location is a statewide collaborative effort involving 97 DMH-funded mental health centers that have liaison relationships with the remaining local DHCD offices. These liaisons have a presence in IDHS offices for a minimum of four hours a month, or may be present for more hours if mutually agreed by the DCHD Local Office Administrator and the mental health center's administrative designee. Currently, each DHCD office has a liaison assigned to interface with the mental health center administration.

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

DMH Work with Community Health and Prevention

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

- A statewide perinatal mental health consultation service has been established for providers to use when a screening indicates that a pregnant or postpartum woman may be suffering from depression. This service is accessed by a toll free number and provides consultation with psychiatrists, information about medications that may be used in the management of perinatal depression during and/or after pregnancy, and referral and linkage to available mental health resources.
- Early Intervention Services 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; psychosocial development; and self-help skills. Evaluations and assessments are provided at no cost to families. Families with eligible children receive an Individualized Family Service Plan (IFSP) which lists the services and supports which must be made available to the family.
- The Domestic Violence and Mental Health Policy Initiative (DV/MHPI), funded by a contract with CMHS and supported by private foundations, is assisting DMH and CHP staff in research and training related to domestic violence. The DMH and the DCHP serve on a governance committee for DV/MHPI along with other child-serving agencies throughout the State. Both the DMH and the DCHP provide technical assistance to the DV/MHPI initiative. The DMH participates with the DCHP in other domestic violence treatment and prevention activities.
- DMH staff continues to participate in the DCHP Healthy Child Care Illinois (HCCI) initiative serving on its governance and planning committee. The DMH serves as the technical advisor on children's mental health issues.

Alcoholism and Substance Abuse. The Division of Alcoholism and Substance Abuse (DASA) administers and monitors funding to a network of community-based substance abuse treatment programs. These programs provide a full continuum of treatment

including outpatient and residential programs for persons addicted to alcohol and other drugs.

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

The Report of the Surgeon General on Mental Health, published in 1999, based on an extensive literature review of relevant and timely research, clearly stated that: “ As many as half of people with serious mental illnesses develop alcohol or other drug abuse problems at some point in their lives....Theories to explain co-morbidity (also known as dual diagnosis) range from genetic to psychosocial, but empirical support for any one theory is inconclusive. In short, the cause of such widespread co-morbidity is unknown. Co-morbidity worsens clinical course and outcomes for individuals with mental disorders. It is associated with symptom exacerbation, treatment noncompliance, likelihood of suicide, incarceration, family friction, and high service use and costs.....Furthermore, patients may be jeopardized by the consequences of substance abuse, namely, increased risk of violence, HIV infection, and alcohol- related disorders. Research amassed over the past 10 years supports a shift to treatment that combines interventions directed simultaneously to both conditions- that is, severe mental illness and substance abuse-by the same group of providers....but access to such treatment remains limited...”

(U.S. Department of Health & Human Services, Mental Health: A Report of the Surgeon General, Rockville, MD, 1999: pp288-289)

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

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

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

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

Illinois has undertaken two initiatives in the last eight years to address the impact of Autism Spectrum Disorder (ASD). The Illinois General Assembly commissioned The Autism Program (TAP), which addresses the needs of ASD-challenged children in the areas of screening, identification, diagnosis, programs and services, workforce development, and research. The second initiative is the Illinois State Board of Education's (ISBE) sponsorship of the Illinois Autism Technical Assistance and Training program, which provides professional development and training to local school districts and special education cooperatives. ISBE has also sponsored Giant Steps, a school program with a professional best practices curriculum for ASD challenged children. Additionally, the IDHS has sponsored the Early Intervention Program (EI), which provides services to children birth to three years of age.

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

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

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

Relationship of the DMH to the Illinois Departments and Organizations.

Illinois Housing Development Authority

Activities Related to Housing

The availability of adequate, safe, affordable housing is a necessary component of a comprehensive community support system. The DMH, through its Comprehensive

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

Housing

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

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

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

Extensive training will be provided to selected DMH staff who will serve as Housing Coordinators (one for each Region). These Coordinators will have the task of working

with developers and provider agencies to set up the needed financing. Local offices of HUD, Federal Home Loan, the Illinois Department of Commerce and Economic Opportunity (DCEO), and other sources will be incorporated in actualizing the direction to achieve this reality. Additionally, Bridge Rental Assistant dollars will be identified to subsidize rents for consumers. Consumers will be required to commit up to 30% of their income for rent, in accordance with HUD standards.

Illinois Department on Aging

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

Illinois Department of Public Health and

Illinois Department of Healthcare and Family Services

Mental Health Issues in Long Term Care

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

The “Money Follows The Person” Initiative

Illinois will receive an estimated \$55.7 million in new federal funding over five years to help people living in nursing facilities return to their homes or a community residence. The “Money Follows the Person (MFP)” grant will facilitate the transition of approximately 3500 persons into their communities over the course of five years. In addition to the federal award, the state has also committed \$23.8 million to this expansion of home and community-based services. The Department of Healthcare and Family Services, the lead agency for the initiative, is working closely with IDHS, Department on Aging, and the Illinois Housing Development Authority on the project. The Secretary of

IDHS announced that this new funding will greatly expand and enhance the department's services and programs to help more people with severe mental illness, developmental disabilities and /or physical disabilities residing in long term care return to their home and community. She emphasized IDHS commitment to maximizing this funding in support of the goals of consumer self-direction, independence and community reintegration. Programs under the MFP grant are designed to: (1) Eliminate barriers or mechanisms that prevent Medicaid-eligible individuals from receiving support for appropriate and necessary long-term services in the setting of their choice; (2) Increase the ability of the state Medicaid program to assure continued provision of home and community based long term care services to eligible individuals who choose to move from an institutional to a community setting; and (3) Ensure that procedures are in place to provide quality assurance for individuals receiving Medicaid home and community -based long-term care services and provide for continuous quality improvement in these services.

Mental Health and the Justice System

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

Illinois Department of Corrections
Illinois Department of Juvenile Justice (Established in FY2006)
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).

The following four initiatives are highlighted as these clearly demonstrate leadership and an increasing clinical role in serving individuals with mental illnesses who have been adjudicated in the criminal courts:

The Jail Data Link Project

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

Rockford Crisis Services Collaborative

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

The Mental Health Juvenile Justice Initiative

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

Law Enforcement and Crisis Intervention Training

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

Illinois State Board of Education

Chicago Public Schools

DMH and the Education System

The DMH has pursued the Positive Behavioral Interventions and Supports (PBIS) model of collaboration between education and mental health primarily through work on the

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

Illinois

Child - Overview of State's Mental Health System

Child - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

Overview of the State's Mental Health System

The Mental Health System at the State Level

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

It is the vision of the Division of Mental Health that all persons with mental illnesses recover and are able to participate fully in life in the community. Within available fiscal resources, the priority for DMH is to provide access to clinically appropriate, effective and efficient mental health care and treatment for individuals who have serious mental illnesses and who have limited social and economic resources. Planning and budgeting decisions are guided by the basic principle that individuals will receive services in the least restrictive, most clinically appropriate environment, with the best quality of recovery-oriented and evidence-based treatment and care possible. The administrative offices of the Division of Mental Health are based in Springfield and Chicago. Statewide efforts to maintain and improve the system of care are coordinated through the Central Office. Planning and program implementation are accomplished in conjunction with regional administrators. The Central Office is responsible for oversight of the system, policy formulation and review, the operation of nine state hospitals, planning, services evaluation, and allocation of funds. Interagency collaborative efforts and leadership in initiatives such as activities related to transformation, consumer participation/involvement, the promotion of evidence-based practices, the planning of clinical services, forensic services, and child and adolescent services are carried out by statewide administrative staff. There are 70.5 FTE positions in Central Office available to accomplish the manifold tasks required of it.

Illinois

Child - Summary of Areas Previously Identified by State as Needing Attention

Child - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

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

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

Consumer Participation and Involvement

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

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

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

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

C&A Services focused on family participation by increasing the availability of family resource developers (FRDs) and the advisory role of youth who utilize or have utilized services. Of the 54 agencies providing SASS services, only three of the agencies have never hired a FRD. There is generally a modest level of turnover in the FRD staff, and at the point that the FY 2007 FRD survey was conducted 41 of 49 reporting agencies (84%)

had FRDs employed. Thirty-one (76%) were FTE positions. Monthly meetings are held for the FRDs in order to provide education, resource development and support for the positions. FRDs from the Federal Systems of Care demonstration grants also attend these meetings. The survey results could not specify the number of positions that were FY 2007 new hires. Some agencies have expanded the support role and are using FRDs to assist with Individual Care Grant application processes and service planning. Each System of Care site has emphasized the importance and hiring of FRDs.

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

Evidence-Based Practices

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

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

Systems Integration

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

Division of Rehabilitation Services' continue its collaboration the 'Brand New Day Initiative' and the provision of Benefits Planning, Assistance and Outreach Project funded by the Social Security Administration. DMH collaborates with the City of Chicago Mayor's Office for Persons with Disabilities on the latter initiative. There is also continuing collaborative work with the Department on Aging on joint training and advocacy programs.

Program Enhancement

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

Service Administration

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

Information Technology

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

Grants

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

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

In FY 2006, a new award was made by SAMHSA to expand System of Care principles and practices to McHenry County, thus providing the opportunity to expand the System

of Care model to other areas in Illinois. The grant was awarded in October, 2005, and the project has shown rapid development. Family CARE stands for Child/Adolescent Recovery Experience and is a \$9 million, six –year federal grant designed to involve families and youth in decision making related to treatment, goal-setting, designing and implementing programs, monitoring outcomes and determining the effectiveness of efforts that promote the well-being of children and youth. The grant is designed to improve access to services for 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. Family Resource Developers have been hired through the grant to assist and support families navigating mental health and education systems. across the county. A variety of committees have been meeting with the aim of involving agencies, clinicians, school administrations, families and youth in designing effective mental health services which build on the strengths of consumers and address cultural and linguistic needs. The Governance Council includes professionals, family members and youth which will ensure that the project is family driven, youth guided, culturally competent, and able to shape policies and strategies to improve mental health care and develop a comprehensive system of care for McHenry County. Staff have been hired and extensive community input was solicited and incorporated into design changes. The team obtained a suicide-prevention grant from another source to provide suicide-prevention training for system of care families, youth, and partners. This project will also focus on promoting Evidence Informed Practices as it continues to develop.

Illinois

Child - New Developments and Issues

Child - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

New Developments and Issues Affecting Mental Health Service Delivery

Mental Health Transformation

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

The Fiscal Integrity of the Public Mental Health Service System

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

System Restructuring Initiative (SRI)

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

Administrative Services Organization

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

- Promote recovery, resiliency, and self-determination for consumers through services based on principles of consumer choice, high quality biopsychosocial assessment and individualized treatment planning, and by implementation of consumer communication, maintenance of a consumer handbook, and a measurable commitment to meaningful consumer leadership within daily operations.
- Improve provider clinical and administrative practices in documentation, appropriateness of service provision (including coordination across providers) and valid claims submission.
- Promote best practices through an utilization management program, system-wide quality management processes, implementation of consumer perception of care surveys and complaint/grievance procedures, and ongoing evaluation of all aspects of the work performed.
- Facilitate the development of the provider system, including but not limited to the following: provider relations functions, provider training and technical assistance, publishing and maintaining a provider manual and provider directory, provider contract monitoring, and provider satisfaction surveys.
- Through contract monitoring, service authorizations, and other appropriate mechanisms, ensure that service resources are distributed statewide and within each service region in appropriate proportion to the distribution of the DHS/DMH priority populations and their clinical needs.
- Coordinate and administer all aspects and mechanisms which are necessary to implement and optimize fee-for-service financing while minimizing clinical risk to consumers and promoting financial viability and service capacity of providers. Implement fee-for-service mechanisms in accordance with the DHS/DMH coordination of benefits policy.
- Coordinate and administer all non-fee-for-service financing mechanisms and service reporting and incorporate mechanisms to accommodate any provider pooled loan payments.
- Design and implement consumer enrollment processes and procedures which ensure that DHS/DMH funding is used only for rehabilitative or medically necessary services for DHS/DMH priority populations.
- Design and implement efficient and effective mechanisms for provider claims submission, validation, processing, adjudication, and payment.
- Implement a state-of-the-art management information system (MIS) which supports the preceding objectives through: reliable, valid, and expeditious data transmission among all appropriate federal, state, and local entities;

efficient and accessible data storage/warehousing/access; and HIPAA compliant procedures and processes throughout the system.

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

Anti-Stigma Campaign

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

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

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

Illinois

Child - Legislative Initiatives and Changes

Child - Legislative initiatives and changes, if any.

Legislative Initiatives And Changes

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

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

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

Moving from Institution to Community: Leadership in Olmstead Activities

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

Illinois

Child - Description of Regional Resources

Child - A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

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

Community services are considered the cornerstone of the mental health delivery system. Services provided and purchased by the DMH are geographically based. The DMH is organized into five Comprehensive Community Service Regions (CCSRs).

Through these Regions, the DMH operates state hospitals and contracts with 151 community mental health providers across the state. The DMH continually seeks input from consumers, family members, advocates, and representatives of public and private organizations through the framework of the Illinois Mental Health Planning and Advisory Council (IMHPAC) to aid in planning efforts. Comprehensive Community Service Regions are charged with the responsibility for managing care, developing the capacity and expertise of providers, monitoring service provision and increasing the quality and the quantity of participation from persons who receive mental health services. Two Regions are located in the Chicago Metropolitan area and surrounding suburbs, and three Regions cover the central, southern and metro-east southern areas of the State. Administratively, each Region has an Executive Director, a lead Clinical Director, a lead Recovery Services Development Specialist, and a Coordinator of Forensic Services. Child and Adolescent Service expertise is provided to Regional staff by statewide C&A Services staff who are centrally located.

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

Illinois

Child - Description of State Agency's Leadership

Child - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

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

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

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

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

IDHS Service Areas

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

DMH and the State Welfare Program

In an ongoing effort to address issues that may provide barriers to work readiness, the DMH and the DHCD work together in establishing and managing liaison relationships between local community mental health centers and local IDHS offices. The aim is to identify customers of IDHS who may be in need of mental health services (screening, assessment, and treatment). Statewide, DMH funds eleven community mental health provider agencies with General Revenue Funds (GRF) to provide for a full or half time Qualified Mental Health Professional (QMHP) staff position onsite at eleven designated

IDHS Family Community Resource Centers. Of these, six DHCD offices located in the Metro Chicago area have a full-time QMHP, one has a part-time QMHP, and four offices in downstate Illinois have the presence of a part-time QMHP. Paralleling this co-location is a statewide collaborative effort involving 97 DMH-funded mental health centers that have liaison relationships with the remaining local DHCD offices. These liaisons have a presence in IDHS offices for a minimum of four hours a month, or may be present for more hours if mutually agreed by the DCHD Local Office Administrator and the mental health center's administrative designee. Currently, each DHCD office has a liaison assigned to interface with the mental health center administration.

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

DMH Work with Community Health and Prevention

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

- A statewide perinatal mental health consultation service has been established for providers to use when a screening indicates that a pregnant or postpartum woman may be suffering from depression. This service is accessed by a toll free number and provides consultation with psychiatrists, information about medications that may be used in the management of perinatal depression during and/or after pregnancy, and referral and linkage to available mental health resources.
- Early Intervention Services 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; psychosocial development; and self-help skills. Evaluations and assessments are provided at no cost to families. Families with eligible children receive an Individualized Family Service Plan (IFSP) which lists the services and supports which must be made available to the family.
- The Domestic Violence and Mental Health Policy Initiative (DV/MHPI), funded by a contract with CMHS and supported by private foundations, is assisting DMH and CHP staff in research and training related to domestic violence. The DMH and the DCHP serve on a governance committee for DV/MHPI along with other child-serving agencies throughout the State. Both the DMH and the DCHP provide technical assistance to the DV/MHPI initiative. The DMH participates with the DCHP in other domestic violence treatment and prevention activities.
- DMH staff continues to participate in the DCHP Healthy Child Care Illinois (HCCI) initiative serving on its governance and planning committee. The DMH serves as the technical advisor on children's mental health issues.

Alcoholism and Substance Abuse. The Division of Alcoholism and Substance Abuse (DASA) administers and monitors funding to a network of community-based substance abuse treatment programs. These programs provide a full continuum of treatment

including outpatient and residential programs for persons addicted to alcohol and other drugs.

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

The Report of the Surgeon General on Mental Health, published in 1999, based on an extensive literature review of relevant and timely research, clearly stated that: “ As many as half of people with serious mental illnesses develop alcohol or other drug abuse problems at some point in their lives....Theories to explain co-morbidity (also known as dual diagnosis) range from genetic to psychosocial, but empirical support for any one theory is inconclusive. In short, the cause of such widespread co-morbidity is unknown. Co-morbidity worsens clinical course and outcomes for individuals with mental disorders. It is associated with symptom exacerbation, treatment noncompliance, likelihood of suicide, incarceration, family friction, and high service use and costs.....Furthermore, patients may be jeopardized by the consequences of substance abuse, namely, increased risk of violence, HIV infection, and alcohol- related disorders. Research amassed over the past 10 years supports a shift to treatment that combines interventions directed simultaneously to both conditions- that is, severe mental illness and substance abuse-by the same group of providers....but access to such treatment remains limited...”

(U.S. Department of Health & Human Services, Mental Health: A Report of the Surgeon General, Rockville, MD, 1999: pp288-289)

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

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

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

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

Illinois has undertaken two initiatives in the last eight years to address the impact of Autism Spectrum Disorder (ASD). The Illinois General Assembly commissioned The Autism Program (TAP), which addresses the needs of ASD-challenged children in the areas of screening, identification, diagnosis, programs and services, workforce development, and research. The second initiative is the Illinois State Board of Education's (ISBE) sponsorship of the Illinois Autism Technical Assistance and Training program, which provides professional development and training to local school districts and special education cooperatives. ISBE has also sponsored Giant Steps, a school program with a professional best practices curriculum for ASD challenged children. Additionally, the IDHS has sponsored the Early Intervention Program (EI), which provides services to children birth to three years of age.

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

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

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

Relationship of the DMH to the Illinois Departments and Organizations.

Illinois Housing Development Authority

Activities Related to Housing

The availability of adequate, safe, affordable housing is a necessary component of a comprehensive community support system. The DMH, through its Comprehensive

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

Housing

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

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

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

Extensive training will be provided to selected DMH staff who will serve as Housing Coordinators (one for each Region). These Coordinators will have the task of working

with developers and provider agencies to set up the needed financing. Local offices of HUD, Federal Home Loan, the Illinois Department of Commerce and Economic Opportunity (DCEO), and other sources will be incorporated in actualizing the direction to achieve this reality. Additionally, Bridge Rental Assistant dollars will be identified to subsidize rents for consumers. Consumers will be required to commit up to 30% of their income for rent, in accordance with HUD standards.

Illinois Department on Aging

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

Illinois Department of Public Health and

Illinois Department of Healthcare and Family Services

Mental Health Issues in Long Term Care

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

The “Money Follows The Person” Initiative

Illinois will receive an estimated \$55.7 million in new federal funding over five years to help people living in nursing facilities return to their homes or a community residence. The “Money Follows the Person (MFP)” grant will facilitate the transition of approximately 3500 persons into their communities over the course of five years. In addition to the federal award, the state has also committed \$23.8 million to this expansion of home and community-based services. The Department of Healthcare and Family Services, the lead agency for the initiative, is working closely with IDHS, Department on Aging, and the Illinois Housing Development Authority on the project. The Secretary of

IDHS announced that this new funding will greatly expand and enhance the department's services and programs to help more people with severe mental illness, developmental disabilities and /or physical disabilities residing in long term care return to their home and community. She emphasized IDHS commitment to maximizing this funding in support of the goals of consumer self-direction, independence and community reintegration. Programs under the MFP grant are designed to: (1) Eliminate barriers or mechanisms that prevent Medicaid-eligible individuals from receiving support for appropriate and necessary long-term services in the setting of their choice; (2) Increase the ability of the state Medicaid program to assure continued provision of home and community based long term care services to eligible individuals who choose to move from an institutional to a community setting; and (3) Ensure that procedures are in place to provide quality assurance for individuals receiving Medicaid home and community -based long-term care services and provide for continuous quality improvement in these services.

Mental Health and the Justice System

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

Illinois Department of Corrections
Illinois Department of Juvenile Justice (Established in FY2006)
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).

The following four initiatives are highlighted as these clearly demonstrate leadership and an increasing clinical role in serving individuals with mental illnesses who have been adjudicated in the criminal courts:

The Jail Data Link Project

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

Rockford Crisis Services Collaborative

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

The Mental Health Juvenile Justice Initiative

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

Law Enforcement and Crisis Intervention Training

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

Illinois State Board of Education

Chicago Public Schools

DMH and the Education System

The DMH has pursued the Positive Behavioral Interventions and Supports (PBIS) model of collaboration between education and mental health primarily through work on the

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

Illinois

Adult - Service System's Strengths and Weaknesses

Adult - A discussion of the strengths and weaknesses of the service system.

SECTION II: IDENTIFICATION AND ANALYSIS OF SERVICE SYSTEM STRENGTHS, NEEDS AND PRIORITIES

Organization of Section II

The organization of this Section for submission using WEBBGAS software is as follows. The full text for the Adult Services Section has been entered under Strengths and Weaknesses of the Service System. Excerpts from this text have also been copied and inserted under WEBBGAS Headings: Unmet Needs, Plans to Address Unmet Needs, Recent Significant Achievements and the State's Vision for the Service System.

A. ADULT SERVICES

Criterion I: The Comprehensive Community Based Mental Health System
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Organizational Structure of the Illinois System of Care

Overview

Illinois has made substantive progress in developing a comprehensive mental health service system for individuals with serious mental illnesses (SMI) and for youth with serious emotional disturbances (SED) and their families. Illinois envisions a well resourced 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 "The Expectation of Resilience and Recovery through Treatment, Accountability and Equal Access". Many of the activities in which the DMH is engaged are providing the foundation to make this vision a reality.

Organization of the Comprehensive System.

DMH services are organized around five geographic Comprehensive Community Service Regions (CCSRs) responsible for contracting activities with 151 community-based outpatient/rehabilitation agencies and 27 local hospitals statewide that provide psychiatric programs, and for oversight of public inpatient beds in nine state operated facilities. The CCSRs are also responsible for integration of a comprehensive care system which 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; today more than 60% of DMH expenditures are allocated for community-based services. In FY 2006, the DMH purchased community based services for more than 150,000 individuals and provided state hospital services for 11,000 individuals.

Available Services and Resources in the Comprehensive System of Care

Health, Mental Health and Rehabilitation Services

Health Services

“There is no Health without Mental Health” has been the slogan of the Division of Mental Health for the past seven years. The diagnosis and treatment of mental disorders is inextricably woven into the broader context of an individual's physical health. Physicians in general practice are very likely to be the access and linkage point for psychiatric services, especially for persons suffering with depressive and anxiety disorders. On the other hand, psychiatrists must be cognizant of the medical issues being faced by the patients they see and be prepared to refer them for the health care they require. Individuals with serious mental illnesses who are Medicaid recipients are entitled to the range of health services covered in the Illinois Medicaid plan. DMH continues to emphasize the importance of assisting adult consumers in the completion of an application for Medicaid services as one means of assuring that access to health services are available. DMH has focused on the establishment of relationships between Federally Qualified Health Centers (FQHCs) and DMH funded community mental health agencies. One such initiative is underway in the Central Region of the state. An initiative recently implemented by the Department of Health Care and Family Services (DHFS) follows a Disease Management model. Illinois Health Connect is a statewide Primary Care Case Management (PCCM) Program for most persons covered by DHFS medical programs. People who are enrolled in Illinois Health Connect will have a “medical home” through a Primary Care Provider who will coordinate and manage their care. This program will benefit many consumers of public mental health services both children and adults. Additionally, a second program, Your Healthcare Plus employs health care teams to assist with problems of chronic diseases including mental illness and uses an “action planning” approach to help consumers understand their illness, how to cope with it and work constructively with their doctors.

The Array of Core Mental Health Services

The array of core mental health services purchased on behalf of Illinois citizens with mental illnesses are described in the DMH Mental Health Program Book which is posted on the DMH website (www.dhs.state.il.us/mhdd/mh/policy/programbook/). The services are based on the tenets of the Community Support Program (CSP) and Child and Adolescent Support Services (CASSP) models. Each core service description contains the following: Definition, Purpose, Eligibility Criteria, Service Elements and Standards. Services are organized into three program levels: Acute Care Program, Mental Health Treatment Services and Rehabilitation and Support Program. The following is a brief summary of the core services.

Acute Care.

Acute Care Program services provide a rapid response to individuals in a mental health crisis, to members of the individual's support system, and the community on a 24-hour a day basis. Such services are intensive, short-term and are oriented toward stabilization of the individuals' condition and management of disruptive and life threatening symptoms. Services include crisis-emergency services (e.g. mobile, walk-in and telephone response, crisis residential services and hospital-based services).

Mental Health Treatment - Outpatient

These core services are delivered to consumers who have been determined on the basis of a mental health assessment to have a mental illness or emotional disturbance with significant impairment in role functioning. Outpatient services that are intended to reduce psychiatric symptoms and promote adaptive functioning are based on an evaluation of an individual's mental health service needs and an individual treatment plan (ITP) that is monitored, reviewed, and modified as needed on an ongoing basis. These services include:

- Assessment, Treatment Planning and Monitoring;
- Counseling and Therapy Services;
- Psychiatric Services:*
- Medication-related Services; and
- PAS/MH Services (Long Term Care screening and assessment service).

Psychiatric Services*

Psychiatric Services are a primary core service in mental health treatment programs. It is noteworthy that block grant dollars allocated to Illinois have largely been directed to improving the quality and availability of this vital clinical service through further infrastructure development. This initiative was one of the three top priorities to increase access to quality psychiatric services in areas of critical need cited by the Illinois Mental Health and Planning Advisory Council (IMHPAC) for both adults and children. Substantive progress has been made in actualizing this initiative. Funds are being used in recruitment and retention of qualified psychiatrists, and to further collaboration with

medical schools.

Rehabilitation Core Services

Rehabilitation core services which are funded include:

- Psychosocial Rehabilitation,
- Assertive Community Treatment (ACT).
- Community Support and Case Management
- Client Transitional Subsidy; -a temporary short-term assistance for medication, clothing and housing support in order to facilitate a consumer's resettlement in the least restrictive, community integrated setting possible.
- Transition to Adult Services, and
- Residential Support Services- for promoting community adjustment and long-term recovery and relapse prevention.
- Residential services -including supported residential and supervised residential services.

Additional Support Services Funded and Provided through DMH:

Psychiatric Medication provides resources for psychiatric medications primarily to adults with serious mental illnesses or children/adolescents with serious emotional disturbance who have insufficient insurance coverage or private resources to pay for them. Three (\$3) million in General Revenue Fund (GRF) has been budgeted yearly to increase accessibility to psychiatric medications. The program emphasizes persons discharged from hospitals and waiting for Medicaid reinstatement, SSI/SSDI applicants waiting for initial Medicaid or All Kids eligibility determination, or applicants for pharmaceutical indigent programs awaiting access. The priority is to access the medications, which produce the most favorable clinical outcome as determined by the treating psychiatrist.

Community Integrated Living Arrangements provide a funding mechanism for an individually-tailored array of supportive services for individuals residing under the supervision of the service provider which promotes residential stability for an individual who resides in his or her own home or in the natural family home.

Emergency Psychiatric Services are provided through a hospital-based service model and include, emergency room psychiatric consultation and assessment activity, crisis/observation beds, transportation, emergency purchase of medications (short term), partial hospitalization, and inpatient hospitalization.

Community Psychiatric Hospitalization provides inpatient psychiatric hospitalization in a community hospital for persons experiencing acute psychiatric conditions.

Employment Services

Supported Employment Services are based on the financial and service integration of DRS funded vocational services and resources with DMH funded mental health treatment

and supportive services. DMH and the DHS Division of Rehabilitation Services (DRS) have collaborated closely in a joint effort - "The Brand New Day Initiative" - to increase access to vocational rehabilitation services including supportive and subsidized 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 collaboration addresses the needs of both adults and youth.

Supported Employment is an evidence-based practice shown to improve employment rates of persons with serious mental illness by as much as 60%. DHS currently has two grants to implement this model in Illinois: a NIH grant to address state infrastructure issues and a Johnson & Johnson/Dartmouth Community Mental Health Program Grant to supports implementation at 4 pilot sites.

Eleven mental health agencies, in partnership with their local DRS offices, are piloting the implementation of Evidence-Based Supported Employment (EBSE). From September 1, 2006 to March 31, 2007, 909 people received EBSE. During that time 34% of them worked in a competitive job resulting in over 17,000 days of employment during this 6 months period. (Some data for the first quarter of 2007 has yet to be reported.) The DMH tracks employment status of adults seeking community mental health services on an on-going basis (**see system performance indicators A1.4 and A1.5**).

A project which addresses both housing and employment is The Corporation for Supportive Housing - Stepping Up Strategy Panel, a Department of Labor (DOL) grant to develop career ladders for supported housing tenants who are employed and in poverty. The DRS has worked with the DOL and Wright City College to develop supported education, job placement, and support opportunities for persons with severe mental illness and other disabilities in the Chicago area that have trouble maintaining stable housing. The five year grant is coming to an end in September of this year. It has resulted in a solid curriculum developed by Wright City College which may be disseminated for use in community colleges to support career development.

Housing Services for Adults

Illinois has been consistent in efforts to develop housing options and support services for individuals with serious mental illness. Substantial portions of block grant funding are allocated for the provision of supervised and supportive residential services. Community supports range from in-home help for families, to community integrated living arrangements where people share a home with services individually tailored to their needs, or independent apartments with supervisory support. Supported and supervised residential programs offer skills training, counseling and other supports to assist individuals with psychiatric disabilities in maintaining a stable living arrangement.

The Legislature has steadily increased the State's commitment to housing for persons with mental illnesses. In FY2005, DMH received an allocation of \$4.7 million for "Supportive Mentally Ill Housing" and a \$250,000 Legislative Award to develop a Pilot

in the Chicago Metropolitan area to be used as a catalyst and model. That year, the DMH contracted with 34 community-based agencies to serve 1,232 persons with disabilities, who were formerly homeless, providing them with affordable housing and supportive services. In FY 2006, there was additional Supportive Mentally Ill Housing funding appropriated by the Legislature to bring the total for this specific Appropriation to \$6,150,000 which allowed contracts with 13 supportive housing providers for new supportive housing services to an additional 279 individuals. In FY 2007, another \$4.3 million was added bringing the total appropriation for the year to \$10.5 million to address the addition of 11 new supportive housing projects that provided supportive housing services to at least another 134 Division of Mental Health consumers. In FY2008, \$3.9 million additional dollars will bring this initiative to a projected \$14.5 million appropriation. These new funds will provide for an additional 12 DMH supportive housing projects statewide that will serve 263 new consumers. DMH also undertook a new initiative to develop strategies to implement a Permanent Supported Housing Model (PSH) in collaboration with a wide array of partners. Beginning in FY2008, any expansion in DMH housing options will focus on the Permanent Supportive Housing (PSH) model. Further expansion of the old model of supervised and supported residential programs is not planned.

Each DMH Region has developed a Comprehensive Housing Development Action Plan. Updates to the Region's Comprehensive Housing Development Action Plan are made annually which includes objectives and methods for leveraging available local, county, and federal resources for low income affordable supportive housing options for persons with psychiatric disabilities. As part of the planning, the Regions regularly convene a housing committee that includes representatives of consumers, service providers, potential local partners, and other concerned entities to discuss housing development as a local community initiative. Housing status is tracked on an on-going basis by DMH (see system performance indicator A1.6).

Educational Services

Educational services in the form of stipends and scholarships for college, trade school, and vocational training are available through DRS and facilitated by mental health providers. Consumers receive support through Psychosocial Rehabilitation and Care Management in pursuing the completion of basic educational requirements (e.g., GED) and other available programs through local public school systems. In FY-2005, FY 2006, and FY 2007, DMH has continued to emphasize consumer and family education and this will continue in FY2008 through a variety of educational activities. A new law establishes uniformity in the School Code making students with disabilities statewide eligible to receive special education services up until the day of their 22nd birthday. This will be particularly helpful to transitioning youth.

Substance Abuse Services

Services for persons with substance use problems are provided by community-based substance abuse treatment programs which are funded through the DHS Division of Alcoholism and Substance Abuse (DASA). These programs provide a full continuum of

treatment including outpatient and residential programs for persons addicted to alcohol and other drugs.

Services for Co-Occurring Substance Abuse and Mental Health Disorder (MISA)

Many adults with serious mental illnesses have co-occurring mental health and substance abuse disorders. In Illinois, substance abuse, particularly, has been a primary presenting problem for nearly half of the individuals admitted for treatment in DMH state hospitals. Although data submitted by providers to the DMH reporting of community services (ROCS) system showed that close to 12% of consumers seeking services having a co-occurring substance abuse diagnosis (See System Performance Indicator A1.9), related research suggests that a much higher proportion of persons with mental illness also have substance use problems. The collaboration of DMH and the DASA to meet the needs of this population were previously described (Section I). DMH and DASA continue to work with the five geographic MISA consortiums that were established in FY 2003. The consortiums meet quarterly at a minimum to problem-solve and develop strategies to meet the needs of individuals with co-occurring disorders. Collaboration has continued on co-location projects in which DASA funded agencies work on site at DMH state hospitals to screen, assess, consult and treat MISA clients. At discharge, efforts are undertaken to transition them to appropriate community-based mental health and substance abuse services, including integrated dual diagnosis treatment (IDDT) services where available. DMH continues to participate in the SAMHSA Co-Occurring Policy Academy and works with DASA and other DHS resources to meet the requirements of the Training and Evaluation Grant funded by SAMSHA CMHS to implement integrated dual diagnosis treatment (IDDT).

Medical and Dental Services

Adults with serious mental illnesses access the same medical and dental care services available to the general population through the service coordination functions provided in case management and therapeutic services. DMH is addressing issues in primary health care with a special emphasis on the relationship between primary health care and mental illness. Adults with mental illness often have neither the insurance nor the financial means to cover their healthcare costs. Assistance is usually provided to them in applying for Medicaid. Those who are Medicaid eligible benefit from the medical services and programs provided through the Department of Healthcare and Family Services (DHFS) which were described above. For hospitalized patients, this process is begun as close to admission as possible. In a continued effort to find resources for patients who are in the community, DMH has produced a resource manual that community providers can utilize to access entitlement supports, Medicaid benefits, and vocational services for the DMH target population.

In addition to treating consumers for their acute psychiatric conditions, DMH state hospitals employ primary care physicians who provide basic general health care. All State Hospitals are required to provide dental screening exams and basic dental care to their inpatients. They do so either by directly employing dentists who work at the hospitals or via a contractual arrangement with an independent provider. Metabolic

Syndrome screens are taking place statewide in state hospitals to identify individuals who may have diabetes.

Integration of primary medical care and behavioral health care is increasing in importance and is being energized by federal funding initiatives. DMH staff continue to explore options for collaboration with the Health Resources and Services Administration (HRSA) funded Federally Qualified Health Centers (FQHCs) in Illinois. The DMH Central Region established an initiative to facilitate dialogue and collaboration between CMHCs and the FQHCs in that Region of the state. Several CMHC'S are participating in this effort and collaboration has continued in the past three years.

Support Services

Effective mental health services across Illinois require the integration of local community-based services from a variety of sources. The development of local networks of service providers has been instrumental to improve this integration. Many of the local networks have representatives from local housing, public health, vocational development, and medical care as a part of their memberships.

IDHS provides an extensive range of services that are available to adults with serious mental illnesses. Liaisons have been developed between local community mental health centers and local IDHS offices for the purpose of facilitating consumer entitlements and identifying those IDHS clients who are in need of assistance in accessing mental health services.

The Home-Based Support Services Program, which is legislatively mandated, provides reimbursement for support services to adults with serious mental illnesses (SMI) or DD; requests must be approved by a Service Facilitator and by IDHS program staff. The statute requires SSI/SSDI disability status as a condition of application and states that those program resources are not intended for services, which are available through other programs or entitlements. Selection for the program is by application and random selection. The program currently serves more than 100 adults with SMI.

GAPS Work Incentive and Planning Assistance Project. To assist in supporting entitlements for mental health consumers, when the Illinois Guidance, Assistance, and Planning Services (GAPS) Project that was funded through the Social Security Administration through 2006 expired, DMH applied for and received a new Work Incentives Agreement funded by the Social Security Administration, which began in October 2006. This agreement funds benefits planning and assistance for persons with disabilities receiving SSI/SSDI and their beneficiaries. The primary goals of the project are to provide (1) accurate information regarding state and federal benefit and work incentive programs; (2) assistance in interpreting and applying this information so that they can make informed decisions regarding employment; (3) to provide technical assistance on benefit planning strategies to service providers and advocates working with persons with disabilities; and, (4) activities with SSI/SSDI recipients regarding the availability of benefits planning and assistance services presented in "lay terms" that are

non-technical and culturally sensitive. DMH GAPS Program services are being provided to persons in suburban Cook County and more than 40 counties across Illinois.

Services provided by local school systems under the Individuals with Disabilities Education Act

Local school systems provide special education and a range of related support services to students with disabilities over the age of 18. Mental health and transitional services include but are not limited to counseling, adapted driver education, parent counseling, psychiatric, psychological and social work services, behavioral intervention planning, transitional services through the STEP program, career and technical education, competitive and supportive employment, interagency linkages for social services, and supports for transition to post-secondary (college) education. Since the same student can use several services, the Illinois State Board of Education (ISBE) uses a point-in-time count to reach an unduplicated total. Based on the data provided by local school districts for the 2005-2006 school year, as of December 1, 2005, at least one of the above services was provided to 1517 students in the Emotional Disability category who were over the age of 18 years, 277 such students in the Autism category, and 58 students over 18 in the TBI Disability category.

Case Management Services

In Illinois, Case Management is a required service for adults with serious mental illnesses who receive substantial services through the public mental health system. It is pivotal to hospital-community linkages and in providing continuity of treatment and supportive services in the community. Due to DMH's early adoption of the Community Support Program and CASSP models, for which Case Management is the critical "hub of the wheel" of services, Case Management services have been continually available in Illinois as a core service, and efforts are made to track service delivery on an on-going basis (**see system performance indicators A1.10—and A1.11**). Continuity of Care Agreements (COCA) between community mental health providers and state hospitals outline assurances of coordinated service approaches by clinicians from both settings who are knowledgeable and attuned to the needs, strengths, and weaknesses of the consumer, the consumers' support networks, and the environment. It is required that care management assignments be solidified during the inpatient treatment process, with face-to-face linkage occurring within seven days post discharge. Compliance with the COCA requirements in discharge, linkage, and face-to-face engagement is monitored by CCSR. Increasing the availability of services to support continuity of care for persons discharged or triaged from state hospitals and increasing the capacity of ACT programming through Medicaid Reimbursements have been priorities in recent years. Two types of case management services assure continuity of care tailored to individual needs:

- **Case Management** includes a variety of case management programs for consumers with special needs (e.g. hearing impaired, homeless, dually diagnosed etc.) and other consumers identified as requiring ongoing support, coordination of multiple service providers, and periodic outreach to maintain service linkage and stability in their community. Clients are provided with identified persons who

maintain supportive contact, help them with practical problems, and assist them in accessing services.

- **Assertive Community Treatment (ACT)/ Intensive Case Management** is the third and most intensive specialized model of service whereby a tightly-knit team of mental health professionals takes full responsibility for a small group of adult clients' day-to-day living and treatment needs.

Both these levels of case management provide sustaining services and activities including assertive outreach, sustained efforts to engage individuals, assessment, planning, linkage, advocacy, and assistance with basic needs which include decent housing, income, and medical benefits.

Other Activities Leading To the Reduction of Hospitalization

Historical Reduction of State Hospitals Beds and change in the Utilization of Psychiatric Inpatient Care

Illinois has shared the de-institutionalization experience common throughout the U.S. over the past three decades, including the closure of large state hospitals and the dramatic downsizing of the remaining large older institutions. At the height of the era of institutions in 1940, Illinois state hospitals had a resident population of 55,587. In contrast, the resident population on 6/30/07 was 1373. Significant decreases of admissions in state hospitals are the result of attention to the issue of local area utilization of state hospital resources and continuity of care. The statewide reduction of bed utilization is based upon the principle that reduction must occur within a context that assures that clinically effective care remains continuous and that alternative and supportive community services are in place.

A variety of strategies have resulted in a significant reduction in admissions to state hospitals from 21,393 adults in FY-1987 to slightly more than 11,349 in FY2007. The reduction in admissions has allowed a reduction in the size of all facilities and closure of several with the concomitant increase in the provision of services in the community to persons who would otherwise have been hospitalized in state hospitals. Paralleling the downsizing of state hospitals, and fostering the movement to the community, Illinois has developed a network of community mental health agencies covering all geographic areas of the State. These providers share the goal of providing the necessary basic services to maintain persons with serious mental illness in the least restrictive setting possible. The reduction in admissions and bed utilization since FY-1993 has largely been the result of a continuing impact of a succession of new initiatives.

- **Single Point of Responsibility** for screening of admissions to state hospitals has had the broadest impact in significantly reducing the rate of hospitalization. In FY-1993, Illinois developed a re-conceptualized system for Single Point of Responsibility referred to as Pre-Admission Screening, which was implemented across the State. In FY 2007, the statewide pre-admission screening percentage reported is 92% (**see Performance Indicator A1.12**).

- **Community Based Programs for High Users:** High users (3+ admissions in a year) of psychiatric hospitalization have been targeted since FY-1994 through the implementation of ACT teams in the geographic areas that have the highest concentration of heavy utilization.
- **Building Community Services:** Several initiatives have had a substantial and sustained impact on the public mental health system of care. In FY-1997 through an initial appropriation of \$7,249,000 in General Revenue Funds (GRF), a system of hospital admission screening, linkage case management, intensive case management, Assertive Community Treatment (ACT), and crisis services were expanded in order to intensify community supports. Each Comprehensive Community Region (CCSR) now ensures that a community mental health provider screens consumers prior to admission to state hospitals. When consumers are discharged or triaged from a state hospital they are enrolled with a care management provider to assure linkage to needed treatment and support services. Reductions in state hospital utilization have resulted in funds becoming available for the development of community-based services designed to maintain individuals in the community and to provide inpatient services when required in community hospitals.
- **Entitlements.** A significant factor in avoiding re-hospitalization is assuring the availability of medical and financial support to consumers upon their discharge from the state hospital. DMH has instituted policies to ensure that state hospital staff work with individuals to determine their potential eligibility for Medicaid services and expedite the process to increase consumer access to medical benefits upon discharge from the state hospital. Community mental health agency staff also work with consumers around this issue. There has also been increasing focus on Medicaid eligibility as the DMH payment system transitions from grant-in-aid funding to fee-for-service.

The trend for reduced rates in admissions and census has begun to reverse over the last few years. The number of adults (non-Forensic) admitted to state hospitals in FY-2005 was 9,462--a slight increase from that seen in FY 2004. In FY 2006, the number of admissions was 10,770 persons. In FY 2007, there were 10,668 civil admissions to state hospitals. The median length of stay for the same population has steadily decreased from 19 days in FY-2000 to 10 days in FY2007. Although as noted, there have been slight increases in admission, at the present time, all civil state hospitals are quite small, with some having a census less than 100, and the largest being under 150. For both admissions per 100,000 and beds per 100,000, this places Illinois below the U.S. average.

Services for Persons Involved In the Criminal Justice System

The incarceration of persons with serious mental illness in correctional settings continues to be a matter of increasing concern in Illinois. The DMH serves a forensic population consisting of individuals determined by the court to be unfit to stand trial (UST) or not guilty by reason of insanity (NGRI). According to data reported by DMH community providers, approximately 2% of persons with mental illness see at intake are forensic outpatients, and about 2% have a correctional history. These figures are fairly low. However, mental health staff has estimated that about 10,000 persons with mental illness

are served annually by Creak Hospital at Cook County jail – more than the total number of people served annually by all the Illinois state hospitals combined. This high incidence is part of a continuing and larger national trend for persons with mental illnesses to comprise an increasing proportion of prison inmates and jail detainees. The DMH tracks key system performance indicators related to criminal justice involvement on an on-going basis (**see system performance indicators A.1.7 and A.1.8**). The DMH has several on-going initiatives in the forensic arena, including the Jail Data Link Program and the mental health court collaboration in Rockford that includes diversion, discharge planning and service linkage to Janet Wattles Community Mental Health Center. These programs were described in Section I and they will be highlighted in Section III of the application.

Strengths, Needs and Priorities for the Mental Health Service System

Important strengths of Illinois' community-based mental health system as described under Criterion I include:

- ✓ The array of core services that are available to adults with serious mental illnesses.
- ✓ Commitment to a recovery orientation by mental health system stakeholders.
- ✓ The focus on consumer and family driven care to actualize key goals identified by the President's New Freedom Commission.
- ✓ Commitment to the implementation of evidence-based practices.
- ✓ Consumer involvement in planning, implementing and evaluating initiatives and ongoing activities of the public mental health system is a pivotal strength in the DMH community service system and supports success in inter-agency collaborations. The need to expand these initiatives remains a priority.
- ✓ Efforts to reduce hospitalization have been successful. Screening and crisis services that contribute to this success will remain a high priority for DMH, as will extensive case management services and ACT.
- ✓ Collaborations with other divisions of the IDHS and with code agencies have been a primary strategy for improving and enhancing services throughout the system.

DMH Priorities and Service Needs:

The following are the priorities for enhancing the adult service system in FY2008:

Efforts to facilitate and improve the quality of consumer participation have been of paramount importance in Illinois and are the source of many strengths. The expansion of the scope of consumer and family involvement continues to be a priority.

Consumer participation objectives for FY 2008 support the DMH priority for furthering work on the recovery vision in Illinois.

The expansion of WRAP programs continues to be an important focus. Family involvement in the development and implementation of treatment plans is important.

Access to family psycho-education needs to be increased as part of the broader issue of increasing the availability of evidence-based practice.

Collaborative initiatives which respond to ongoing consumer needs will continue to be a priority. Work with the Department of Corrections, County Jails, and Criminal Justice System, the Divisions of Alcoholism and Substance Abuse on issues related to co-morbid disorders, Rehabilitation in vocational and employment services, and the Department on Aging on the mental health needs of older persons is worthy work representative of these efforts.

Maintaining and enhancing activities aimed at reducing hospitalization such as crisis services, face-to-face screening prior to hospital admission, case management services, including the ACT program, and the development of community-based resources to provide ongoing clinical care and linkages to supportive services in the community remain an important DMH priority.

Transformation Activities in FY2008: Achieving the Promise

Overall, the DMH vision for the community mental health system is one that is oriented towards fostering resilience and recovery, and one that is consumer and family driven. It is our belief that system transformation, as all constructive endeavors, must be based on an assessment of needs, available strengths from which to build and change, and a set of priorities which provide clear direction and lend structure to the process and the activities aimed toward positive results. The Report of the President's New Freedom Commission on Mental Health provides an important foundation for on-going planning efforts in this regard. In Criterion I, the FY2008 plan addresses four of the six New Freedom Commission goals:

Americans understand that mental health is essential to overall health.

Affirming the state's vision of Recovery is an essential feature of this goal. DMH will do this by actively providing recovery oriented training to all interested stakeholders and supporting the role and credentialing of Certified Recovery Support Specialists (CRSS). (See Objective A1.3). DMH is continuing to advance and expand the public awareness campaign to reduce stigma associated with mental illnesses.(See Objective A1.8)

Mental health care is consumer and family driven.

Consistent with the priority noted above, the DMH Office of Recovery Services will continue enhancement of the statewide system to educate consumers of mental health services in leadership, personal responsibility and self-advocacy through participation in Consumer Conferences, the use of Wellness Recovery Action Plans (WRAP), and through the Consumer Education and Support Initiative. (See Objectives A1.1 and A1.2)

Early mental health screening, assessment, and referral to services are common practice.

DMH Forensic Services will continue to expedite, facilitate, monitor and coordinate services to persons with serious mental illnesses in the criminal justice system. Those found unfit to stand trial or not guilty by reason of insanity and treated in state operated mental health facilities require restoration of fitness to conclude court involvement and

reentry to community services at the earliest possible time. Case finding, data coordination, planned linkages and services through Mental Health courts are being advanced to meet the mental health needs of persons detained in county jails and incarcerated in the Department of Corrections. (See Objectives A1.9 through A1.13)

Excellent mental health care is delivered and research is accelerated.

The DMH is continuing its work on advancing evidence-based practice in Illinois: During FY 2008, training and implementation in the use of medication algorithms will be increased and expanded to additional agencies. Coordination of medication algorithms between Community Mental Health Centers and State Operated Hospitals for the purpose of continuity of care will be undertaken for the first time. Consistency in medication management practices can improve patient outcomes in the continuum of treatment that begins in state operated facilities and continues with community mental health providers. An effort will be made to strengthen fidelity and support the provision of ACT services. DMH and DRS are committed to implementing and expanding supported employment. Planning to implement family psychoeducation continues. (See Objectives A1.4, A1.5, A1.6 and A1.7). Joint planning with DASA for services to persons with co-occurring disorders will build upon the lessons learned from the Integrated Dual Diagnosis Treatment (IDDT) project (See Objective A1.14). DMH staff are engaged in active planning to begin implementation of Illness Management and Recovery (IMR) within the state.

Criterion 2: Mental Health System Data Epidemiology
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INDIVIDUALS RECEIVING PUBLICLY FUNDED SERVICES

Prevalence Estimate

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, is estimated that in FY 2007, there were 510,469 adults with serious mental illnesses residing in Illinois.

Definitions of DMH Population Eligible to Receive Services

Descriptive eligibility criteria for core services provided in the Illinois public mental health system have been developed and specified using certain broad clinical-diagnostic categories as well as more specific indicators of need. The concept of “eligible and target populations” demarcates, respectively: A) a broader eligibility definition for the population who meet minimum criteria and may be served and B) a narrower priority or

target population who must be served. The CMHS prevalence estimation methodology seems to overlap the target and eligible population definitions that are currently used by the DMH. While there is a substantive gap between the total prevalence and the annual numbers served, we know that a certain percentage of these individuals may not need or request service in a particular year and an unknown proportion of those who do need service may be served in the private sector. Estimating the size of the non-served portion of the total estimated prevalence is contingent upon the availability of utilization data for privately provided psychiatric services which is not currently available.

Definitions of DMH Eligible and Target Populations

The Eligible Population (Adults and Children/Adolescents):

- Must have a mental illness, defined as “a mental or emotional disorder verified by diagnosis contained in the DSM-IV or ICD9-CM which substantially impairs the person’s cognitive, emotional and/or behavioral functioning, excluding the following unless they co-occur with a diagnosed mental illness: V-codes, organic disorders, psychoactive substance induced organic mental disorders, mental retardation, pervasive developmental disorders associated with mental retardation, and psychoactive substance use disorders.
- Must have significant impairment in an important area of life functioning as a result of the mental disorder identified above and as indicated on the Global Level of Functioning (GAF) for adults and Children’s Global Assessment Scale (CGAS) for children.
- All ages

The Adult Target Population:

- Must be 18 years of age or older.
- Must have a *serious mental illness* (SMI) defined as, “emotional or behavioral functioning so impaired as to interfere with their capacity to remain in the community without supportive treatment. The mental impairment is severe and persistent and may result in a limitation of their capacities for primary activities of daily living, interpersonal relationships, homemaking, self-care, employment or recreation. The mental impairment may limit their ability to seek or receive local, state, or federal assistance with housing, medical and dental care, rehabilitation services, income assistance and food stamps, or protective services”.

Demographic Factors

In Illinois, three major ethnic and racial minority groups represent over 30% of the total population – 15.1% African Americans; 12.3% Hispanic Americans; and 3.4 % Asian American/Pacific Islanders. The DMH Bureau of Strategic Planning, Evaluation and System Analysis continues to evaluate access and utilization of mental health services by specific ethnic groups using data such as that generated for URS Tables 2A and 2B. In recent years, the IDHS has also focused on the segment of the state’s population, which

remains uninsured or under insured without sufficient resources to purchase needed mental health services. An increasingly accepted guide for identifying this segment is the utilization of the 200% poverty level which provides census-based demographic data which assists in targeting service delivery and developing cost models which support a system of care for the neediest persons in the State.

Individuals Receiving Services In FY2007

Information on the number of persons served in FY-2007 is derived from Basic Tables 2A and 2B, which is being prepared for the FY-2007 Uniform Reporting System Tables. National Outcome Measures (NOMs)/Performance Indicators with quantitative targets related to increased access to services are described at the end of Section III.

The number of individuals with Serious Mental Illness (DMH eligible population) reported as receiving services from DMH-funded agencies in FY-2006 was 122,029, approximately 94% of the total number of adults receiving services. FY2007 data is currently being gathered.

Progress In Performance Measurement

The DMH has established reporting requirements and standards for data submission that are incorporated in all DMH funded agencies contracts. Data is submitted to the Reporting of Community Services (ROCS) information system. All data is submitted electronically using one of two mechanisms: (1) DMH developed software -- Reporting of Community Services (ROCS) is available at no cost to community providers or (2) Third Party proprietary software purchased directly from a vendor by community providers. If proprietary software is used, data must be submitted using data reporting standards developed by DMH. DMH regularly obtains downloads from the Illinois Medicaid agency. These service claims data are routinely integrated with the reporting of services otherwise funded by the DMH. Case registration data fields that are part of DMH reporting requirements are formatted to permit integration and matching across services funded by the DMH and the DDD, and they lay the groundwork for future matching with other state agencies, including the DASA, the DRS. Assessments are routinely undertaken to determine when new data elements to support decision-making should be added and when others should be eliminated. DMH has made several modifications over the last few years 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 reporting standards require full reporting of consumer and service data by community providers. Data for consumers receiving treatment in DMH state hospitals are also reported electronically to the DMH Clinical Information System (CIS).

Unduplicating Clients and Tracking Services Across Systems.

In preparation for the move to a fee-for-service payment system, since FY 2006, all individuals seeking mental health services are 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. The RINS will lead to improved tracking of services received by consumers across state systems, as well as increased accuracy in unduplication of consumers receiving services in the mental health system.

Performance Measurement

Data reported to the ROCS and the CIS are used as the basis for computing performance indicators that have been established by DMH to monitor system performance. 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.

DMH staff have successfully participated in federally funded studies and activities related to performance measurement, including the Data Infrastructure Grant opportunities over the years. This included piloting the implementation of MHSIP Consumer Oriented Mental Health Report Card performance measures, the Five State Feasibility Study of Performance Measurement, the Sixteen State Pilot Indicator Study on Mental Health Performance Measures, the State Data Infrastructure Grants, and the current State Data Infrastructure Grants for Quality Improvement.

Strengths, Needs And Priorities

Important strengths of Illinois' community-based mental health system as described under Criterion 2 include:

- ✓ The DMH has an extensive array of computerized information that provides an important resource for analyzing service provision and service needs.
- ✓ Through federally funded studies and DMH initiatives, our databases and analytic capabilities have steadily grown.
- ✓ The Reporting Of Community Services (ROCS) provides data as to the types of services provided, as well as the number of persons served.
- ✓ However, external resources, such as the Data Infrastructure Grant have continued to assist MIS development and system analysis which remain an important DMH priority.
- ✓ Since FY 2006, all individuals seeking mental health services are assigned unique ID numbers which 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. This will lead to improved tracking of services received by consumers across state systems, as well as increased accuracy through the unduplication of consumers receiving services in the mental health system.

DMH Priorities and Service Needs:

The DMH places a high priority on the maintenance and improvement of its management information systems to meet the challenges ahead. This work has been valuably

supported by the requirements and activities undertaken through the Data Infrastructure Grant.

Transformation Activities in FY2008: Achieving the Promise

The Report of the President's New Freedom Commission on Mental Health provides an important foundation for on-going planning efforts in data epidemiology. In Criterion II, the FY2008 plan addresses two of the six New Freedom Commission goals:

Disparities in mental health services are eliminated.

The DMH continues efforts to increase access to services by adults with serious mental illnesses. In FY 2004, 56.1% of adults receiving services met DMH criteria; in FY 2005, the percentage increased very slightly to 56.5% and in FY 2006 it was 56.6%. Data for FY 2007 will be provided in the implementation report. This goal will continue to be pursued in FY 2008. (See Performance Indicator A2.1- Increased Access to Services by the DMH Target Population)

The definition of the DMH eligible population is somewhat broader than the definition for the target population. In FY 2004, 95.3% of adults receiving services met the eligible population criteria, while in FY 2005, the percentage was 94.8%; in FY 2006 there was a slight decrease to 94.2%. FY 2007 data for this indicator will be provided in the implementation report. We will continue to focus on this indicator in FY 2008. (See Performance Indicator A2.2 -Increased Access to Services by the DMH Eligible Population.)

Consistent with this important NFC goal, the DMH is continuing to track data on gender, race/ethnicity, and age as a means discovering, analyzing, and solving disparity issues. (See: Performance Indicators A2.1 (NOM)-Number Of Adults Served By Gender (Access to Services); A2,2 (NOM)- Number Of Adults Served By Race/Ethnicity. (Access to services); A2.3 (NOM)-Number Of Adults Receiving Services By Age (Access to services)

Technology is used to access mental health care and information.

DHS MIS staff are working with DMH staff to migrate to a web-based data collection platform. The first step in this initiative has been to convert the collection of PAS/MH data from a diskette-based reporting system to a web-based data reporting system. In FY2008, this work on this initiative will continue to expand.

As noted in Section 1, DHS/DMH is planning to reconstitute administrative services through an Administrative Services Organization (ASO) in FY2008. One of the major responsibilities of the ASO will be to implement a state-of-the-art management information system (MIS) which supports a range of data related functions including consumer enrollment, service utilization, provider claims submission, validation, processing, adjudication, and payment through reliable, valid, and expeditious data

transmission among all appropriate federal, state, and local entities. The ASO will also provide for access to this data by developing a datamart that is accessible to DMH staff.

Quantitative goals and targets that relate to the comprehensive system of care are presented in Section III as System Performance Indicators.

CRITERION 4: Targeted Services To Homeless, Rural, and Elderly Populations.

This section describes services to the homeless, rural and elderly populations in Illinois, related service system initiatives, and concludes with some analysis of the system's strengths, needs and priorities.

The Homeless Population in Illinois

The IDHS Emergency Food and Shelter (EF&S) program issues an annual report that reviews trends in services provided to homeless persons in Illinois. Several trends in the characteristics of the population have been noted within recent years. Homelessness is affecting fewer people, becoming more rural, occurring in a younger population, and there is a significant percentage of homeless individuals who have a disability.

The FY2006 Report

The most recent report by EF&S (FY2006) provides an interesting profile of the homeless population receiving services. The following information is significant to understanding the causes of homelessness and the characteristics of the homeless population.

After experiencing decreases in the number of people served by the EF&S program in 2004 and 2005, the number of participants increased by more than 10,500 to 49,150 in FY2006. Sixty percent of the participants in FY2006 were males. The number of total households (the measurable unit of family composition) increased from 26,340 in 2005 to 33,400 in 2006, an increase of 7,060 households. It is to be noted here that of these, single males comprised 20,525 households and single females, 5,712. The remainder were: couples with no children (311), couples with children (812), a single male with children (209) and a single female with children (5,831). The increase is seen as due primarily to improved reporting of the City of Chicago.

The 6,852 households with children noted above accounted for 14,122 participants under the age of 18 (29% of the total served) of which 50% (7,062) ranged from newborn infants through five years of age. Combined with the 18 through 21 year old group (3,029) nearly 35% (34.89) of the homeless persons served by the EF&S program were under the age of 22. In comparison, only 2.16% of those served (1,063) were over the age of 62 while those 41-61 (32%) and those 22-40 (31%) were similar in numbers which dispels the myth that homelessness is predominantly an issue for older adults.

This is consistent with the finding that the major causes of homelessness are identified as income and family/neighborhood issues which have the most impact on households with children. Of the 33,400 households served by EF&S in FY2006, the largest group, 38 percent (12,700) cited income as the primary cause of their homelessness. Insufficient income, loss of job, loss of public assistance, and mismanagement of money were reasons given on this category. Another 22 percent (7,353) gave reasons related to family and neighborhood such as overcrowded conditions, domestic violence, gang violence, and disputes with neighbors and landlords. The remaining 40% cited the lack of affordable and decent housing, alcohol and substance abuse, medical problems, release from correctional facilities, and relocation as primary reasons for being homeless.

Some racial disparity was noted in the report. In FY2006, the racial composition of the homeless population served by EF&S consisted of 62 percent African American and 29 percent European-American. The other categories tracked: Hispanic or Latino (3,650), American Indian/ Alaskan Native/Pacific Islander/Asian (918), and Other Race (3,298) accounted for the remaining nine (9%)percent.

Forty-three percent of those served by the EF&S program reported a disability in FY2006(21,262 of 49,150). Substance abuse and alcohol abuse continued as the most common reported disabilities at 26% and 23% respectively. Mental illness comprised 16% of the disabilities reported in FY2006 and was reported by 7% (3,428) of the total number of persons served. It was the third most prevalent disability in FY2006 after 10% (4,957) reported a physical disability and 21% (10,368) reported substance and/or alcohol abuse. Prior to FY2006, Mental Illness had been the second most common disability in the homeless population served by EF&S (6% of the EF&S clients), after having been third most common up until FY2002, and was reported for 2,573 persons in 2004.

Outreach and Services to Homeless Adults

Homeless adults with serious mental illnesses require linkage to outpatient and inpatient mental health services and to housing, employment, and other support services. The DMH has encouraged providers to develop working relationships and working agreements with neighboring shelters, soup kitchens and pantries in order to identify where outreach and engagement service needs were to be focused and to develop co-affiliation services for this population.

Project for Assistance in Transition from Homelessness (PATH)

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

Rural Mental Health Services for Adults

Definition of “rural localities” in the State

In Illinois, the definition of rural has been based upon the U.S. Bureau of the Census designation of Metropolitan Statistical Areas (MSA) which are assigned to counties that contain a central city or twin cities having a population of 50,000 or more. The classification of counties into MSA (metro) and non-MSA (non-metro) categories has been found to be the best and most common way to define urban and rural. Thus, the term "rural" in Illinois is used to refer to residents in 76 non-MSA counties and residents not in municipalities of 25,000 or larger. (Rural Revitalization: The Comprehensive State Policy For the Future, Governor's Rural Affairs Council, April, 1990 pp. 2-4) Based on Illinois' definition of rural areas, 76 non-metropolitan counties are being targeted for assessment of the mental health needs of residents, evaluation of current services and programs, and the identification and eventual resolution of problems in service delivery unique to rural environments.

The DMH is a member of the Governor's Rural Affairs Council and provides the mental health perspective on rural issues. The Council provides an opportunity to network with a variety of state government agencies and community institutions, which can support mental health services in rural areas.

Public Act 95-16 signed by the Governor in July, 2007 that gives Illinoisans living in rural communities increased access to psychiatric care by requiring the Illinois Department of Healthcare and Family Services to reimburse psychiatrists and federally-qualified health centers (FQHCs) for mental health services provided via telepsychiatry. This allows rural Medicaid patients to receive treatment through tele-psychiatry- the use of technology, primarily videoconferencing- to provide psychiatric care despite the distance. Now people who need quality mental healthcare, but live long distances from mental health providers, will be able to get the help they need. This also addresses the shortage of psychiatrists working in rural communities, a problem that affects not only Illinois, but the nation.

Mental Health Services in Rural Areas

Mental health services for persons with serious mental illnesses are available in rural Illinois through hospital programs and community mental health centers. The DMH provides grant funding to community mental health centers, certifies mental health centers for Medicaid Clinic, Rehabilitation, and Case Management options and provides Emergency Psychiatric Services funds, which can purchase emergency services through a community clinic or private psychiatric hospital. DMH providers offer crisis/emergency services, outpatient services including psychiatric services, care management, PSR, and residential services in rural areas across the state.

Since FY1997, the Comprehensive Community Service Regions (CSSR) serving Greater Illinois have worked on enhancing and developing core mental health services for adults with serious mental illness residing in rural areas. CSSR staff work closely with mental health providers serving the more sparsely populated rural areas to design services which

are as accessible as possible and allow for a range of services to meet the treatment and support needs of rural residents as effectively as possible.

The DMH has conducted surveys of mental health needs in rural areas and subsequently developed a *Rural Mental Health Technical Assistance Resource Packet* for rural mental health providers and consumer leaders, which was disseminated to over 100 providers. While the DMH has been responsive to many of the concerns identified in the surveys, family education and self help resources continue to be under-supplied and there continues to be an overall access problem, especially with regard to psychiatric services. Major concerns across rural counties include the need for transportation and for “one-stop” services shopping. These concerns suggest the need for a broader partnership among state agencies.

Services to Older Adults

More than 1.9 million persons over the age of 60 reside in Illinois, representing nearly 20% of the state population. It is conservatively estimated that 15-25% of individuals over age 60 experience symptoms of mental disorders as they are considered to have a higher incidence than other age groups due to increasing number of life stressors. Therefore, older adults may be more vulnerable to experiencing mental health problems. Despite this fact they often do not seek, or are not successful, at linking with needed mental health services. Several systems of care play a role in the delivery of mental health services to the older adult including mental health, aging, primary medical care, and public health. In recognition of the importance of coordinating services for this population, DMH jointly coordinates an Advisory Committee on Geriatric Services with the Illinois Department on Aging (IDOA). This Advisory Committee has focused its efforts on the assessment of the mental health needs of the elderly, identification of model programs, best practices and staff competencies, and increased awareness of geriatric mental health concerns. Training, consultation, and technical assistance in the area of mental health and aging continue to be provided through the efforts of the Advisory Committee. Recent developments in this on-going collaboration are discussed further in Section III.

Geropsychiatry Services

This mental health and aging systems initiative establishes a geropsychiatric specialist in a comprehensive community mental health center with access to a psychiatrist, board certified in Geropsychiatry, to improve access, availability and quality of mental health services for older adults (age 60 and older) with mental health needs. The program strives to positively enhance integration of mental health, aging, primary medical care and public health systems to enhance the effectiveness of mental health service delivery to this population. The GeroPsychiatry Initiative has received national recognition. In 2005, it received the American Society on Aging/Pfizer Award of Excellence-the only mental health program which ever received this award. In 2006, it was recognized as an exemplary program by the National Technical Assistance Center for Older Adult, Mental Health, and Substance Abuse Services. Statewide expansion of the program is currently being proposed by the Illinois Department on Aging.

Strengths, Needs, and Priorities:

- ✓ Continued commitment to developing and implementing service models for persons with mental illnesses who are homeless.
- ✓ 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.
- ✓ Through the innovative use of PATH funds, Illinois has continually increased services including expanded intensive outreach to homeless individuals with serious mental illnesses.
- ✓ The CCSRs serving Greater Illinois are committed to developing and implementing service models for persons with mental illnesses who reside in rural areas. As we have noted, the DMH participates in a range of collaborative initiatives, such as the Governor's Rural Affairs Council, as well as providing direct services that include crisis/emergency services, outpatient services including psychiatric services, care management, PSR, and residential services in rural areas across the state.
- ✓ Public Act 95-16 signed by the Governor in July, 2007 that gives Illinoisans living in rural communities increased access to psychiatric care by requiring the Illinois Department of Healthcare and Family Services to reimburse psychiatrists and federally-qualified health centers (FQHCs) for mental health services provided via telepsychiatry. This allows rural Medicaid patients to receive treatment through telepsychiatry- the use of technology, primarily videoconferencing- to provide psychiatric care despite the distance.
- ✓ The Geropsychiatry program, although it is small, has been nationally recognized. It is targeted toward the needs of older adults with mental illness, especially in rural areas.

DMH Priorities and Service Needs:

The priority for DMH in working with the special populations described in this criterion, is to promote work on models of service provision which can best meet their needs. Integrated service models need to be adapted and utilized for the many homeless persons who have co-occurring mental illnesses and substance abuse problems. Increased homelessness in rural areas indicates the importance of expanding services for this population. Work with IDOA to expand the Geropsychiatry program more broadly in rural areas and to develop statewide applications continues to be a priority. IDOA has the support of the growing population of aging citizens in the state who want better health services, including mental health services. These individuals can be a rich source of support in expanding the availability of specialized services to meet the needs of this population.

A DMH survey some years ago found that major concerns across rural counties include

the need for transportation and for “one-stop” services shopping. These concerns suggest the need for service partnerships among state agencies. Under the auspices of the IDHS, just such a partnership, Team Illinois, was developed to improve the lives of persons residing in poverty-stricken, service deficient rural areas which are selected for the targeting of a broad range of state-operated and state-funded services. Bringing mental health services to persons isolated by distance and shortages of clinical professionals through approaches such as video-conferencing and telepsychiatry is a matter of urgent importance.

Transformation Activities in FY2008: Achieving the Promise

The Report of the President’s New Freedom Commission on Mental Health provides an important foundation for on-going planning efforts for adults who are homeless, those residing in rural areas, and improving services to the elderly. In Criterion IV, the FY2008 plan addresses three of the six New Freedom Commission goals:

Disparities in mental health services are eliminated.

The number of homeless adults accessing DMH-funded services has been tracked for many years. In FY 2006, there were 6,635 homeless adults receiving DMH funded services which represents a slight increase (8%) over the number of persons accessing service in FY 2005. We will continue to track this information in FY2008 (See System Performance Indicator A4.1)

The number of adults living in the 76 rural counties of Illinois who receive DMH-funded services is tracked on an ongoing basis and an increase in number has been evident. By FY 2005, the number had increased by 3,500 individuals since this system performance indicator was first established (28,510). During the last fiscal year (2006) a 5% (32,280) increase in the number of rural residents receiving services was noted. Tracking and efforts to increase the number of adults in rural areas receiving services will continue to be a priority. (See System Performance Indicator A4.2)

The DMH collaborates closely with the Illinois Department On Aging (IDOA) to improve access to mental health services by older adults. In FY2008, the DMH and the IDOA will convene meetings with stakeholders to plan services for older adults and expand treatment options such as the GeroPsychiatry program. (See Objective A4.3)

Early mental health screening, assessment, and referral to services are common practice.

By the end of FY2008, \$236,000 in federal Project for Assistance in the Transition from Homelessness (PATH) funding will be redirected to provide case management services to 185 additional adults who are homeless and who are PATH eligible. (See Objective A4.1)

Technology is used to access mental health care and information.

Consistent with Public Act 95-16, the DMH is moving forward to develop and solidify the infrastructure and introduce the technology necessary for the successful use of tele-psychiatry, particularly in rural areas in which there is a shortage of psychiatrists and other needed mental health clinicians. Internet access, video conferencing, and other applications provide an opportunity to enhance the quality of care in rural mental health services.

Criterion 5. Management Systems

The DMH continues to work towards an integrated system of care that includes both state hospitals and community-based providers, including those responsible for emergency health services regarding mental health. In this section, initiatives to enhance financial resources and human resources including significant achievements are described. There is also a brief analysis of the systems strengths, needs and priorities.

ENHANCING FINANCIAL RESOURCES

Increased Financial Resources For Community Services

With the increased emphasis on community-based treatment in the last twenty years came an increase in the proportion of budget spending on community mental health services. Compared to 8% of the DMH's budget in FY-1973, more than 60% of the mental health budget in FY-2007 was allotted to fund community programs.

Since FY-1999 the DMH has created a transition line for each state hospital. This funding line can be used for continued state hospital operations if needed, or can be used for expanding community services as census reductions free up resources. In FY-2006 \$12,281,877 was allocated in transition funding to the Regions, and in FY 2007 \$12,071,107 was allocated.

Increased Financial Resources For The Adult Population

Financial resources for the adult, as well as the children and adolescent populations come from the General Revenue Funds (GRF) appropriated by the Legislature, Block Grant funds, and the redirection of dollars accrued from the reduced utilization of state hospital services and annualized income from previous initiatives. Through careful planning, previously established initiatives have proven to be beneficial to mental health consumers both in quality of care and increased financial resources.

Between FY-1996 and FY2000, the Department requested and received appropriations of General Revenue Funds (GRF) for the continuing expansion and development of Care Management and Crisis Intervention services designed to aggressively promote continuity of care for persons discharged or triaged from state hospitals, Psychosocial Rehabilitation Services (PSR), and to increase service capacity and staff expertise in programs serving persons with dual diagnosis (mental illness and substance abuse).

In FY 2006, Illinois was awarded an Immediate Services Program for \$368,000 and Regular Services Program for \$643,104 jointly by SAMHSA and FEMA to provide crisis counseling to individuals displaced to Illinois by Hurricane Katrina.

Increasing Federal Financial Participation (FFP)

The DMH has worked closely with CMHCs in an aggressive plan to increase the claiming of federal Medicaid funds to support community based mental health services. Since FY1996 DMH has implemented procedures to increase enrollment and billing of persons leaving state hospitals, and modification of certain technical aspects of the billing process. These activities permitted greater flexibility in generating Medicaid funds for community mental health programs. As a result, there has been a steady increase in the amount of FFP generated to support mental health services in Illinois. In contrast to FY1991, when Medicaid community billing for adult services was \$130,000, Medicaid billing had risen to \$123,821,924 by the end of FY2004, increased to \$129,028,640 in FY2005, and in FY2006 it was \$149,599,641.

ENHANCING HUMAN RESOURCES

Staff Recruitment and Retention

Human resource development is a critical aspect of community-based services for both adults with serious mental illness and children with serious emotional disturbance and their families. It is important to ensure that persons providing mental health services have the required knowledge, skills, competencies and attitudes. In addition, the mental health service system must be able to recruit and retain skilled staff.

There have been several efforts to impact these issues in the past several years. The continued focus on, and support of public/academic linkages is one such effort. All state hospitals in Illinois have agreements with universities to serve as training sites for psychiatric residency programs. These sites provide an opportunity for psychiatric residents to work with patients with serious and persistent mental illnesses, as well as children and adolescents with SED, and to learn how the publicly funded mental health system operates. There are also similar programs with Departments of Social Work, Psychology, and Nursing in universities across the state. These programs provide fertile ground for the recruitment of program graduates who are well grounded in public mental health as a result of their residencies.

Mental Health and Law Enforcement Training

The DMH regularly collaborates with law enforcement agencies and emergency services at general hospitals to facilitate appropriate and effective psychiatric intervention to persons in crisis. DMH, in conjunction with the U.S. Attorney's Office of the Central and Northern Districts of Illinois, has developed initiatives aimed at improving the attitudes of law enforcement and mental health professionals towards each other's views, duties, roles, and skills. DMH has also worked with the Illinois Law Enforcement Training and Standards Board (LETSB) to develop a one-day training program targeted for experienced police officers on dealing with individuals who are mentally ill and in a behavioral crisis.

Human Resource Development Related To The Adult Services

The Recovery Vision

Training events on implementing the Recovery Vision in Illinois continue to be a priority of the DMH. These events are offered statewide, through Regions to providers, consumers, and family members.

The Mental Illness Substance Abuse (MISA) Training Institute

Since FY1999 when the DMH implemented MISA Basic Level Training for staff in community agencies and state hospitals there has been a significant continuing effort between DASA and the DMH to provide training and resources toward meeting the clinical needs of persons with both a mental health and a substance abuse diagnosis. The two agencies have also funded the MISA Institute to serve as a central resource for information by maintaining a resource library, a MISA web-site, and a newsletter, as well as providing training and consultation to the five MISA consortia. The role of the Institute has expanded to include training for staff in non-MISA consortium sites. In FY 2005 and 2006, the Institute collaborated with the DMH and the DASA on the implementation of a SAMHSA CMHS grant focusing on IDDT.

Strengths, Needs and Priorities

- ✓ The DMH has made a substantial, successful and sustained commitment to increasing the portion of the DMH funds allocated to community-based treatment 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.
- ✓ Innovative directions in the use of limited fiscal resources to promote expansion and growth of needed services such as initiating a fee-for-service payment mechanism to purchase services for individuals from community mental health agencies.

DMH Priorities and Service Needs:

Like many states, Illinois has experienced fiscal problems in recent years, leading to decreases in allocations for human services. There is therefore an even greater need to increase revenue from federal Medicaid funds.

The development of alternative cost efficient training supports remains a priority. The DMH does not have dedicated resources for a training department of its own and fiscal problems have resulted in the cancellation of several training contracts in the past few years.

Training events that assist in the implementation of the Recovery Vision in Illinois as well as training related to evidence-based practices continue to be a priority of DMH.

In the wake of 9/11, the DMH has recognized the need for a statewide mental health plan for responding to terrorist activities, as well as natural and other disasters.

Transformation Activities in FY2008: Achieving the Promise

The Report of the President's New Freedom Commission on Mental Health provides an important foundation for on-going planning efforts directed toward enhancing financial and human resources. In Criterion V, the FY2008 plan addresses two of the six New Freedom Commission goals:

Early mental health screening, assessment, and referral to services are common practice.

The DMH will continue to emphasize Mental Health and Law Enforcement Training by collaborating with law enforcement agencies and emergency services at general hospitals to facilitate appropriate and effective psychiatric intervention to persons in crisis.

Excellent mental health care is delivered and research is accelerated.

In FY2008, the DMH will continue to work on increasing Medicaid funding for the Illinois mental health service system. Barriers to increasing Medicaid billing and to enhancing eligibility for clients who use DMH funded mental health services (including patients in state psychiatric hospitals need to be identified and eliminated. Medicaid policies and procedures need to be clarified and the documentation requirements of providers streamlined. Work will continue in developing and maintaining a system for utilization management within the Medicaid program and the implementation of fee-for-service funding. (See Objective A5.1)

Medicaid billing has risen substantially over the years. In FY2006 Medicaid billing for adults had grown from \$123,821,924 in FY2004 to \$149,599,641, an increase of nearly 21%. (*See System Performance Indicators A5.1, A5.2*).

Illinois

Adult - Unmet Service Needs

Adult - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

Listed below are several key areas in which the DMH has determined additional focus is necessary:

Promoting the expectation of recovery and making it a shared vision across the service delivery system.

Service re-entry for those individuals leaving correctional settings and other institutional settings for community-based care.

Increasing opportunities for supportive housing through a wider array of housing options, housing subsidies where supportive housing is not needed, and better coordination with institutions (jails, hospitals) for persons being discharged.

Utilizing Web-based information systems for the collecting and reporting of data.

These needs were identified by key stakeholders during statewide mental health planning meetings that were held during the last fiscal year.

Illinois

Adult - Plans to Address Unmet Needs

Adult - A statement of the State's priorities and plans to address unmet needs.

DMH Priorities and Service Needs

The following are the priorities for enhancing the adult service system in FY2008:

Criterion 1:

- Efforts to facilitate and improve the quality of consumer participation have been of paramount importance in Illinois and are the source of many strengths. The expansion of the scope of consumer and family involvement continues to be a priority.
- Consumer participation objectives for FY 2008 support the DMH priority for furthering work on the recovery vision in Illinois.
- The expansion of WRAP programs continues to be an important focus. Family involvement in the development and implementation of treatment plans is important.
- Access to family psycho-education needs to be increased as part of the broader issue of increasing the availability of evidence-based practice.
- Collaborative initiatives which respond to ongoing consumer needs will continue to be a priority. Work with the Department of Corrections, County Jails, and Criminal Justice System, the Divisions of Alcoholism and Substance Abuse on issues related to co-morbid disorders, Rehabilitation in vocational and employment services, and the Department on Aging on the mental health needs of older persons is worthy work representative of these efforts.
- Maintaining and enhancing activities aimed at reducing hospitalization such as crisis services, face-to-face screening prior to hospital admission, case management services, including the ACT program, and the development of community-based resources to provide ongoing clinical care and linkages to supportive services in the community remain an important DMH priority.

Criterion 2:

- The DMH places a high priority on the maintenance and improvement of its management information systems to meet the challenges ahead. This work has been valuably supported by the requirements and activities undertaken through the Data Infrastructure Grant.

Criterion 4:

- The priority for DMH in working with the special populations described in this criterion, is to promote work on models of service provision which can best meet their needs. Integrated service models need to be adapted and utilized for the many homeless persons who have co-occurring mental illnesses and substance abuse problems. Increased homelessness in rural areas indicates the importance of expanding services for this population. Work with IDOA to expand the Geropsychiatry program more broadly in rural areas and to develop statewide

applications continues to be a priority. IDOA has the support of the growing population of aging citizens in the state who want better health services, including mental health services. These individuals can be a rich source of support in expanding the availability of specialized services to meet the needs of this population.

- A DMH survey some years ago found that major concerns across rural counties include the need for transportation and for “one-stop” services shopping. These concerns suggest the need for service partnerships among state agencies. Under the auspices of the IDHS, just such a partnership, Team Illinois, was developed to improve the lives of persons residing in poverty-stricken, service deficient rural areas which are selected for the targeting of a broad range of state-operated and state-funded services. Bringing mental health services to persons isolated by distance and shortages of clinical professionals through approaches such as video-conferencing and telepsychiatry is a matter of urgent importance.

Criterion 5:

- Like many states, Illinois has experienced fiscal problems in recent years, leading to decreases in allocations for human services. There is therefore an even greater need to increase revenue from federal Medicaid funds.
- The development of alternative cost efficient training supports remains a priority. The DMH does not have dedicated resources for a training department of its own and fiscal problems have resulted in the cancellation of several training contracts in the past few years.
- Training events that assist in the implementation of the Recovery Vision in Illinois as well as training related to evidence-based practices continue to be a priority of DMH.
- In the wake of 9/11, the DMH has recognized the need for a statewide mental health plan for responding to terrorist activities, as well as natural and other disasters.

Illinois

Adult - Recent Significant Achievements

Adult - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

Update on Areas Needing Attention in FY 2007 Plan - Significant Achievements –
Excerpted from Section I

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

Consumer Participation and Involvement

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

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

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

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

C&A Services focused on family participation by increasing the availability of family resource developers (FRDs) and the advisory role of youth who utilize or have utilized services. Of the 54 agencies providing SASS services, only three of the agencies have never hired a FRD. There is generally a modest level of turnover in the FRD staff, and at

the point that the FY 2007 FRD survey was conducted 41 of 49 reporting agencies (84%) had FRDs employed. Thirty-one (76%) were FTE positions. Monthly meetings are held for the FRDs in order to provide education, resource development and support for the positions. FRDs from the Federal Systems of Care demonstration grants also attend these meetings. The survey results could not specify the number of positions that were FY 2007 new hires. Some agencies have expanded the support role and are using FRDs to assist with Individual Care Grant application processes and service planning. Each System of Care site has emphasized the importance and hiring of FRDs.

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

Evidence-Based Practices

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

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

Systems Integration

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

Support Services (SASS) for children and adolescents and their families. DMH and the Division of Rehabilitation Services' continue its collaboration the 'Brand New Day Initiative' and the provision of Benefits Planning, Assistance and Outreach Project funded by the Social Security Administration. DMH collaborates with the City of Chicago Mayor's Office for Persons with Disabilities on the latter initiative. There is also continuing collaborative work with the Department on Aging on joint training and advocacy programs.

Program Enhancement

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

Service Administration

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

Information Technology

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

Grants

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

Illinois

Adult - State's Vision for the Future

Adult - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

Illinois has made substantive progress in developing a comprehensive mental health service system for individuals with serious mental illnesses (SMI) and for youth with serious emotional disturbances (SED) and their families. Illinois envisions a well resourced 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 "The Expectation of Resilience and Recovery through Treatment, Accountability and Equal Access". Many of the activities in which the DMH is engaged are providing the foundation to make this vision a reality.

Illinois

Child - Service System's Strengths and Weaknesses

Child - A discussion of the strengths and weaknesses of the service system.

SECTION II: IDENTIFICATION AND ANALYSIS OF SERVICE SYSTEM STRENGTHS, NEEDS AND PRIORITIES

Organization of Section II

The organization of this Section for submission using WEBBGAS software is as follows. The full text for the Child Services Section has been entered under Strengths and Weaknesses of the Service System. Excerpts from this text have also been copied and inserted under WEBBGAS Headings: Unmet Needs, Plans to Address Unmet Needs, Recent Significant Achievements and the State's Vision for the Service System.

B. CHILD & ADOLESCENT SERVICES

Criterion I: The Comprehensive Community Based Mental Health System

Organizational Structure of the Illinois System of Care

Overview

Illinois has made substantive progress in developing a comprehensive mental health service system for individuals with serious mental illnesses (SMI) and for youth with serious emotional disturbances (SED) and their families. Illinois envisions a well resourced transformed mental health system that is consumer directed and community driven with a continuum of integrated and effective culturally inclusive programs, services (prevention, early intervention and treatment), and supports, that promote healthy lifelong development through equal access and that 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. The Illinois Vision for Mental Health is "The Expectation of Resilience and Recovery through Treatment, Accountability and Equal Access". Many of the activities in which the DMH is engaged are providing the foundation to make this vision a reality.

Organization of the Comprehensive System.

Central Office Structure

The Child and Adolescent Services office is led by a qualified Child Psychiatrist and consists of 25 FTE Statewide C&A Staff. Twenty are located in a Chicago office which has statewide responsibility, three are in Central Office, one in Region 3, and one in Region 2. With fewer staff available in the past year, contracting responsibilities have shifted to the Regional staff. C&A staff accompany regional staff and consult, but no longer carry any direct responsibility for contract work and monitoring. The model appears to be working well, reducing duplicated effort and allowing the Regions to draw upon C&A expertise to support their contract and monitoring role.

The CCSRs

The five geographic Comprehensive Community Service Regions (CCSRs) are responsible for contracting activities with 151 community-based outpatient/rehabilitation agencies which include 124 child serving agencies which are either specialized or are community mental health centers with children's programming. They also contract with 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 assigned staff specially designated to address child and adolescent and juvenile 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 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.

Available Services and Resources in the Comprehensive System of Care

Health, Mental Health and Rehabilitation.

Health

“There is no Health without Mental Health” has been the slogan of the Division of Mental Health for the past seven years. The DMH continues to emphasize the importance of assisting families of children and adolescents with serious emotional disturbances in accessing Medicaid and state insurance benefits. The State of Illinois has undertaken a key initiative to ensure access to health care for children and adolescents- All Kids, a new initiative which expanded the coverage and benefits of the previous insurance program- KidCare – was implemented in July 2006. The program is administered by the Illinois Department of Health Care and Family Services (DHFS).

Illinois Health Care Programs: Funded by the Legislature last year, All Kids is the Governor's new state program that offers comprehensive, affordable health insurance for children in Illinois. All Kids is the first program in the nation to make sure that every uninsured child, regardless of income or medical condition has access to health care. Expanded eligibility under All Kids began July 1, 2006 when existing KidCare plans were folded into All Kids. Children who had not been eligible under the Kid Care program may now be eligible for benefits under the All Kids expansion. The program provides access to healthcare services for all children 18 years or younger who live in Illinois. Every uninsured child may be eligible regardless of income, current health condition or citizenship. With a few listed exceptions, such as a newborn child, a parent losing a job which provided insurance benefits, a child on COBRA insurance, children must have had no insurance coverage for a 12 month period to qualify for All Kids. Children with insurance coverage may also qualify if their families meet certain preset income limits. All Kids provides access to the following services: doctor visits, hospital visits, dental care, vision care including eyeglasses, prescription drugs, check-ups, immunization shots, and it covers special medical services such as medical equipment, speech therapy and physical therapy and mental health services. The amount a family

pays is based on their income: Some families will have no monthly costs. Families who have more income will pay reasonable monthly premiums and co-payments. There are never any co-payments for regular check-ups or immunizations

In addition to the All Kids program, Family Care extends healthcare coverage to parents living with their children 18 years old or younger. Family Care also covers relatives who are caring for their children in place of their parents. Like All Kids, Family Care covers doctor visits, dental care, specialty medical services, hospital care and emergency services. Parents can get Family Care if they live in Illinois and meet the Family Care income limits which go up as the family size goes up. For example, a family of 4 can make up to \$36,000 per year and may be eligible for Family Care. Parents must be US citizens or meet immigration requirements. Applications for coverage by these programs are easy to obtain through a toll-free telephone number (1-866-ALL-KIDS) or on-line at www.allkidscovered.com.

Through All Kids, Illinois has created a continuum of health benefits coverage for low-income children in the state. The plans are funded by state revenue, as well as federal funds under Title XIX, Medicaid, and Title XXI, the State Children's Health Insurance Program. All Kids Assist covers children from birth through age 18 whose family income is at or below 133 percent of poverty. All Kids Moms and Babies covers pregnant women and their babies with family income at or below 200 percent of poverty. Individuals enrolled in these plans have no cost sharing requirements. All Kids Share covers uninsured children with family income above 133 percent and at or below 150 percent of poverty. Families pay a small co-payment for some services. All Kids Premium covers uninsured children with family income above 150 percent and at or below 185 percent of poverty. The families of these children pay modest monthly premiums in addition to co-payments for some services. Children who have health insurance whose family income is above 133 percent and at or below 185 percent of poverty are eligible for All Kids Rebate. Under this program, the state reimburses families for all or part of the cost of purchasing private or employer-sponsored health insurance for their children. All Kids Assist and All Kids Moms and Babies cover a full range of Medicaid services including dental care. All Kids Share and All Kids Premium cover the same services with the exception of abortions and home and community-based waiver services. All four plans cover a broad range of benefits for special needs populations. The same provider networks (including physicians, pharmacies, community mental health and substance abuse providers) are used for all four plans.

Mental Health Services

The array of core mental health services purchased on behalf of Illinois residents of all ages are described in the DMH Mental Health Program Book which is posted on the DMH website (www.dhs.state.il.us/mhdd/mh/policy/programbook/). The services are based on the tenets of the Community Support Program (CSP) and Child and Adolescent Support Services (CASSP) models. Each core service description contains the following: Definition, Purpose, Eligibility Criteria, Service Elements and Standards. Services are organized into three program levels: Acute Care Program, Mental Health Treatment

Services and Rehabilitation and Support Program. The following is a brief synopsis of core services provided to children and adolescents.

Acute Care. Acute Care Program services provide a rapid response to children and youth in a mental health crisis, to members of their support system, and the community on a 24-hour a day basis. These services are intensive, short-term and are oriented toward stabilization of an individual's condition and management of disruptive and life threatening symptoms. Services include crisis-emergency services (e.g. mobile, walk-in and telephone response, crisis residential services and hospital-based services).

Mental Health Treatment. These services, which are intended to reduce psychiatric symptoms and promote adaptive functioning, are based on an evaluation of an individual's mental health service needs and an individual treatment plan (ITP) that is monitored, reviewed, and modified as needed on an ongoing basis. In addition to the core services offered in outpatient settings (e.g. Assessment, Treatment Planning and Monitoring; Counseling and Therapy Services; Psychiatric Services: Medication-related Services), youth with serious emotional disturbances and their families may receive specialized core services including Screening, Assessment and Support Services (SASS); Child and Adolescent Wraparound Services; and services through the Individual Care Grant Program for Mentally Ill Children (ICG/MI).

Screening, Assessment and Support Services (SASS) programs were first established in 1989. The primary objectives of SASS are to develop community-based screening and assessment capability, intensive home-based services, and crisis intervention services. The philosophy of service is short-term intervention which is child-centered, family-focused and community-based. Parents are involved in service provision and evaluation. Since FY2005, the DMH has participated in a significant effort to deliver SASS services collaboratively with the DCFS and the DHFS.

Wraparound Services. The Wraparound Approach is essential to the provision of case management services. DMH has defined the way these services are to be provided to families, offering both traditional and non-traditional supports by using the local network of community providers and associations. In this approach, there is a definable planning process involving the child and family, which results in an individualized plan for that child and family that focuses on strengths and needs across multiple settings. DMH provides funds to SASS programs throughout the state to support wraparound services **(Performance Indicator C3.8).**

Individual Care Grant 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. If the funding is awarded for a community grant, parents and providers work together to provide highly individualized services in the community. These individualized services include intensive home-based support, treatment and respite care which allow the child to remain at home. A parent, along with the community mental health center may also decide that residential treatment is the appropriate option. Families are encouraged to place their children close to home to optimize parental involvement in treatment. In FY2006, the ICG program awarded 114 grants, provided 449 ICG residential placements, and 185 children and adolescents received community services under the ICG program. As of

April 1st, 2007, there were 479 active ICG clients. Of this number, 267 were in residential care and 134 were in community-based care. A total of 81 new grants were awarded and 570 ICG clients used ICG services in FY 2007. Of these, at the end of the year, 62 percent were in Residential Treatment Centers and 38 percent were using the grant for intensive community based services. The ICG Advisory Council which was established in FY-2001 continues to provide input to planning and service delivery.

Rehabilitation

As noted in the adult service section rehabilitative support services are funded by DMH. For children, the service focus is on Case Management which consists of supportive services including Case Management, Client Transitional Subsidies, and Transition to Adult Services.

Employment Services

Employment is considered one of the key services required for youth transitioning to adulthood. The DHS Division of Rehabilitation Services (DHS/DRS) helps high school students with disabilities plan for their future and assists these students in finding employment with services provided through the Transition Program and the Secondary Transition Experience Program (STEP). DHS/DRS has a strong commitment to serving school age youth with disabilities. The counselors work closely with transition specialists housed in high schools, staff in individual schools and school districts, and community partners to help students achieve their employment, post-secondary education and independent living goals. Whether in school or out, a young person with any limiting disability may be eligible for assistance. DMH and the DHS Division of Rehabilitation Services (DRS) have collaborated closely in a joint effort -“The Brand New Day Initiative” - to increase access to vocational rehabilitation services including supportive and subsidized 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 collaboration addresses the needs of both adults and youth.

Other DRS Transition Initiatives that serve students with disabilities and benefit youth with SED include:

- STEP Program ~ The Secondary Transition Experience Program (**STEP**) is a work training/placement program to prepare youth for transition to employment during and after high school. The purpose of STEP is to offer students with disabilities, as part of their Individual Education Plan (IEP) and Transition Plan, the opportunity to participate in career exploration, independent living experiences and community work experiences in preparation for a life after high school, and particularly employment. In FY2006, DRS reports that 20,494 transition students were served, including 17,1128 STEP students and 3,366 non-STEP students. DRS provided 150 STEP contracts serving approximately 600 high schools.
- DRS maintains Cooperative Agreements with Illinois State Board of Education and school districts and provides two transition programs in school settings. Transition Specialists participate in ongoing education/vocational rehabilitation

planning for customers and potential customers attendance at student and school staffings, school/joint agreements, personnel meetings, and in the development of the vocational/transition portion of the IEP. The cost of these specialized counselors is shared between the local school district and DHS/DRS. Services for students who have not achieved their vocational objectives by the time they leave school are continued through the local DRS office. Additionally, each DHS/DRS office assigns Vocational Rehabilitation counselors to schools to assist students transition from school to work by improving linkages to DHS/DRS services and/or referring them to other adult oriented services.

- NEXT STEPS, a training and resource system, uses volunteer teams to provide training to parents and caregivers in planning and advocacy for positive transition outcomes for children and youth with disabilities. The NEXT Steps service network of 22 teams statewide is sponsored by DRS. It is currently the largest ongoing network and the only rehabilitation-sponsored and coordinated system in the nation. Implementation of local and statewide coordination, consistent in-service for the corps of volunteer trainers, ongoing technical assistance, and curriculum support are features unique to Illinois. Teamwork and workshops focus on four critical goals of Transition: Employment and Education, Independent Living, Social and Interpersonal relationships, and self-Advocacy. Continuous outreach to un-served or underserved populations is practiced.
- Transition Planning Committees: DRS coordinates and sustains local Transition Planning Committees (TPCs) which identify existing resources and unmet needs, facilitate an on-going exchange of information, and develop local customer training programs. Quarterly Transition Consortia are convened to address transition issues, provide networking opportunities, and facilitate information-sharing among regional TPC members, Vocational Rehabilitation staff, educators, post secondary schools, community partners, state agencies, parents and consumers. In October 2006, DRS co-sponsored the Second Annual Statewide Transition Conference. More than 500 participants attended the conference, which focused on supporting the successful transition of students and encouraging the creation of person-centered goals for young people with disabilities.

Housing Services

Housing services are generally not provided to children and adolescents, but they do benefit from housing services and programs if they are in a homeless family that requires shelter or living with adult consumers who are being set up with permanent supportive housing. Child-serving agencies are cognizant of the critical needs of families and may refer or link them to appropriate housing services when the need is apparent. Residential Treatment services are provided through the ICG/MI program to children and adolescents who are unable to function in their home and community environments due to the seriousness of their level of emotional disorder. Children in the child welfare system may be placed in foster care and receive SASS services or they may be placed in group home or residential treatment programs by DCFS.

The DMH continues to collaborate with the Chicago Housing Authority to implement the Urban Systems of Care (USC) initiative which established community-related services tailored to the needs of children and adolescents at each housing development who are at risk of emotional problems or who are exhibiting such problems and need to be linked to a local mental health provider. The approach requires collaboration with key community stakeholders such as resident governing bodies, social service providers, child welfare agencies, schools and juvenile justice representatives. The primary services rely heavily upon a wraparound approach to service delivery as an effective intervention. The aim of this program is to sustain families in their environments, prevent homelessness, and support them in obtaining appropriate housing alternatives as needed.

Education Services

Special Education In Illinois

The Illinois State Board of Education (ISBE) reports that 15% of Illinois students of school age (ages 6-21) received special education services in 2005. More than 10% of those receiving special education services were classified as Emotionally Disturbed (ED) (29,915 students), the special education category that most closely approximates the federal definition of Serious Emotional Disturbance. Another 7,055 students were classified under Autism.

For pre-school children ages 3-5 years, the number receiving special education services is increasing annually (6.44% in 2004 and 4.66% in 2005). More infants and toddlers with disabilities are being identified and served at a younger age. These children transition to early childhood special education services when they reach the age of 3. Collaboration with Head Start, pre-kindergarten, and child care programs has resulted in identification of more pre-school aged children who may need special education services and has provided more placement options for children with IEPs. There has been a gradual increase in the number identified with Autism from 2.9% in 2003 to 3.57% in 2005, (1,248 of the 34,967 children in that age group who received special education services in 2005), reflecting greater accuracy in the early childhood diagnosis of this disorder. ISBE identified 292 children in this age group as being in the ED category bringing the total number of children ages 3-21 with an emotional disability in 2005 to 30,207.

For young adults in the Individual Care Grant (ICG) Program, educational and vocational services must be an integral part of the transition plan as they move to adulthood. Since the ICG youth are identified as having serious emotional disturbances, early vocational training is highlighted and some begin this as part of their residential treatment. The Adult Network and ICG Transition Coordinator also work with the Division of Rehabilitation Services (DRS) and with the Illinois State Board of Education (ISBE) to develop, coordinate and finalize transition plans for these young adults. (See also the mental health in schools model described later in this section.)

School Systems: Service provision under the Individuals with Disabilities Education Act (IDEA)

When DMH partnered with ISBE and DCFS to implement the wraparound approach to the delivery of children's services, it was clear that children served under the Individuals with Disabilities in Education Act (IDEA) were most often those who required community based mental health care. The Wraparound approach strengthened the collaboration needed to serve these youth and made the shared agenda of community mental health providers and schools of greater importance. The DMH has pursued a model of service provision that meets the needs of local schools while also addressing the needs of children served through the Individuals with Disabilities in Education Act (IDEA). The model is organized around the needs of the families, schools and communities. This approach includes universal, selected and targeted strategies while addressing cultural factors, stigma, outreach and other barriers to engagement. As a result students experience school wide behavioral interventions, which promote learning and provide positive approaches to the task of learning as well as integrated mental health services.

Substance Abuse Services for Youth

Services for youth with substance use problems are provided through the IDHS Division of Alcoholism and Substance Abuse (DASA), which administers funding to a network of community-based substance abuse treatment programs. DASA programs provide a full continuum of treatment including outpatient and residential programs for persons addicted to alcohol and other drugs.

Services For Youth with Co-Occurring (Substance Abuse/Mental Health) Disorders

The DMH C & A Directors, in collaboration with the DASA, continues to explore the need for staff training and current program capacity issues to address the clinical needs of this population in the Chicago area.

Medical and Dental Services

These essential healthcare services are available to children and youth with SED regardless of income and are accessed through case management or referral. Mental Health providers actively assist families to obtain health insurance coverage for their children under the All Kids program and to be assisted with medical bills through Medicaid. SASS agencies in particular, require families to apply for Medicaid benefits as part of their admission process. In some areas subsidized clinics are available to provide these services at minimal cost and access can be facilitated by the mental health provider.

Support Services

IDHS

An extensive range of services are available to youth with serious emotional disturbances through IDHS. Liaisons have been developed between local community mental health centers and local IDHS offices for the purpose of facilitating consumer entitlements and identifying those IDHS clients who are in need of assistance in accessing mental health services.

Family Assistance Program

The IDHS administers the Family Assistance Program which is legislatively mandated in Illinois. The Family Assistance Program provides a monthly stipend to enrolled families who have a child with a serious emotional disturbance (SED) or developmental disability (DD), which they can use for treatment and/or specialized care services at their own discretion. Parent enrollees must have an annual income of \$50,000 or less. Selection for the program is by application and random selection. The program currently serves 130 families of SED children.

MHJJ- Juvenile Justice System.

Experts in mental health and juvenile justice estimate that the rate of mental disorder among youth in the juvenile justice system is substantially higher than among the general population of youth. It has been estimated that 14% of youth in juvenile detention have a major depressive disorder and may also have a co-occurring substance abuse disorder. These youth have disorders that can be effectively treated with psychopharmacological and behavioral interventions, which are usually more successful when they are coordinated with other major service systems impacting the child and family. To address this, the DMH has funded the Mental Health Juvenile Justice Initiative since FY-2000. This successful initiative is now statewide and provides services to juveniles detained in all the detention centers in Illinois.

Post-Traumatic Services

For the past three years the Illinois Department of Children & Family Services (DCFS) has funded a training initiative for child welfare staff and service providers to examine and respond to the trauma children and families have experienced as a result of physical abuse, neglect, sexual abuse and domestic violence and its effect on their behavior, performance and adjustment, especially in foster care and other supportive environments. The DMH statewide Child and Adolescent Services office has consultatively participated in the development of the initiative. In FY2008, funding is being provided through the Illinois Children's Mental Health Partnership to expand this education and training initiative to mental health providers. DMH C&A staff are currently working closely with DCFS to explore ways of generalizing and adapting the components of the DCFS approach to a broader population and to develop an adaptive training model which will support mental health trauma work with children served in the public mental health system and other community systems as well as to enhance these services to those in the child welfare system.

Case Management for Children and Adolescents

Case Management, a required service for youth with serious emotional disturbances who receive substantial services through the public mental health system, is defined as the coordination of services between the mental health provider and other agencies in order to provide the child and family with immediate and comprehensive care. It is considered a critical component in the effort to assure continuity of care, to sustain youth with serious emotional disturbance in his/her community, enhance his/her quality of life, and thereby reduce the use of state hospitals. Youth with serious emotional disturbances and

their families, by the nature of their difficulties, cannot be served in isolation. Community mental health agencies serving children have been required to participate in local networks of child-serving agencies, which facilitate supportive services to families. In an outpatient setting, the mental health provider utilizes a general case management approach as part of care, that is, an outreach - oriented set of service activities at variable levels of intensity, determined by client need, with the intention of maintaining the client's linkage to necessary mental health services and social supports within the least restrictive clinically appropriate setting. Within this Bridges Program, intensive case management is provided to this especially high risk grouping of children who have multiple, severe needs requiring extensive in-home supports and involvement among various child-serving systems.

The Screening Assessment Support Services (SASS) initiative was designed to support an integrated network of individualized services that would meet the specific needs of youth and their families. SASS programs offer case management services to facilitate access to the health, welfare, educational, medical, dental, and vocational services required by these youth and their families. In crisis situations or in cases following hospitalization, SASS programs provide Linkage Case Management services in which a SASS case manager assumes primary responsibility for identifying and accessing needed services for the child and family through mobilizing the family's natural helping network and utilizing community resources. All SASS providers are required to sign Continuity of Care Agreements with state hospitals and state-funded hospital programs for youth and are monitored for compliance by CCSRs through performance measurements.

Youth Transitions:

The DMH recognizes the importance of developmental passage for young adults with serious emotional disturbance and strongly encourages active clinical support to youth who are in need of continuing into adult services. These youth are typically without the education and vocational skills that could facilitate their employment and may also lack the family support that many young adults now enjoy until their mid-twenties. Those who have lived in institutional settings for a long time do not have the community living skills or the community connections that aid in the transition to adult life. Without support, these youth are at risk for joblessness, homelessness, incarceration and welfare dependence. Adult Networks and community-based providers work with the young adult to assure needed services and supports are in place.

In FY2007, grants of \$100,000 each were awarded to one agency in each region to conduct a pilot project in transitioning youth. The projects addressed two transitional groups: (1) Youth who have received services in the Child & Adolescent System who are 16 and older and need to be prepared to enter adulthood and be served by the Adult system. (2) Youth with serious emotional disturbances transitioning from correctional services back into their home communities are being targeted for services regardless of their age. To facilitate the transition process for those re-entering from correctional services, two full time statewide C&A staff have been assigned the task of acting as liaisons with the eight state correctional centers which house youth. The focus of these pilots was on infrastructure building and basic services. The outcomes of these programs will provide information on the kinds of models which work best. In FY2008, an additional five pilot

projects will be initiated at \$100,000 each bringing the total allocated for transition to \$1,000,000.

Child Welfare wards who reach the age of 18-21 and are in need of specialized services due to serious emotional disturbances are the subjects of collaborative work between DMH and the Department of Children & Family Services (DCFS). DCFS has funded two Transitional Living Programs (TLPs) for wards with serious emotional disturbance and DMH has funded the required mental health services. Although capacity is available for 50 residents, the programs are serving 25 residents at any given time as a means of providing more intensive programming. The Thresholds program in Chicago has 15 residents and the SIRSS program in Carbondale serves 10. A Memorandum of Understanding between DCFS and DMH provides for an oversight committee composed of staff and providers from both departments which meets monthly. The experience has so far been positive in developing a common agenda and working out problematic situations. Adult mental health service providers are glad to help with transition and iron out anticipated problems. DCFS funded providers and mental health providers have successfully worked on resolving conflicting programmatic attitudes and policies.

Activities Leading to a Reduction in Child and Adolescent Hospitalization

A variety of strategies have resulted in a significant reduction in admissions to state hospitals from 1,272 children and adolescents in FY-1989 to 79 in FY2007. Currently, there are only two state operated inpatient programs for children and adolescents. One is a small 9-bed inpatient program at Choate Mental Health Center near the southern tip of Illinois. It serves 6-9 children with serious disturbances at any given time due to the absence of other inpatient resources in that area. McFarland MHC located at Springfield, has a 25 bed forensic unit for adolescent boys which generally serves only 15 boys at a time given the requirement for more intensive team intervention with this higher risk cohort. (Forensic services are also provided for DMH by contract with Streamwood Hospital.)

The Screening, Assessment, and Support Services (SASS) program has had a major impact on hospital admissions. SASS was initiated by the DMH in 1989 with a primary responsibility of screening adolescents prior to their admission to state hospitals. As DMH began to fund community hospitalization, SASS expanded its screening efforts for these services providers as well. The SASS program was expanded to a tri-agency funded program (DMH, DCFS and DHFS) in FY 2005. Wraparound funding, as described above, is also utilized in efforts to keep children twelve years of age and under out of state hospitals in several areas of Illinois. This initiative utilizes SASS and other specialized community-based services to maintain the child in the community.

Strengths, Needs and Priorities for Children and Adolescent Services

Important strengths are:

- ✓ The array of core services that are available to youth with serious emotional disturbances and their families.
- ✓ The commitment to practices that lead to resilience and a focus on recovery by mental health system stakeholders.

- ✓ Planning for family driven care based on the goals identified by the President's New Freedom Commission which serves as the foundation for current and future planning efforts.
- ✓ A commitment to the dissemination of information regarding the implementation of evidence-based practices as evidenced by work that is occurring within the System of Care Initiatives, and through partnerships with the Children's Mental Health Partnership.
- ✓ The Governor's 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.
- ✓ 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.
- ✓ The Statewide DMH Child and Adolescent Program has established a Teen Advisory Group composed of adolescent consumers that continues to provide input on the planning and delivery of services.
- ✓ Family Resource Developer positions have been created as part of the System of Care initiative.
- ✓ 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. The ICG Program provides funding for intensive community treatment for children and adolescents with serious emotional disturbances who meet the criteria of severe mental illness and impaired reality testing, who would ordinarily be served in ICG funded residential programs. These individualized ICG or SASS services include intensive home-based support, treatment and respite care which allow the child to remain at home.

DMH Priorities and Service Needs:

Continued expansion of the scope and quality of parent and youth involvement remains a priority. Family involvement continues to emerge as a gathering strength in the C&A community service system as well as in successful inter-agency collaborations.

The development of early intervention programs and collaborative initiatives for children of all ages is a major priority of the Statewide C&A Services Office as is the promotion and growth of early childhood consultation in the State designed to support and strengthen services to very young children.

Another concern is the need to enhance family involvement in the development and implementation of individualized treatment plans for children and adolescents receiving mental health services.

Inter-agency collaborations have been an important support and strategy for the DMH in improving services for children and adolescents. The DMH has an active collaboration with the Children's Mental Health Partnership to implement Evidence Based Practices. The DMH also has strong and improving initiatives in collaboration with other agencies including the juvenile justice system, mental health services in schools, and the substance abuse service system to address co-occurring mental illness and substance abuse disorders, and the child welfare system. These initiatives respond to ongoing needs and will remain a priority.

Activities aimed at reducing hospitalization and out of state residential treatment have been successful. Screening through the SASS program and crisis services have contributed to this success. Case management services, Wraparound services, and ICG/MI community services also help to reduce hospitalization and residential treatment while providing ongoing clinical care and linkage to supportive services in the community. These services will remain a high priority for DMH.

Transformation Activities in FY2008: Achieving the Promise

Overall, the DMH vision for the community mental health system is one that is oriented towards fostering resilience and recovery, and one that is consumer and family driven. It is our belief that system transformation, as all constructive endeavors, must be based on an assessment of needs, available strengths from which to build and change, and a set of priorities which provide clear direction and lend structure to the process and the activities aimed toward positive results. The Report of the President's New Freedom Commission on Mental Health provides an important foundation for on-going planning efforts in this regard. In Criterion I, the FY2008 Children's plan addresses four of the six New Freedom Commission goals:

Americans understand that mental health is essential to overall health.

DMH is advancing a public awareness campaign to reduce the stigma experienced by children/adolescents, and their families associated with mental illnesses. Funding has been obtained through collaboration with the Illinois Children's Mental Health Partnership (See Objective C1.5.).

Mental health care is consumer and family driven.

DMH C&A Services is continuing to work with parents and parent-led organizations to facilitate parent-to-parent support through the use of Family Resource Developers (FRD's), to increase the number of FRD's employed in child-serving mental health agencies, and to encourage substantive feedback from parents and parent led organization on enhancing the quality of services at all levels of care. (See Objective C1.1) Efforts to enhance and integrate the role and contribution of the DMH C&A Teen Advisory Group will also continue. (See Objective C1.2.)

Early mental health screening, assessment, and referral to services are common practice.

Community service options in the DMH ICG program will be further strengthened in FY2008 and the number of youth served is expected to increase. (See Objective C1.4)

Excellent mental health care is delivered and research is accelerated.

As noted above, DMH committed to continuing to advance the implementation of evidence-informed practices in the child and adolescent service system through training events and the use of research and practice experience documented in a clearly laid out curriculum. (See Objective C1.3).

Criterion 2: Mental Health System Data Epidemiology

INDIVIDUALS RECEIVING PUBLICLY FUNDED SERVICES

Prevalence Estimate

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 lower limit at a level of functioning of 50 (LOF=50). The figure has been updated by CMHS using 2004 census information to 115,615 or a 6% estimate for children and adolescents aged 9 to 17 based on a 17.5% poverty rate.

Definitions of DMH Population Eligible to Receive Services

Descriptive eligibility criteria for core services provided in the Illinois public mental health system have been developed and specified using certain broad clinical-diagnostic categories as well as more specific indicators of need. The concept of “eligible and target populations” demarcates, respectively: A) a broader eligibility definition for the population who meet minimum criteria and may be served and B) a narrower priority or target population who must be served. The CMHS prevalence estimation methodology seems to overlap the target and eligible population definitions that are currently used by the DMH. While there is a substantive gap between the total prevalence and the annual numbers served, we know that a certain percentage of these individuals may not need or request service in a particular year and an unknown proportion of those who do need service may be served in the private sector. Estimating the size of the unserved portion of the total estimated prevalence is contingent upon the availability of utilization data for privately provided psychiatric services which is not currently available.

Definitions of DMH Eligible and Target Populations

The Eligible Population (Adults and Children/Adolescents):

- Must have a mental illness, defined as “a mental or emotional disorder verified by diagnosis contained in the DSM-IV or ICD9-CM which substantially impairs the person’s cognitive, emotional and/or behavioral functioning, excluding the following unless they co-occur with a diagnosed mental illness: V-codes, organic disorders, psychoactive substance induced organic mental disorders, mental retardation, pervasive developmental disorders associated with mental retardation, and psychoactive substance use disorders.
- Must have significant impairment in an important area of life functioning as a result of the mental disorder identified above and as indicated on the Global Level of Functioning (GAF) for adults and Children’s Global Assessment Scale (CGAS) for children.
- All ages

Definition of Child and Adolescent Target Population:

- Must be 0 years of age through 17 years of age.
- Must have a serious emotional disturbance as defined by the diagnostic, functional, and utilization criteria.

Demographic Factors

In Illinois, three major ethnic and racial minority groups represent over 30% of the total population – 15.1% African Americans; 12.3% Hispanic Americans; and 3.4 % Asian American/Pacific Islanders. The DMH Bureau of Strategic Planning, Evaluation and System Analysis continues to evaluate access and utilization of mental health services by specific ethnic groups using data such as that generated for URS Tables 2A and 2B. In recent years, the IDHS has also focused on the segment of the state's population, which remains uninsured or under insured without sufficient resources to purchase needed mental health services. An increasingly accepted guide for identifying this segment is the utilization of the 200% poverty level. This provides census-based demographic data which assists in targeting service delivery and developing cost models to support a system of care for the neediest persons in the State.

Children and Adolescents Receiving Services in FY2007

The number of youth with Serious Emotional Disturbance (eligible population) reported served in FY2006 was 30,353, approximately 85% of the total served. Information on the number of persons served in FY2007 is derived from Basic Tables 2A and 2B, which is being prepared for the FY-2007 Uniform Reporting System Tables.

Progress In Performance Measurement For Adults With SMI And Children And Adolescents With SED

The DMH has established standards and reporting requirements for data submission that are incorporated in all DMH funded agency contracts. Data is submitted to the Reporting of Community Services (ROCS) information system. All data is submitted electronically using one of two mechanisms: (1) DMH developed software -- Reporting of Community Services (ROCS) is available at no cost to community providers or (2) Third Party proprietary software purchased directly from a vendor by community providers. If proprietary software is used, data must be submitted using data reporting standards developed by DMH. Additionally, DMH regularly obtains downloads from the Illinois Medicaid agency. These service claims data are routinely integrated with the reporting of services otherwise funded by the DMH. Case registration data fields that are part of DMH reporting requirements are formatted to permit integration and matching across services funded by the DMH and the DDD, and they lay the groundwork for future matching with other state agencies, including the DASA, the DRS. Assessments are routinely undertaken to determine when new data elements to support decision-making should be added and when others should be eliminated. DMH has made several modifications over the last few years 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 reporting standards

require full reporting of consumer and service data by community providers. Data for consumers receiving treatment in DMH state hospitals are also reported electronically to the DMH Clinical Information System (CIS).

Unique Identifiers: Since FY 2006, all individuals seeking mental health services are being 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. The RINS will lead to improved tracking of services received by consumers across state systems, as well as increased accuracy in unduplication of consumers receiving services in the mental health system.

Performance Measurement Data reported to the ROCS and the CIS are used as the basis for computing performance indicators that have been established by DMH to monitor system performance. 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. DMH staff have successfully participated in federally funded studies and activities related to performance measurement, including the Data Infrastructure Grant opportunities over the years. This included piloting the implementation of MHSIP Consumer Oriented Mental Health Report Card performance measures, the Five State Feasibility Study of Performance Measurement, the Sixteen State Pilot Indicator Study on Mental Health Performance Measures, the State Data Infrastructure Grants, and the current State Data Infrastructure Grants for Quality Improvement.

Child and Adolescent Outcomes Analysis: In FY2007, the DMH contracted with DATSTAT, a Seattle –based contractor, to complete a Web-based Clinical Outcomes Analysis system. The software would consist of three measures: (1) A clinical instrument such as the CAFAS, used at points in time that would yield evidence of positive or negative change; (2) The Columbia Impairment Scales for Parents and Youth; and (3) Goal Attainment Scaling methodology. Users of the web-based system will be able to generate immediate feedback reports at each level of service. Clinicians will be able to generate reports and graphic profiles on their individual clients across specified time periods. Agency site coordinators of the system will be able to generate agency wide service reports. DMH will be able to compile system-wide data from all the participating agencies. Although there have been a few setbacks it is anticipated that this work will continue vigorously through FY2008 with the system being established and in use by the end of the fiscal year.

Strengths, Needs And Priorities

Important strengths of Illinois' community-based mental health system as described under Criterion 2 include:

- ✓ The DMH has an extensive array of computerized information that provides an important resource for analyzing service provision and service needs.

- ✓ Through federally funded studies and DMH initiatives, our databases and analytic capabilities have steadily grown.
- ✓ The Reporting Of Community Services (ROCS) provides data as to the types of services provided, as well as the number of persons served.
- ✓ However, external resources, such as the Data Infrastructure Grant have continued to assist MIS development and system analysis which remain an important DMH priority.
- ✓ Since FY 2006, all individuals seeking mental health services are assigned unique ID numbers which 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. This will lead to improved tracking of services received by consumers across state systems, as well as increased accuracy in unduplication of consumers receiving services in the mental health system.

DMH Priorities and Service Needs:

The DMH places a high priority on the maintenance and improvement of its management information systems to meet the challenges ahead. This work has been valuably supported by the requirements and activities undertaken through the Data Infrastructure Grant.

Transformation Activities in FY2008: Achieving the Promise

The Report of the President's New Freedom Commission on Mental Health provides an important foundation for on-going planning efforts in data epidemiology. In Criterion II, the FY2008 Child and Adolescent plan addresses two of the six New Freedom Commission goals:

Disparities in mental health services are eliminated.

The DMH continues efforts to increase access to services by children and adolescents with serious emotional disturbance. In FY 2004, the percentage of children and adolescents meeting the DMH target population criteria was 33.7%. This percentage decreased in FY 2005 to 30.4% and increased slightly in FY 2006 to 32%. Data for FY 2007 will be provided in the implementation report. Also, note that this is likely an underestimate due to the fact that the DMH is still unable to access SASS data. (See Performance Indicator C2.1- Increased Access to Services by the DMH Child/Adolescent Target Population)

The definition of the DMH eligible population is somewhat broader than the definition for the target population. In FY 2004, the percentage of children and adolescents meeting the DMH eligible population criteria was 91.3%. The percentage decreased in FY 2005 to 89.5%, further decreasing to 86.5% in FY 2006. Data for FY 2007 will be provided in the implementation report. (This is likely to be an underestimate due to the fact that the

DMH is unable to access SASS data). See Performance Indicator C2.2- Increased Access to Services by the DMH Eligible C& A Population

Technology is used to access mental health care and information.

In FY2008, work will continue on the completion of the Child and Adolescent Outcomes Analysis program, a Web-based Clinical Outcomes Analysis system. As noted above, this system will feature the ability to generate immediate feedback at the individual, agency, and statewide levels.

As noted in Section 1, DHS/DMH is planning to reconstitute administrative services through an Administrative Services Organization (ASO) in FY2008. One of the major responsibilities of the ASO will be to implement a state-of-the-art management information system (MIS) which supports a range of data related functions including consumer enrollment, service utilization, provider claims submission, validation, processing, adjudication, and payment through reliable, valid, and expeditious data transmission among all appropriate federal, state, and local entities. The ASO will also provide for access to this data by developing a datamart that is accessible to DMH staff.

Quantitative goals and targets that relate to the comprehensive system of care are presented in Section III as System Performance Indicators.

Criterion 3: Children's Services

Section II. Identification and Analysis of The Service System's Strengths, Needs and Priorities

The grant under section 1911 for the fiscal year involved will not be expended to provide any service of such system other than comprehensive community mental health services; and the Block Grant funds of this grant will be expended to provide only comprehensive community mental health services. Other funding sources have been and will be available to fund the interagency collaborative efforts described below.

Establishment of a defined geographic area for the provision of the services of such system. Defined geographic areas (CCSRs) have been established for the provision of services.

Responsible Agency for the Coordination of all Children's Services

Children's Services in Illinois are provided by several agencies under the direction of the Office of the Governor. The most prominent are: the IDHS, the Department of Children and Family Services (DCFS), the newly established Department of Juvenile Justice (IDJJ); and the Department of Healthcare and Family Services (DHFS). The Illinois State Board of Education (ISBE) oversees and provides guidance

for educational services including health and social services funded by and provided in local school systems.

Responsible Agency For the Coordination of State Children’s Health Insurance Program (SCHIP)

The Department of Health and Family Services (DHFS) is responsible for coordinating this effort which is known as All Kids (See Criterion I).

Responsible Agency For Mental Health Services For Children

The coordination and development of a community-based system of public mental health services for children and families is the responsibility of the DMH.

Description Of Interagency Collaboration Initiatives

Background. Beginning with the award of the Child and Adolescent Support Services Program (CASSP) grant in 1985, the IDHS has actively pursued interagency collaboration with other departments invested in services to children and families. The Joint Services Children Initiative funded by the DCFS and the DMH from 1986 to 1988 designed and delivered services to adolescents at risk of restrictive care either through involvement in child welfare or mental health. Subsequently, the Directors of the DMH and the DCFS finalized congruent geographic boundaries that facilitate access to service (1992). In 1994, the DMH, in collaboration with the Illinois State Board of Education, DCFS, and DASA, assisted in the development of Child and Adolescents Local Area Networks (C&A-LANs) and in the provision of Wraparound training throughout Illinois to increase the coordination of care for youth with emotional or behavioral challenges. The Wraparound approach strengthened the collaboration needed to serve these youth and made the shared agenda of community mental health providers and schools of greater importance. The DMH has also pursued a model of service provision that meets the needs of local schools while also addressing the needs of children served through the Individuals with Disabilities in Education Act (IDEA).

Social Services.

As described previously, the DMH collaborates with other Divisions under the umbrella of IDHS, as well as free-standing state agencies. Many of the social services that are needed by children and adolescents and their families are accessed through IDHS Divisions such as Human Capital Division and Community Health and Prevention. These services are described in more detail in Section I under specified headings.

Teen R.E.A.C.H.

This program was developed by the DCHP and began in 1998 with approximately \$8.5 million in funding from TANF available through the IDHS as a result of the success of the welfare-to-work program and the national movement to self-sufficiency. The mission of Teen REACH (Responsibility, Education, Achievement, Caring and Hope) is to expand the range of choices and opportunities to enable, empower, and encourage youth from 6 through 17 years of age to achieve positive growth and development, improve

their expectations for future success, and avoid and/or reduce harmful, risk-taking behaviors through educational and prevention services delivered during out of school hours. Teen REACH targets low-income youth, with an emphasis on youth from families receiving public assistance, and youth at risk of dropping out of school or juvenile delinquency. Minority youth represent approximately 84 percent of the participants. This program is the result of collaborative prevention planning which included the DMH and is based upon the realization that structured activities after the school day can mean the difference between success for a young person or the emotional sequel of a life scarred by drugs, gangs, pregnancy, and dropping out of school. Regular participation in Teen REACH appears to reduce violent behaviors while providing regular opportunities to reinforce self-esteem and self worth, as documented by the agencies. This innovative community based after-school program is considered one of the necessary supports to families in achieving self-sufficiency.

In FY 2005, Illinois was awarded a grant under the U.S. Department of Education's Gaining Early Awareness and Readiness for Undergraduate Programs (GEAR UP) initiative. Illinois' GEAR UP project, which began in October 2005, builds upon and will be operated from Teen Reach programs across the state. The GEAR UP program will further strengthen Teen Reach efforts.

Illinois Family Partnership Network

The mission of the Illinois Family Partnership Network (IFPN) is to create greater capacity for developing and supporting family leadership in Illinois. The IFPN is composed of 30 local and statewide organizations as well as state agencies that are committed to increasing family involvement so that outcomes for children can be improved. The vision for the IFPN is that all families are able to support themselves and raise their children in communities that can provide the necessary resources and supports. Understanding that family involvement is fundamental to successfully improving outcomes for children, the DMH participates on the Steering Committee of the IFPN to assist in developing a statewide network of parents, organizations, and state agencies. The Illinois Federation of Families (IFF) is an active participant in IFPN. Through the work of IFPN and IFF the needs of parents of children with serious emotional disturbance can be recognized statewide. Both organizations are exploring ways in which they can collaborate to address the need for advocacy training for parents and to provide information as well as a collective voice with access, support and ownership at the state, regional and local levels. Throughout the state the DMH co-sponsors IFPN conferences that aim to foster children's academic, social and emotional learning through family-school partnerships.

Educational Services and Services Provided Under the Individuals with Disabilities Education Act (IDEA)

Mental Health and the Schools: System of Care-Chicago

The Surgeon General's Report on Mental Health states that schools are a major setting for the potential recognition of mental disorders in children and adolescents. Many community mental health agencies, recognizing the critical role a school plays in a

child's life, have developed strong working relationships with schools. Ideally, services should be initiated before there is a mental health problem that interferes with academic success. However, capacity across the array of mental health services, including child psychiatric expertise, is not sufficient to identify, assess and treat children *before* there is a crisis in that child's life. In FY-2000, the DMH developed a model for mental health services in schools to address children's mental health needs that are beyond the school's expertise. The model is organized around the needs of the families, schools and communities and includes universal, selected and targeted strategies while addressing cultural factors, stigma, outreach and other barriers to engagement. As a result students experience school wide behavioral interventions that promote learning and provide positive approaches to the task of learning as well as integrated mental health services.

The DMH has continued with an expert group to initiate the model that utilizes school consultation teams, offers psychiatric expertise, and expands community mental health capacity to respond to the needs of students and their families. Much of this work has been initiated under the System of Care Grant awarded by SAMHSA CMHS (see Section III, Criterion 3).

Juvenile Justice Services

Mental Health and Juvenile Justice (MHJJ)

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. In order to address these needs, the DMH developed a collaborative project with the juvenile justice system that was initiated in FY 2000. The DMH provides funding for 24 system liaisons. Liaison staff works with detention centers and the courts to identify youth with major affective disorders and psychosis who are exiting from detention; and to assure linkage with community mental health programs for assessment and treatment. Each liaison serves approximately 50 youth and their families per year. This initiative strengthens the linkages among the courts, probation, detention, the schools, mental health, health and other community-based services. With the community mental health services in place to address the clinical needs of the youth, the liaison can also access wraparound funds to accommodate supports for the youth.

Substance Abuse Services

Services for Youth with Co-Occurring Disorders

As part of assessment at intake, mental health staff track the proportion of children and adolescents who are dually diagnosed with mental health problems and substance abuse (*see Performance Indicator C3.2*). As reported above, relatively few children are identified (a little over 1%). DMH C & A program staff in collaboration with the DASA continues to explore the need for staff training and current program capacity issues in clinically addressing the needs of this population. The MISA Subcommittee of the Metro C & A Region Advisory Council is engaged in strategic planning with the DASA. The Training and Consultation Subcommittee was formed to identify the training and

consultation needs of community mental health and DASA staff when working with children and youth with co-occurring mental health and substance abuse issues. The Assessment and Program Development Subcommittee was formed to explore how programmatic and systems issues might be addressed to decrease gaps in service delivery that children, youth and their families might experience in the course of care. These subcommittees will continue their work and share findings through the Metro C & A Region and DASA structures

Health and Mental Health Services

Access to Health Care:

Collaboration with the Department of Healthcare and Family Services supports access to healthcare programs which ensure access to health care for children and adolescents: ALLKIDS, an expansion of the previous KidCare program, was implemented in July 2006. See Criterion I Above.

Community Health and Prevention

Collaboration between the DMH and the Division of Community Health and Prevention (DCHP) is addressing two arenas: (1) Mental health services to families that have experienced domestic violence: (2) Identification of children's mental health needs in child care settings. The DMH participates in the quarterly meetings of the DCHP Healthy Child Care Illinois initiative and contributes to the development of the initiative's annual meetings in which nurse consultants from around the state came together to discuss the mental health needs of children in child care settings. Additionally, the DMH is collaborating with DCHP and the members of the Postpartum Depression Task Force to address the needs of women who experience depression during pregnancy and postpartum.

Community and Residential Services Authority

Since 1986, the DMH has been an actively participating member of the Community and Residential Services Authority (CRSA), which was created in 1985 by the Illinois General Assembly. The membership of the Authority includes child-serving state agencies, education, public and private sector gubernatorial appointees and members of the General Assembly. CRSA combines interagency deliberations to resolve multiple agency disputes and to plan for a more responsive, efficient and coordinated system to address the needs of children and their families. Many of the children who experience behavior disorders or severe emotional disturbances have multiple and diverse service needs which do not clearly fit the service eligibility criteria or funding streams of state and local public agencies. CRSA successfully negotiated the participation of eight state human service agencies in a pooled fund which is used to carry out an inter-agency service plan when children and families are unable to fully qualify for services from a state agency.

Illinois Children's Mental Health Partnership (ICMHP)

The Children's Mental Health (CMH) Act of 2003 created the Illinois Children's Mental Health Partnership (ICMHP). The Partnership is charged with developing a Children's

Mental Health Plan containing short-term and long-term recommendations for providing comprehensive, coordinated mental health prevention, early intervention and treatment services for children from birth to 18. The ICMHP is comprised of members of child-serving agencies and other mental health system stakeholders including parents of children with emotional and serious emotional disturbances. DMH Child and Adolescent Service System staff are active members of the ICMHP and are active partners in promoting its vision.

The ICMHP has been successful in garnering state funds for children's mental health needs. The DMH Child and Adolescent Office works closely with the ICMHP in planning how the funds are to be used and implementing those plans. In FY2008, ICMHP is anticipating a \$6.5 million budget which will include funding the expansion of key projects in services to transitioning youth, early childhood consultation, and early intervention. Five new pilot projects will be initiated statewide to provide transitional services for older adolescents (16-17 years old) who are transitioning from C&A services to adult services and for any youth with SED transitioning from correctional services to the community. The projects will provide direct basic services and will serve to build the infrastructure for continuing expansion and service effectiveness. The outcomes of these programs will provide vital information as to the kind of models which work best in serving these two transitional groups. An Early Intervention Initiative provides a granting opportunity to selected DHS agencies in each region. The aim is to outreach in venues which are outside the normal service paths for children with serious disturbances, identify children at risk, especially those at risk of depression, and to intervene early. Flexibility is being emphasized as each agency develops its own plan and approach to early intervention based on the unique geographic, cultural, and interagency service environments in each region. By the end of FY2008, two agencies in every region will be in a position to coordinate early intervention services. Additionally an Early Childhood Consultation program is being expanded statewide in FY2008 to engage consultants who travel to the selected agencies and provide case consultation, education in early childhood issues, and training to identified agency staff for a period 12-18 months. Agencies successfully completing the training and consultation program will receive funds to expand their services and provide support to other agencies in their area which are developing this specialization. Plans for these initiatives are addressed more fully in Section III.

Strengths, Needs and Priorities

The strength of the DMH service delivery system for children and adolescents is multifold, and is based on collaboration with IDHS Divisions and free-standing state agencies to ensure continuity of care and service integration:

- ✓ 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, a collaboration with DCFS and DHFS have expanded the provision of SASS services.

- ✓ The Mental Health in Schools Model, that strive to strengthen inter-agency collaborations using the school as a setting for prevention, early identification, and intervention activities. This approach is being extended in several areas of the state through federal funding from SAMHSA.
- ✓ The statewide Mental Health Juvenile Justice (MHJJ) program which brings services to youth in county detention centers across the State is a collaboration between juvenile justice and DMH
- ✓ 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 such services to youth in transition, early intervention, and the promotion of Evidence Informed Practices.

DMH Priorities and Service Needs:

The service system priority continues to be one of collaboration to provide a seamless system of care, given the multiple problems of children and adolescents, as well as their families, who are involved with overlapping service systems. The expansion of Mental Health in Schools and Systems of Care such as McHenry county's model is an important need and priority. The DMH is continuing to focus on the implementation of evidence-based practices for children. Additionally, the C&A statewide office is undertaking joint work with DCFS toward the continuing education of mental health providers on addressing trauma issues. Collaborative efforts with Children's Mental Health Partnership, DHFS, and the IDHS Community Health and Prevention Division (CHP) to develop consultation approaches and promote evidence informed practices are an active priority.

Transformation Activities in FY2008: Achieving the Promise

The Report of the President's New Freedom Commission on Mental Health provides an important foundation for on-going planning efforts in service integration for children and adolescents. The service system priority continues to be one of collaboration to provide a seamless system of care, given the multiple problems of children and adolescents, as well as their families, who are involved with overlapping service systems. An additional priority on which DMH is focusing is the implementation of evidence-based practices for children. In Criterion III, the FY2008 Child and Adolescent plan addresses two of the six New Freedom Commission goals:

Early mental health screening, assessment, and referral to services are common practice.

In FY2008, the DMH will collaborate with Chicago Public Schools, the Illinois State Board of Education (ISBE), University of Illinois at Chicago, and the Illinois Department of Children and Family Service (IDCFS), to continue development of an integrative approach for providing a range of prevention, early identification, and intervention activities as components of the emerging "mental health in schools" model. (See Objective C3.1.) In collaboration with the Illinois Children's Mental Health Partnership, DMH is initiating ten new early intervention programs and expanding early childhood consultation to twelve agencies statewide (See Objectives C3.4 and C3.5). These

initiatives will be evaluated. An initial report documenting outcomes, lessons being learned, gaps and challenges, any successful innovations, and a plan for specific next steps and the long term vision for continuing expansion of these initiatives will assist in instituting the service.

Excellent mental health care is delivered and research is accelerated.

In FY2008, an additional transitional service program for youth aging into the adult mental health service system and for those transitioning from correctional settings in each of the five CCSRs which will bring the number of programs statewide to ten. Outcomes of the programs that were initiated in FY2007 will be evaluated to learn what is needed to provide effective programs for individuals in this age group and in similar situations. This initiative is an effort to establish the groundwork required to develop a service model and the necessary infrastructure to replicate and expand these services statewide. (See Objective C3.3)

The Mental Health Juvenile Justice (MHJJ) initiative will continue work to increase the number of juvenile detainees with serious mental illnesses who are identified, screened, and linked with appropriate community-based services. Evaluation of the MHJJ program has found that these services result in overall clinical improvement, decreased functional impairment and reduced rates of recidivism for youths enrolled in the program. Based upon evaluation findings, the program will work on increasing the clinical services that have been found to be most strongly associated with positive outcomes, increasing the number of service sessions provided for Black and Hispanic youth, and increasing the number of minority youth referred to the MHJJ program. (See Objective C3.2).

<p>CRITERION 4: Targeted Services To Homeless And Rural Populations.</p>

The Homeless Population in Illinois

The IDHS Emergency Food and Shelter (EF&S) program issues an annual report that reviews trends in services provided to homeless persons in Illinois. **See this Criterion in the Adult Section above.**

Outreach to Homeless Youth and Families

Income is reported to be the main cause of homelessness for adults but once this event happens children are directly affected. Over the past couple of years the proportion of the caseload attributing homelessness to income problems has fluctuated at around one-third of the state's Emergency Food and Shelter (EF&S) population. In FY 2006, 6, 852 households with children accounted for 14,122 participants under the age of 18 (29% of the total served) of which 50% (7,062) ranged from newborn infants through five years of age. Combined with the 18 through 21 year old group (3,029) nearly 35% (34.89) of the

homeless persons served by the EF&S program were under the age of 22. In 2006, the proportion of the caseload attributing homelessness to income problems was 38% among the population served by the state's Emergency Food and Shelter (EF&S) population. Income as a precipitator of homelessness ranged from 25% for households of females with children to 41% for homeless couples with children. Eviction was the most common reason given by these households as the primary cause of their homelessness. Another 22 percent (7,353) of homeless households cited reasons for homelessness related to family and neighborhood such as overcrowded conditions, domestic violence, gang violence, and disputes with neighbors and landlords. One third of these households (2,432) were single females with children.

Mental health planning and services to homeless youth is complicated by the inherent invisibility of this population as well as the priority of meeting their basic needs when they are reachable. Likewise, homeless families are not exempt from the problems presented by their children with severe emotional disturbance but these are often overshadowed by the urgency of meeting the family's survival needs. Over the years, workgroups have been convened which consisted of homeless youth service/shelter providers and DMH-funded mental health providers to identify barriers to effective services for this client group. The IDHS maintains services to homeless youth who are 20 years of age or younger and cannot return home and/or lack the housing and skills necessary to live independently. The Homeless youth program is administered by community-based agencies and is available in six Illinois counties and the city of Chicago. The IDHS-funded programs provide these important services for homeless youth:

- **Emergency shelter:** Either through placement in a shelter, group home or by purchasing lodging, youth are given a safe, clean, dry place to sleep.
- **Transitional services:** Focus on skills necessary to support oneself, including education, employment services, and subsidized housing.
- **Drop-in center/outreach:** Programs seek to find homeless youth and assess their needs. Program staff may attempt to reunite them with family or refer them to transitional services.
- **Services for singles:** Single programs serve youth who do not have children.
- **Services for pregnant or parenting youth:** Programs specialize in the needs of homeless youth with children.

In FY2006, 19 Homeless Youth providers served approximately 625 youth, ages 14-20 in their emergency shelters and transition living programs. Additionally, an undetermined number (as identifying data is not collected) are served in the Homeless Youth Outreach programs across the state. The program is funded at an average of \$4.5 million each year. Each youth is assessed for needs and strengths and a case plan is developed for service provision which includes case management, provision of food and shelter, life skills training, employment assistance, advocacy, education assistance, and parenting skills. Mental health services are accessed when needed.

Homeless youth/shelter providers have worked successfully with mental health service providers in several areas of Illinois. SASS agencies in Rockford and East St. Louis continue to work closely with shelters, usually providing an initial mental health assessment, crisis intervention service, and mental health case management.

Services In the Metropolitan Chicago Area:

Services to homeless youth and their families are being addressed in the Urban Systems of Care (USC) initiative which was previously See Criterion I above. Collaboration between Urban Systems of Care homeless providers and citywide homeless services providers has been essential to examine the array of necessary supports available to reduce the risk of homelessness. USC providers and city-wide homeless services providers routinely coordinate their efforts at addressing this population.

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 ten 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. Funding for the expansion of the S.O.S. program to include youth and families at four of the City of Chicago Warming Centers has occurred. Mental health services are intensive and include crisis services, assessment, referral and linkage. All services are community based and linkages are made with programs designed to intervene with young children. The principal intervention team includes a qualified mental health professional and case manager. Ancillary staff includes a child psychiatrist, a speech and language therapist and other mental health.

This program is exemplary in that it has actively focused available resources to meet the needs of the homeless children it serves. S.O.S. works closely with two universities to bring clinical resources to homeless young children. The University of Illinois Department of Psychiatry assigns psychiatrists doing their residency to the program on an ongoing basis to provide psychiatric evaluations and consultation. The Department of Developmental and Behavioral Pediatrics of the Pritzker School of Medicine, University of Chicago, works closely with the program to provide developmental and pediatric health evaluations. The United Way has provided funding to establish a "medical home" model of service for the children aged 3 to 5 and their families in the program. This has resulted in outreach to homeless families with young children requiring medical care and referral and linkage with health providers who follow up on the health needs of the child. The program participates in a group of nine providers statewide who are receiving early childhood consultation services (See objective C3.5 in Section 3) which has allowed for some sharing of interventions and approaches unique to homeless children with mental health providers. In FY2006, Beacon Therapeutic School's Shelter Outreach Service reports that it served 1400 (rounded figure) homeless children in 600 homeless families residing in Chicago shelters. The program found and secured appropriate permanent housing for 300 families through its case management services.

Rural Mental Health Services - Youth and Their Families

The term "rural" in Illinois is used to refer to residents in 76 non-Metropolitan Statistical Area (MSA) counties and residents not in municipalities of 25,000 or larger. (Rural

Revitalization: The Comprehensive State Policy For the Future, Governor's Rural Affairs Council, April, 1990 pp. 2-4) Based on Illinois' definition of rural areas, 76 non-metropolitan counties are being targeted for assessment of the mental health needs of residents, evaluation of current services and programs, and the identification and eventual resolution of problems in service delivery unique to rural environments. The DMH is a member of the Governor's Rural Affairs Council and provides the mental health perspective on rural issues. The Council provides an opportunity to network with a variety of state government agencies and community institutions, which can support mental health services for youth in rural areas.

The establishment of SASS programs in rural areas has addressed the need for family-based crisis intervention and intensive mental health services to rural families and has been of inestimable value to families of youth with serious emotional disturbances. Since FY-1997, when SASS services were made available in all 76 rural counties through the addition of 23 new programs in Southern Illinois, the problem-solving encountered by SASS programs and the local area networks in these areas in delivering services has provided valuable information for strategic service planning of services in rural settings. Accompanying the SASS expansion in the rural areas of Illinois, the CCSRs serving these areas have undertaken the planning and coordination of services for families with children and youth having serious emotional disturbances. Agencies that were pocketed in isolation now network with other child-serving agencies. There has also been increasing emphasis on the unique and central function of schools as networking partners in the process of improving access and availability of services to rural families

Strengths, Needs and Priorities

In addition to the broader strengths noted in the Adult Section 2, there are several specific strengths to be noted for children and adolescents in this Criterion:

- ✓ The DMH has put in place outreach services for homeless children and youth. 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 ten 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 IDHS Homeless Youth program which has existed for many years provides outreach and a range of services for homeless youth ages 14-21.
- ✓ In rural areas, SASS programs continue to work closely with community providers to enhance service delivery for children and adolescents.
- ✓ Innovative approaches that integrate DMH services with rural schools have been developed.
- ✓ Public Act 95-16 signed by the Governor in July, 2007 that gives Illinoisans living in rural communities increased access to psychiatric care by requiring the Illinois Department of Healthcare and Family Services to reimburse psychiatrists and federally-qualified health centers (FQHCs) for mental health services

provided via telepsychiatry. DMH is planning to move forward to provide child psychiatry consultation and services through telepsychiatry in Region 4 and Region 5 which are very rural. Six agencies will be selected to study and report on what would be needed to carry out a telepsychiatry program effectively.

DMH Priorities and Service Needs:

The FY2006 EF&S Report clearly points to the principal priority of DMH. One third of the homeless population (which were served by EF&S) were under the age of 18. New and expanded service models and implementation are required to meet the needs of this population. Programs and service models already existing such as Beacon therapeutic School's Shelter Outreach Service require statewide replication and continuing expansion.

A DMH survey found that major concerns across rural counties include the need for transportation and for "one-stop" services shopping. These concerns suggest the need for a broader partnership among state agencies. Initiatives with universities located in rural areas such as Southern Illinois University (SIU) are aimed at developing strategies to better align service delivery for children and adolescents in rural areas. Other approaches, including video-conferencing and telepsychiatry are assertively advanced and increasingly utilized.

Transformation Activities in FY2008: Achieving the Promise

The Report of the President's New Freedom Commission on Mental Health provides an important foundation for on-going planning efforts for youth with serious emotional disturbance who are homeless and those residing in rural areas. In Criterion IV, the FY2008 plan addresses three of the six New Freedom Commission goals:

Disparities in mental health services are eliminated.

Since FY 1999 the number of homeless youth entering community-based services in the public mental health service system has been tracked permitting an initial evaluation of the system's ability to provide access to mental health services for runaway youth and children in families who are homeless and who have serious emotional disturbances. In FY 2005, 401 youth were identified as undomiciled or homeless at their initial assessment; this number decreased in FY 2006, with 365 youth reported as homeless. (See System Performance Indicator C4.1)

The DMH continues to track the number of rural youth served (see System Performance Indicator C4.2) in the public mental health system. There appears to be a trend toward increased access of services by this population. In FY2004, 9,744 youth received services in FY 2004, 10,247 youth received services in FY 2005 and 11,014 in FY 2006.

Technology is used to access mental health care and information.

and

Excellent mental health care is delivered and research is accelerated.

In FY2008 a telepsychiatry pilot project focusing on child psychiatry consultation will be implemented in six rural sites in Illinois. An initial allocation of \$300,000 will support the purchase of child psychiatry time and permit thoughtful study and evaluation of the process, equipment, and infrastructure necessary to expedite this service. (See Objective C4.1)

Criterion 5. Management Systems

The DMH continues to work towards an integrated system of care that includes both state hospitals and community-based providers, including those responsible for emergency health services regarding mental health. In this section, initiatives to enhance financial resources and human resources including significant achievements are described. There is also a brief analysis of the systems strengths, needs and priorities.

Enhancing Financial Resources

Increased Financial Resources For Community Services

With the increased emphasis on community-based treatment in the last twenty years came an increase in the proportion of budget spending on community mental health services. Compared to 8% of the DMH's budget in FY-1973, more than 60% of the mental health budget in FY2007 was allotted to fund community programs.

Since FY-1999 the DMH has maintained a transition line for each state hospital. This funding line can be used for continued state hospital operations if needed, or can be used for expanding community services as census reductions free up resources. In FY2007 \$12, 071,107 was allocated in transition funding to the Regions.

Increased Financial Resources For The Child And Adolescent Population

In FY-1996, with the redirection of funds from inpatient care to community-based services, \$7,146,521 was spent on SASS programs, including service expansion in Central Illinois. By FY-1997, with further enhancement, SASS programs covered a geographic area that includes 100% of the State's child and adolescent population. \$8,697,743 was provided. In FY-1999, the budget included \$10,612,300 based on the redirection of funds gained from the closure of the metro C&A facility. These funds were allocated to purchase community-based hospital care, expansion of community-based outpatient and SASS services, and the establishment of the Urban Systems of Care initiative, which targets youth of the Chicago Housing Developments.

Other efforts have increased the financial resources available to support service delivery to children and adolescents and their families. The System of Care – Chicago Project funded by SAMHSA for \$9.5 million dollars, which was described in a previous section of this application, has brought a great deal of resources into the state over the last 4 years and will continue to do so over the next year. Statewide C&A Regional staff also collaborated with three counties (McHenry, Champaign and St Clair) to submit three new applications for System of Care grants. The McHenry County application was funded, thus new additional Federal dollars are now available for the child and adolescent system of care.

Increasing Federal Financial Participation (FFP)

The DMH has worked closely with CMHCs in an aggressive plan to increase the claiming of federal Medicaid funds to support community based mental health services. In FY-1996, the DMH implemented procedures to increase enrollment and billing of persons leaving state hospitals, and modification of certain technical aspects of the billing process. These activities permitted greater flexibility in generating Medicaid funds for community mental health programs. As a result, there has been a steady increase in the amount of FFP generated to support mental health services in Illinois.

In the last three years there has been an increasing focus on generating FFP in the state. The DMH has undertaken an ambitious effort to move from using primarily grant-in-aid funding to purchase services to the use of fee-for-service as a primary purchasing mechanism. This initiative known as the System Restructuring Initiative (SRI) was described in Section I, and is further described in Section III of this application.

Medicaid Billing for the Child and Adolescent Population

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

Enhancing Human Resources

Staff Recruitment and Retention

Human resource development is a critical aspect of community-based services for both adults with serious mental illness and children with serious emotional disturbance and their families. It is important to ensure that persons providing mental health services have the required knowledge, skills, competencies and attitudes. In addition, the mental health service system must be able to recruit and retain skilled staff.

There have been several efforts to impact these issues in the past several years. The continued focus on, and support of public/academic linkages is one such effort. All state hospitals in Illinois have agreements with universities to serve as training sites for psychiatric residency programs. These sites provide an opportunity for psychiatric residents to work with patients with serious and persistent mental illnesses, as well as children and adolescents with SED, and to learn how the publicly funded mental health system operates. There are also similar programs with Departments of Social Work, Psychology, and Nursing in universities across the state. These programs provide fertile ground for the recruitment of program graduates who are well grounded in public mental health as a result of their residencies.

Mental Health and Law Enforcement Training

The DMH regularly collaborates with law enforcement agencies and emergency services at general hospitals to facilitate appropriate and effective psychiatric intervention to persons in crisis. DMH, in conjunction with the U.S. Attorney's Office of the Central and Northern Districts of Illinois, has developed initiatives aimed at improving the attitudes of law enforcement and mental health professionals towards each other's views, duties, roles, and skills. DMH has also worked with the Illinois Law Enforcement Training and Standards Board (LETSB) to develop a one-day training program targeted for experienced police officers on dealing with individuals who are mentally ill and in a behavioral crisis.

Human Resource Development Related To The Children And Adolescent Services

In FY-1999, the DMH contracted with the University of Illinois at Chicago Department of Psychiatry to oversee the implementation of a Statewide Child and Adolescent Training Initiative. The initiative was funded and implemented in FY-2000. Training occurred statewide with national experts presenting state of the art practice in the delivery of services to youth with serious emotional disturbance. The content was geared towards the needs of mental health providers, which were determined in a comprehensive survey. The continuation and recent activities involved in this initiative are described in Section III.

Strengths, Needs and Priorities

- ✓ 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.
- ✓ 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.
- ✓ Innovative directions in the use of limited fiscal resources to promote expansion and growth of needed services such as initiating a fee-for-service payment mechanism to purchase services for individuals from community mental health agencies.

DMH Priorities and Service Needs:

Like many states, Illinois has experienced fiscal problems in recent years, leading to decreases in allocations for human services. There is therefore an even greater need to increase revenue from federal Medicaid funds.

The development of alternative cost efficient training supports remains a priority. The DMH does not have dedicated resources for a training department of its own and fiscal

problems have resulted in the cancellation of several training contracts in the past few years.

Training events that assist in the implementation of evidence-informed practices continue to be a priority of DMH.

In the wake of 9/11, the DMH has recognized the need for a statewide mental health plan for responding to terrorist activities, as well as natural and other disasters.

Transformation Activities in FY2008: Achieving the Promise

The Report of the President's New Freedom Commission on Mental Health provides an important foundation for on-going planning efforts in towards enhancing financial and human resources. In Criterion V, the FY2008 plan addresses two of the six New Freedom Commission goals:

Early mental health screening, assessment, and referral to services are common practice.

The DMH will continue to emphasize Mental Health and Law Enforcement Training by collaborating with law enforcement agencies and emergency services at general hospitals to facilitate appropriate and effective psychiatric intervention to youth and support to families in crisis.

In FY 2008, \$6.5 million dollars has been allocated for mental health services for children and adolescents through a partnership with the Illinois Children's Mental Health Partnership. These dollars will be spent on a range of pilot projects including: early intervention programs, early childhood consultation, telepsychiatry, and services to transitioning youth. (While the outcomes of these projects are geared toward the goal above, the processes are applicable as well to the goal below.)

Excellent mental health care is delivered and research is accelerated.

In FY2008, the DMH will continue to work on increasing Medicaid funding for the Illinois mental health service system. Barriers to increasing Medicaid billing and to enhancing eligibility for consumers who use DMH funded mental health services (including patients in state psychiatric hospitals) need to be identified and eliminated. Medicaid policies and procedures need to be clarified and the documentation requirements of providers streamlined. Work will continue in developing and maintaining a system for utilization management within the Medicaid program and the implementation of fee-for-service funding. (See Objective C5.1)

Medicaid billing has risen considerably for services for children and adolescents in the past several years. In FY 2005, the total was \$19,960,808. Medicaid billing increased to \$22,005,772 in FY 2006. Final figures are not yet available for FY 2007 (**see System Performance Indicator C5.1**)

The System of Care Chicago grant has brought major new funds targeting the child and adolescent population into the state. This grant, which was funded at \$9.5 million over a six year period, will continue for one more year. The system of care grant awarded by SAMHSA CMHS to McHenry County in FY 2005 was also funded at \$9 million dollars per year over a six year period. The McHenry SOCC will continue through FY 2011.

The DMH has contracted with the University of Illinois at Chicago Department of Psychiatry to oversee the implementation of a Statewide Child and Adolescent Training Initiative. The DMH C&A staff continue to collaborate with the University of Illinois on this effort as well as others. Another initiative to help enhance the competencies of C&A service providers has occurred as a part of the System of Care Chicago Grant. The initiative includes the provision of education and training in Evidenced Informed Practices and consultation to child and adolescent providers. These efforts are expected to continue and expand during FY 2008.

Illinois

Child - Unmet Service Needs

Child - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

The DMH has identified the following unmet service needs within the system:

Incorporating "resilience" with recovery to increase the applicability of concept and practice to children and their families.

Address cross-systemic issues in screening, prevention and early intervention especially as related to violence and trauma by:

Identifying and promoting current practices including the role of schools as the prime location for prevention and early intervention.

Promote screening and prevention across systems (e.g. child welfare, juvenile justice) and special populations, workforce

Increasing trauma informed care and practices

Focusing on the persons too old for child services but too young for adult services who may require assistance re-entering the community from a child-serving institution.

Increasing coordination between schools and mental health system to address the needs of transitioning youth.

These needs were identification by stakeholders during state mental health planning meetings during the last fiscal year.

Illinois

Child - Plans to Address Unmet Needs

Child - A statement of the State's priorities and plans to address unmet needs.

Plans to Address Unmet Needs

DMH Priorities and Service Needs:

Criterion 1:

- Continued expansion of the scope and quality of parent and youth involvement remains a priority. Family involvement continues to emerge as a gathering strength in the C&A community service system as well as in successful inter-agency collaborations.
- The development of early intervention programs and collaborative initiatives for children of all ages is a major priority of the Statewide C&A Services Office as is the promotion and growth of early childhood consultation in the State designed to support and strengthen services to very young children.
- Another concern is the need to enhance family involvement in the development and implementation of individualized treatment plans for children and adolescents receiving mental health services.
- Inter-agency collaborations have been an important support and strategy for the DMH in improving services for children and adolescents. The DMH has an active collaboration with the Children's Mental Health Partnership to implement Evidence Based Practices. The DMH also has strong and improving initiatives in collaboration with other agencies including the juvenile justice system, mental health services in schools, and the substance abuse service system to address co-occurring mental illness and substance abuse disorders, and the child welfare system. These initiatives respond to ongoing needs and will remain a priority.
- Activities aimed at reducing hospitalization and out of state residential treatment have been successful. Screening through the SASS program and crisis services have contributed to this success. Case management services, Wraparound services, and ICG/MI community services also help to reduce hospitalization and residential treatment while providing ongoing clinical care and linkage to supportive services in the community. These services will remain a high priority for DMH.

Criterion 2:

- The DMH places a high priority on the maintenance and improvement of its management information systems to meet the challenges ahead. This work has been valuably supported by the requirements and activities undertaken through the Data Infrastructure Grant.

Criterion 3:

- The service system priority continues to be one of collaboration to provide a seamless system of care, given the multiple problems of children and adolescents, as well as their families, who are involved with overlapping service systems. The expansion of Mental Health in Schools and Systems of Care such as McHenry county's model is an important need and priority. The DMH is continuing to focus on the implementation of evidence-based practices for children. Additionally, the C&A statewide office is undertaking joint work with DCFS toward the continuing education of mental health providers on addressing trauma issues. Collaborative efforts with Children's Mental Health Partnership, DHFS, and the IDHS Community Health and Prevention Division (CHP) to develop consultation approaches and promote evidence informed practices are an active priority.

Criterion 4:

- The FY2006 EF&S Report clearly points to the principal priority of DMH. One third of the homeless population (which were served by EF&S) were under the age of 18. New and expanded service models and implementation are required to meet the needs of this population. Programs and service models already existing such as Beacon therapeutic School's Shelter Outreach Service require statewide replication and continuing expansion.
- A DMH survey found that major concerns across rural counties include the need for transportation and for "one-stop" services shopping. These concerns suggest the need for a broader partnership among state agencies. Initiatives with universities located in rural areas such as Southern Illinois University (SIU) are aimed at developing strategies to better align service delivery for children and adolescents in rural areas. Other approaches, including video-conferencing and telepsychiatry are assertively advanced and increasingly utilized.

Criterion 5:

- Like many states, Illinois has experienced fiscal problems in recent years, leading to decreases in allocations for human services. There is therefore an even greater need to increase revenue from federal Medicaid funds.
- The development of alternative cost efficient training supports remains a priority. The DMH does not have dedicated resources for a training department of its own and fiscal problems have resulted in the cancellation of several training contracts in the past few years.
- Training events that assist in the implementation of evidence-informed practices continue to be a priority of DMH.
- In the wake of 9/11, the DMH has recognized the need for a statewide mental health plan for responding to terrorist activities, as well as natural and other disasters.

Illinois

Child - Recent Significant Achievements

Child - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

Update on Areas Needing Attention in FY 2007 Plan - Significant Achievements –
Excerpted from Section I

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

Consumer Participation and Involvement

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

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

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

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

C&A Services focused on family participation by increasing the availability of family resource developers (FRDs) and the advisory role of youth who utilize or have utilized services. Of the 54 agencies providing SASS services, only three of the agencies have never hired a FRD. There is generally a modest level of turnover in the FRD staff, and at

the point that the FY 2007 FRD survey was conducted 41 of 49 reporting agencies (84%) had FRDs employed. Thirty-one (76%) were FTE positions. Monthly meetings are held for the FRDs in order to provide education, resource development and support for the positions. FRDs from the Federal Systems of Care demonstration grants also attend these meetings. The survey results could not specify the number of positions that were FY 2007 new hires. Some agencies have expanded the support role and are using FRDs to assist with Individual Care Grant application processes and service planning. Each System of Care site has emphasized the importance and hiring of FRDs.

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

Evidence-Based Practices

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

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

Systems Integration

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

Support Services (SASS) for children and adolescents and their families. DMH and the Division of Rehabilitation Services' continue its collaboration the 'Brand New Day Initiative' and the provision of Benefits Planning, Assistance and Outreach Project funded by the Social Security Administration. DMH collaborates with the City of Chicago Mayor's Office for Persons with Disabilities on the latter initiative. There is also continuing collaborative work with the Department on Aging on joint training and advocacy programs.

Program Enhancement

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

Service Administration

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

Information Technology

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

Grants

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

Illinois

Child - State's Vision for the Future

Child - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

Illinois has made substantive progress in developing a comprehensive mental health service system for individuals with serious mental illnesses (SMI) and for youth with serious emotional disturbances (SED) and their families. Illinois envisions a well resourced transformed mental health system that is consumer directed and community driven with a continuum of integrated and effective culturally inclusive programs, services (prevention, early intervention and treatment), and supports, that promote healthy lifelong development through equal access and that 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. The Illinois Vision for Mental Health is "The Expectation of Resilience and Recovery through Treatment, Accountability and Equal Access". Many of the activities in which the DMH is engaged are providing the foundation to make this vision a reality.

Illinois

Adult - Establishment of System of Care

Adult - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

SECTION III: PERFORMANCE GOALS AND ACTION PLANS TO IMPROVE THE SERVICE SYSTEM

Plan Organization

As the Illinois Mental Health Authority, the DMH is responsible for public mental health services for both children and adults. The previous organization of the plan reflected this service integration. The organization of the FY 2008 Block Grant Plan continues the transition begun in FY2007. **The Illinois DMH Block Grant Plan for FY 2008 is organized by Section separately for adults and children. Section III-A (Adults) and Section 111-B (Children & Adolescents) are each organized within the context of the five legislative criteria. This organization is reflected in the Narrative, as well as in the section that contains the relevant system performance indicators which follows the Narrative. This section describes the objectives specified for FY2008 that relate to comprehensive mental health service delivery.**

Illinois Transformation Agenda

Since July, 2003, when the President's New Freedom Commission on Mental Health released its final report, the Division has focused its efforts at reforms and improvements in the Illinois public mental health system in accordance with the six principal goals of a transformed system of care which were articulated by the Commission:

- (1) Americans understand that mental health is essential to overall health. (See Criterion I)**
- (2) Mental health care is consumer and family driven. (See Criterion I)**
- (3) Disparities in mental health services are eliminated. (See Criterion 2 and Criterion 4)**
- (4) Early mental health screening, assessment, and referral to services are common practice. (See Criterion I, Criterion 3, Criterion 4, and Criterion 5.)**
- (5) Excellent mental health care is delivered and research is accelerated. See Criterion 1 and Criterion 5)**
- (6) Technology is used to access mental health care and information. (See Criterion 2 and Criterion 4.)**

The Commission's goals and recommendations were based on the key principle that public mental health systems should be altered to make recovery from mental illness the expected outcome from a transformed system of care:

“We envision a future when everyone with a mental illness will recover, mental illnesses can be prevented or cured, mental illnesses are detected early, everyone with a mental illness at any stage of life has access to effective treatment and supports – essentials for living, working, learning, and participating fully in the community”

Beginning in 2003 and continuing through 2004, the Illinois Department of Human Services (DHS) convened Work Out Groups composed of DHS staff and key

stakeholders to focus, discuss, and recommend actions in response to a range of perceived challenges being presented in the mental health system of care. Among these groups were three that addressed the following:

1. Leadership/Planning for a continuum of care across multiple systems –
Optimal integration of funding streams/resource alignment.
2. A continuum of care infused with evidence-based and best practices.
3. Identification /analysis of service system gaps.

The DHS Work Out Groups were an important component in the development of comprehensive mental health planning and first articulated the existence of significant cross-system mental health issues in the evolutionary human services climate.

A Strategic Vision Report, a product of the DMH System Restructuring Initiative (SRI), was completed in May, 2005 and described the extensive effort in planning for the conversion of the system to a Fee-For-Service model as well as instituting recovery principles as cornerstones of the process. Based on feedback from planning retreats with state agency staffers and from more than 200 stakeholders through the use of focus groups, the report identified the need to increase DMH's leadership role, consistent with state statute, with respect to the policies and allocation of resources to serve people diagnosed with mental illnesses and to invite greater collaboration across agencies and service systems utilizing DMH as the locus of mental health expertise and direction. For consumers and their families, mental health services needed to be integrated with other health and human services so as to appear seamless in access when needed. The ideal system of care in Illinois would be characterized by: (1) A focus on recovery as the goal of service delivery, emphasizing outcomes rather than the services themselves; (2) Data-driven policy and program decisions based upon an improved capacity to analyze and disseminate relevant information; (3) Individualized service planning with the active participation of the consumer with emphasis on his/her choice of what services are most needed at any particular point; and, (4) An increased role for mental health consumers and advocates in shaping mental health policy, including more influence in the allocation of scarce health and human services resources.

The initiatives and informant group activities which took place in 2004 and 2005 set the stage for two comprehensive state planning meetings which occurred in FY2007. The goals of the Director of the Division of Mental Health, Dr. Lorrie Rickman Jones, in convening these meetings were straightforward and clearly based on the developments and feedback of the preceding years:

- To renew collective commitment to collaborating in the interest of the system.
- To reach consensus regarding the vision/values that underlie mental health service delivery (establishment of recovery as a unifying principle).
- To prioritize cross-cutting goals for quality mental health services that span multiple agencies.

After extensive discussion, the following mission and vision statements were composed and presented for approval:

Mission Statement:

“Illinois envisions a well resourced transformed mental health system that is consumer directed and community driven with a continuum of integrated and effective culturally inclusive programs, services (prevention, early intervention and treatment) and supports that promote healthy lifelong development through equal access, and that supports recovery and resilience.”

Vision Statement

The Illinois Vision for Mental Health is "The Expectation of Resilience and Recovery through Treatment, Accountability and Equal Access"

The Division of Mental Health (DMH), in collaboration with state agencies and stakeholders, is moving forward with a comprehensive cross-system planning approach for public mental health services with emphasis on the effective coordination of services into a more cohesive system which will benefit all residents of the State and the utilization of the principles of the Recovery Model in the provision of clinical and supportive mental health services. Based on the suggestions and recommendations of participants at the meetings, the DHS Division of Mental Health has moved toward the establishment of Transformation Work Groups, each having representative membership of a range of key stakeholders and the ability to obtain expert feedback on their focused issue. These groups will focus on the priorities in planning for a comprehensive mental health system identified by the discussion groups at the comprehensive planning meetings.

SECTION III-A: ADULT PLAN

Criterion 1. Comprehensive Community-based Mental Health System

Consumer Involvement/Participation

The provision of mental health care that is consumer and family driven is an important priority of the Illinois Division of Mental Health. This priority is consistent with the President’s New Freedom Commission recommendations to involve consumers and families in orienting the mental health system towards recovery, and to improve access to, and accountability for mental health services. Several years ago, in an effort to create uniformity in consumer participation across the state, the DMH Office of Recovery Services (formerly known as the Office of Consumer Affairs), working in collaboration with DMH Regional Managers and consumer specialists, developed a statewide consumer participation plan. The plan was founded on the identification of successful practices in various parts of the state that have led to increased consumer participation. These practices were incorporated into the strategic planning efforts of the DMH regions. Since this time, a wide variety of initiatives have been implemented to support consumer participation. These initiatives are described below.

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.

Under the leadership of the DMH Director of the Office of Recovery Support Services, the Wellness Recovery Action Plan (WRAP) model has been adopted by Illinois. A WRAP steering committee meets on a monthly basis to plan and review progress on the WRAP initiative. Through the establishment of WRAP classes in community agencies and the introduction of the principles of WRAP at consumer forums and conferences, thousands of consumers throughout the state have benefited from receiving orientation and education in the principles and components of this emerging best practice in recovery-based services. Since the inception of the Wellness Recovery Action Plan (WRAP) Initiative in Illinois in FY 2003, nearly 200 individuals (including consumers currently receiving services) have completed training to receive Certificates as WRAP Facilitators through completion of a 40-hour intensive course. Eighty (80) new individuals received this training in FY 2007. Refresher/Continuing Education courses are held bi-annually for Certified WRAP Facilitators. Additionally, training on WRAP for providers who work with teens through Child and Adolescent agencies and the Mental Health Juvenile Justice Initiative began in FY 2007.

Consumer Conferences.

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

Implementation of Evidence-Based Practices.

In FY 2004, the DMH was awarded a SAMHSA CMHS grant to implement and evaluate integrated dual diagnosis treatment (IDDT). A key goal of the grant was to establish an advisory board consisting of consumers, family members, advocates and community providers among others. Consumers have been on-going members of the IDDT advisory committee since its inception and will continue throughout FY 2007.

Consumer participation objectives for FY 2008 support the DMH priority for furthering work on the recovery vision in Illinois. They support the efforts of 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.

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

Indicators:

- **Number of Regional consumer conferences held**
- **Number of Certified WRAP Facilitators reached through statewide survey project**
- **Number of WRAP and Recovery Education Groups conducted in FY 2008**
- **Number of consumer participants in Consumer Education and Support teleconferences**

Consumer Education and Support.

Dissemination of accurate information regarding services for consumers is the primary focus of the Consumer Education and Support Initiative, begun in FY07 as an outgrowth of the DMH System Restructuring Initiative (SRI). DMH has recognized the need for providing consumers with the tools they need to cogently and effectively participate in the development and evaluation of the service system. Characteristic of consumer involvement is advocacy based on personal experience which frequently fails to touch upon the broader issues being confronted in 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 FY2008, Block Grant funds will be expended to conduct pre-arranged conference calls with consumers in all parts of the State. The calls will focus on service information, data, new developments, and issues that consumers should be aware and knowledgeable of as well as problem-solving approaches, and feedback mechanisms consumers can use to promote improved user-friendly services.

Objective A1.2: In FY2008, the DMH Office of Recovery Services will conduct a series of conference calls designed to disseminate important information to consumers across the State.

Indicators:

- **Number of conference calls completed in FY2008.**
- **Number of consumer participants in Consumer Education and Support teleconferences.**
- **Amount of block grant funds allocated for this purpose**

Specialized/Targeted Efforts Related to Recovery

Certified Recovery Support Specialist (CRSS).

In collaboration with the Illinois Certification Board (ICB), the Divisions of Mental Health, Rehabilitation, and Alcoholism and Substance Abuse has developed the Illinois Model for Certified Recovery Support Specialist (CRSS). The Model has defined baseline competencies and skills for CRSS professionals. Individuals are certified as having met specific predetermined criteria. The purpose of certification is to assure that quality services are provided by individuals who meet the criteria for CRSS. 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. The CRSS, through collaboration with the ICB, is now competency-based rather than curriculum-based. Access to this new credential became available through the ICB beginning in July of 2007. As a means of disseminating information regarding this new credential, training on the conceptual approach to certification was provided for interested stakeholders at conferences convened by the MISA Training Institute in FY 2007.

Recovery In-service Training

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

Objective A1.3: Continue to provide recovery oriented training to all interested stakeholders and support the role of Certified Recovery Support Specialists (CRSS).

Indicator:

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

Engagement Toward Recovery: A Service by Consumers for Consumers

As Psychosocial Rehabilitation Services (PSR) services were developed in each Region, it became apparent that many potential consumers of PSR, particularly those who have greater levels of functional impairment, found it difficult to access, enter and engage in PSR. To address this issue DMH used \$557,000 of block grant funds in FY01 to establish engagement services which consist of structured and unstructured activities which expose isolated consumers to the possibility of recovery and learning about the consumer recovery movement through building social bonds with recovered and recovering consumers. Beginning in early FY2002, recovered consumers who could speak with credibility and authenticity regarding the experience of recovery have been recruited to fill full-time equivalent (FTE) positions earmarked for consumers as engagement specialists (CES). Since this time, twenty-eight (28) community mental health agencies have received one-year start-up funding for the engagement specialist initiative. During FY 2006, the MHPAC Planning Committee requested that a survey be conducted with community mental health providers funded under the Engagement

initiative to determine (1) the sustainability of the CES initiative after DMH funding sunsets, and (2) to determine the impact of the initiative. The results of the survey revealed that 89% (25) of the community service providers who received start-up funding for the initiative still employed consumer engagement specialists. To determine the impact of employing CES', the survey focused on the ten agencies receiving funding in FY 2006. Although the numbers of engaged consumers attributed to work performed under the CES initiative varied widely from agency to agency, all 10 sites reported an increased number of consumers engaged in treatment, with some increases being over 60 per agency.

Adoption and Implementation of Evidence-Based Practices

Despite the existence of a wide range of clinical treatments and programs with strong empirical support, research suggests that access to these services in the community is quite limited. In recognition of this issue, the President's New Freedom Commission on Mental Health has noted the importance of expanded implementation of evidence-based practices. The DHS Division of Mental Health aims to provide excellent mental health care that maintains and expands access to effective mental health services, and in particular to evidence-based practices (EBPs) and best practices.

The DMH has made significant strides in implementing and planning for the implementation of EBPs in the last few years. Efforts are underway to pilot each of the adult EBPs identified by SAMHSA. In July 2007, the DMH convened a statewide conference, entitled Evidence-Based Practices in Illinois: A State of Change. Experts on each of the EBPs made presentations on focusing on implementation, organizational and financing issues that should be taken into consideration when planning for implementation. Approximately 300 individuals (consumers, family members, advocate, providers and state agency staff) attended the two day conference. These efforts address SAMHSA'S National Outcome Measure of Implementing Evidence-Based Practices. Progress related to specific FY 2007 performance objectives and indicators in this arena are described below, as well as objectives and indicators for FY 2008.

Medication Algorithms

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

service delivery practice to the use of medical algorithms. Level 3 is the actual training of the service provider to implement medication algorithms. The cumulative total of facilities participating in the CIMA project through FY 2007 is: Level 1 (Education)-40; Level 2 (Implementation Planning)-22; and Level 3 (Training)-19.

During FY 2007, seven (7) agencies completed Level 1 Education regarding CIMA and Medical Algorithms as an EBP. Four agencies participated in Level 2-Implementation Planning and then completed Level 3-Clinical Training.

The schizophrenia, depression and bipolar algorithms were updated and approved by the CIMA Advisory Committee during FY 2007. A training and education conference on the use of medication algorithms was conducted on June 6, 2007 in Springfield. The principals for the CIMA also made a presentation of the DMH EBP Conference that was held in July 2007. A website that provides downloads of educational and other materials that support algorithm use was launched in January 2007. It is routinely updated and can be accessed at: <http://www.uicomp.uic.edu/dept/psychiatry/CIMA/index.shtml>.

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

Objective A1.4: Continue and increase training and implementation of medication algorithms as an evidence-based practice.

Indicators:

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

Supported Employment (SE)

Supported Employment is an evidence-based practice that has been shown to improve employment rates of persons with serious mental illness by as much as 60%. The DMH currently has two grants to assist in implementing this model in Illinois: a NIH/SAMHSA Planning grant to address state infrastructure issues and a Johnson & Johnson/Dartmouth Community Mental Health Program Grant to support implementation at four pilot sites. The NIMH/SAMHSA grant will officially end in September 2007 while DMH will be entering into year three of four of the Johnson and Johnson/ Dartmouth grants in FY 2008. The DMH and the DHS/Division of Rehabilitation Services (DRS) are actively collaborating to implement this evidence-based practice initiative.

Evidence Based Supportive Employment (EBSE) Pilot Sites

Eleven EBSE pilot sites have been established within the state. Four pilot sites were established as a result of work within the NIH/SAMHSA and Johnson and Johnson/Dartmouth Grants. In FY 2006 (continuing into FY 2007), six pilot sites were established using Mental Health Block Grant funding to fund 6 employment specialist positions on six established Assertive community Treatment (ACT) teams. The eleventh site is a community mental health agency that was an early adopter of EBSE.

Outcomes and Accomplishments – FY 2007

The outcomes for the seven FY 2007 goals that were established under the NIH/SAMHSA and Johnson and Johnson/Dartmouth Grants are described below:

- (1) Work with four pilot sites to establish consensus to implement EBSE – Four new pilot sites have been established after reaching consensus to implement EBSE. (J & J/Dartmouth)
- (2) Establish a financing plan for EBSE – The plan has been completed and will be piloted in FY 2008. (NIH/SAMHSA)
- (3) Adapt EBSE fidelity criteria for inclusion into DMH service standards - Service and billing codes related to EBSE have been incorporated in the DMH service taxonomy. EBSE fidelity criteria has also been included in the FY 2008 pilot agency contracts. (NIH/SAMHSA)
- (4) Establish a statewide EBSE steering committee – During FY 2007 the committee, which is comprised of a wide range of stakeholders was established. The committee will continue into FY 2008. (NIH/SAMHSA)
- (5) Build state capacity to provide technical assistance (TA) for EBSE – A technical assistance model for EBSE has been developed and work will continue on refining the model in FY 2008. Staff from the early adopter community mental health agencies have as well as 2 DMH staff and one DRS staff person have received training from Dartmouth to provide TA. Varying levels of TA are being provided to the 11 pilot agencies (NIH/SAMHSA and J & J/Dartmouth)
- (6) Establish a protocol for ongoing evaluation of EBSE implementation – The SHAY, which is an organizational assessment) has been implemented. Baseline data has been collected and follow-up data has been collected during year 1 and 2 (FY 2006 and FY 2007) of the implementation (NIH/SAMHSA)
- (7) Submit an implementation proposal for funding – A structure has been developed for the proposal. It is expected that a proposal will be developed and submitted in FY 2008 (NIH/SAMHSA)

Additional accomplishments include:

- The development of clear guidelines for community mental health agencies on how to bill for EBSE services
- Establishment of billing/service codes
- DRS & DMH agreement on how to blend funding to support full implementation and reward milestone outcomes
- A well-established statewide steering committee
- Ongoing learning of technical assistance needs and strategies to guide mental health agencies and their local DRS offices on how to implement

- Provision of training and technical assistance to the 11 pilot sites
- Frequent presentations to stakeholder groups at consumers conference, NAMI conferences as well as in other venues
- Establishment of an outcome measurement system for use with the pilot sites

Objective A1.5 Continue to expand the implementation of Evidence Based Supportive Employment.

Indicators:

- **Number of consumers receiving supported employment who are employed in competitive jobs**
- **Number of technical assistance sessions provided to the 11 pilot sites to increase fidelity to the SE model**

Assertive Community Treatment

ACT is the most intensive specialized model of case management in which a team of mental health professionals takes responsibility for a small group of program participants' day-to-day living and treatment needs. These individuals typically require assertive outreach and support to remain connected with the necessary mental health services to maintain their stability in the community. Often these consumers have a history of repeated admission to psychiatric inpatient or excessive use of emergency services. Previous efforts to provide linkage to necessary services have failed and the need for multiple services requires extensive coordination. The active participation of nurses, psychiatrists, and specialists trained in substance abuse is crucial to the success of the ACT model. Illinois was an early adopter of the ACT model beginning implementation in 1992. During FY 2007, the block grant objective to develop a plan to monitor the fidelity of ACT services was accomplished.

Fifty ACT teams are currently operating statewide. During FY 2007, the Illinois ACT model was revised as part of the State Medicaid Plan amendment to bring it into line with the National ACT Model. It is expected that in FY 2008, there will be a reduction in the number of ACT teams statewide as more emphasis is placed on achieving fidelity with the National ACT model. Agencies are in the process of determining if they have the capacity to deliver the evidence-based ACT model, or if they will adopt a step-down model of Community Support. During FY 2008, DMH will provide additional technical assistance to agencies that elect to provide ACT services to help them to make the transition in meeting the National ACT fidelity requirements.

Objective A1.6. Continue provision of Assertive Community Treatment that meets national fidelity model requirements.

Indicators:

- **Number of ACT teams meeting National fidelity standards by the end of FY 2008**

Integrated Dual Diagnosis Treatment (IDDT)

In fiscal year 2007, the Division of Mental Health continued with its work on the three year Training and Evaluation grant funded by SAMHSA CMHS in FY 2004. Training and evaluation in the IDDT model continued with nineteen agencies (17 community-based agencies and 2 state hospitals) located in Chicago. During the last fiscal year it was established that consultation and technical assistance were key to strengthening the ability of agencies to move toward providing Integrated Dual Diagnosis Treatment services.

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

During FY 2007, the following accomplishments were completed with the participating agencies:

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

Also during the FY 2007 fiscal year, the IDDT project increased its quality improvement approach with additional statewide education and leadership to promote IDDT. The

project advisory committee continued to meet and provide valued feedback on promoting IDDT and recovery.

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

Family Psychoeducation

Although three regions were initially involved in planning implementation of Family Psychoeducation, only one was able to sustain its planning committee, which evolved as a public/private Family Psychoeducation (FP) implementation group. The activities of this committee have resulted in the formation of a number of family psychoeducation programs.

Staff from community agencies, along with DMH Region One and central office staff, continue to meet and provide mutual consultation on clinical, financial, and implementation issues, and to report on progress in individual program growth. These collaborative efforts to implement EBP FP in Illinois have resulted in the increase of: 1) The number of providers who have adjusted their treatment focus to extend services to more families, when doing so would clearly benefit the person with the illness, and 2) Formal EBP-model FP programs.

It is expected that stability for FP may be achieved after: 1) Providers understand that the practice is consistent with the new DMH and Medicaid funding; and 2) DMH identifies the resources for training, assisting, and monitoring providers' fidelity to the FP model. The objective for FY 2008 will focus on continuing EBP implementation efforts and mental health system monitoring of the variables that shape Illinois' ability to expand FP as an evidence-based practice.

Objective A1.7. Assess the planning and implementation capacity of DMH to assist providers to consistently implement Family Psychoeducation as an evidence-based practice.

Indicators

- **A report on the implementation efforts, status and capacity of Family Psychoeducation as an EBP for FY 2008**
- **Number of EBP model FP programs implemented in FY 2008**

Illness Management and Recovery (IMR)

DMH staff are also engaged in active planning to begin implementation of IMR within the state.

DMH Anti-Stigma Campaign

The Report of the President's New Freedom Commission on Mental Health noted that the "stigma that surrounds mental illnesses is one of three major obstacles preventing Americans with mental illnesses from getting the excellent care that they deserve". One way in which to address this issue is to implement strategies geared toward reducing the stigma associated with mental illness. During FY 2007, the Division of Mental Health has allocated \$200,000 to implement an anti-stigma campaign targeting adults. The DMH used this funding to develop public service brochures, and T-shirts, buttons, and a variety of other items that carry the anti-stigma message and DMH phone and web contact information to access services. The Division also distributes materials developed and supported by SAMHSA for the national "What a Difference a Friend Makes" anti-stigma campaign. A public relations firm has been contracted to insure that public service announcements and opportunities to distribute anti-stigma information occur at large public entertainment events and through mass media outlets. The Department of Human Services is also expanding exposure of the anti-stigma message by insuring that the materials are distributed at the conferences and other public activities that are sponsored by other DMH Divisions.

Objective A1.8. Continue to advance and expand the public awareness campaign to reduce stigma associated with mental illnesses.

Indicators:

- **Number of focus groups conducted by contractor to obtain information to be used in campaign**
- **Work will be undertaken to explore the establishment of a consumer speaker bureau to address stigma issues; the number of presentations by consumers to address stigma issues when the bureau is established**
- **Materials developed for dissemination that address stigma issues**

Forensic Services and collaboration with the Criminal Justice System

Forensic Services oversees and coordinates all forensic mental health services for the Department of Human Services - Division of Mental Health. A primary responsibility of Forensic Services is coordinating the inpatient and outpatient placements of adults and juveniles remanded by Illinois County Courts to the Department of Human Services under Statutes finding them Unfit to Stand Trial (UST) (725 ILCS, 104 -16) and Not Guilty by Reason of Insanity (NGRI) (730 ILCS, 5/5-2-4). The DMH has implemented a number of criminal justice system related initiatives with key stakeholders to address concerns regarding the large number of individuals with mental health needs who are involved with the criminal justice system.

Current Activities

DMH Jail Linkage Project.

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

The current phase of the Jail Data Linkage Project funded by the Federal Anti-Drug Abuse Act and is administered by the Illinois Criminal Justice Information Authority began in FY 2006 with funding of \$374,000 and is now being implemented in three counties. In contrast to Phase 1, (1) dedicated case managers have been hired, under contract to community mental health agencies, so that better coordinated services can be provided; (2) the web-based database has been significantly upgraded. During FY 2007, 2757 individuals with open DMH cases were identified in county jails through the Data Linkage Project. Seven hundred and sixty-five of those identified were referred to community services. Of those referred, 251 were confirmed to have kept an appointment within 1 to 30 days. An additional 98 were confirmed as having kept an appointment within 31-60 days. Twenty-nine individuals were confirmed as not keeping appointments. FY 2007 data collection has demonstrated a need for additional follow-up procedures to insure an accurate measurement of the referral and linkage of jail inmates to services. The referral process was voluntary for inmates and DMH relied on CMHCs to maintain systems for reporting when referred jail inmates sought out services. The Jail Data Link Project continues to be a primary DMH initiative for linking adults in Illinois' county jails with SMI to mental health services. Improved reporting will be a goal for FY 2008 and the FY 2008 dataset will be used as the baseline for measuring future progress.

In FY2007, DMH submitted a FY 2008 grant application to the US Department of Justice, Bureau of Justice Assistance for approximately \$400,000. If received, these funds will support initiation of a third phase that will be used to expand the Data Link Project to seven additional counties.

Mental Health Court Initiatives

Mental Health Courts adjudicate cases where there is a question of mental health fitness to stand trial or establish accountability for behavior. When mental health fitness cannot be established criminal offenders may be determined Unfit to Stand Trial (UST) or Not

Guilty by Reason of Insanity (NGRI). The DMH is directly involved in expanding the Cook County Mental Health Court through a Federal award for jail diversion that targets between 185 to 265 consumers over three years (2006 - 2008) at \$399,000 annually. During FY 2007, 30 new referrals were made and there were 35 new admissions to the Cook County Mental Health Court Program. Two cases were terminated and re-sentenced. Twelve cases were accepted into Thresholds ACT services. Sixteen persons were adjudicated as NGRI and released and maintained in the community for a total of 76 NGRI conditional releases being monitored during the period. Agency compliance with court reporting and service delivery requirements for this population was 100%. A total of 372 discharged UST patients were linked to community services in FY 2007. The documented number of discharged UST patients that followed-through with appointments in community agencies within thirty days of release from jail custody is 156.

DMH has collaborated with two community providers (Thresholds and TASC), the Chicago Police Department, and the University of Illinois on a Jail Diversion Targeted Expansion Grant funded by SAMHSA that is referred to as the Community Re-Integration Collaborative (CRC). The CRC includes the Crisis Intervention Team Program (CIT) that uses specially trained police officers to respond to mental health crisis. The objectives of CRC continue to be: (1) to support community based mental health services for individuals who have a mental illness or co-occurring disorder who are diverted from the criminal justice system; (2) assure that jail diversion programs are based on best practices; (3) form and support interagency collaboration between the appropriate criminal justice, mental health and substance abuse systems; and (4) engage in policy analysis and developmental activities at a local level to promote implementation and sustenance of diversion activities. In meeting these goals CRC has successfully completed its year-two implementation phase and expanded Cook County Mental Health Court services. During FY 2007 265 new CIT officers were trained. The Division of Mental Health will continue, during FY 2008 efforts to improve its linkage and support of persons with SMI released from Illinois' jails to reduce the length of time involved in processing and treating UST referrals in inpatient facilities, improve transition and follow-up monitoring with community services and develop and maintain a tracking system for UST patients who require a continuation of outpatient fitness restoration services.

Thus far, five Illinois Mental Health Courts have been established that work with DMH funded agencies in their local areas: Cook, DuPage, Winnebago, Madison and Kane Counties. McClean County is also considering the development of a Mental Health Court.

Collaboration with the Illinois Sheriffs Association (ISA)

DMH continues to take an active role in collaborating with the Illinois Sheriffs' Association to work on areas of mutual concern identified through surveys and discussion with Association members.

Community Consultation

The DMH operates programs for forensic patients at five state hospitals. The forensic population includes those persons determined by the court to be unfit to stand trial (UST) or not guilty by reason of insanity (NGRI). In an effort to ensure continuity of care when

these individuals are discharged from state services, DMH Forensic staff provide consultation to community agencies that provide mental health services. DMH staff monitor the services and activities of conditional releases through contacts with community mental health service providers.

Outpatient Fitness Restoration Service Monitoring and Expansion

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

The following objectives are being continued from FY 2007 and will be maintained in FY08. A new objective for FY2008, Objective A1.13, on monitoring outpatient fitness restoration services is being added.

Objective A1.9. Maintain the tracking system for persons adjudicated Not Guilty by Reason of Insanity (NGRI) who have been released to the community.

Indicator:

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

Objective A1.10 Evaluate linkage services for individuals with serious mental illness released from Illinois jails and the outcome goals of the implementation stage of the CRC grant initiative.

Indicators:

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

Objective 1.11. Provide continuity of care for individuals found unfit to stand trial (UST) that are restored to fitness in state operated inpatient forensic programs.

Indicators:

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

Objective A1.12. Reduce the length of stay from the time that court orders are received to the discharge of patients referred to DHS/DMH under UST statutes.

Indicators:

- The period of time between DHS receipt of court orders to placement of patients in forensic inpatient programs.

- The period of time from inpatient admission to recommendation for a court hearing based on resolution of fitness issues.
- The period of time between recommendation for a court hearing and discharge from the inpatient program.

Objective A1.13. Develop and maintain a tracking system for persons receiving outpatient fitness restoration services.

Indicators:

- Number of adult persons receiving outpatient fitness restoration services in FY08.
- Number of juveniles receiving outpatient fitness restoration services in FY08.
- Number of new cases referred for outpatient fitness restoration in FY08.
- Agency compliance with court reporting FY08
- Agency compliance with providing fitness restoration services for UST patients in FY08.

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

Addressing the treatment needs of individuals with co-occurring disorders requires the collaboration of mental health and substance abuse agencies at both the state, and the local level. The Division of Mental Health (DMH) and the Division of Alcohol and Substance Abuse (DASA) have worked diligently over the years to collaborate, develop and implement initiatives focusing on consumers with co-occurring disorders. These collaborations include co-location projects that continued through FY 2007 at four state hospitals; Elgin, Chicago Read, Madden, and McFarland. Sharing service delivery site resources allows DASA funded providers to perform screening and assessment for consumers on-site, and provide consultation to DMH staff regarding the substance abuse treatment needs of consumers when these services are 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. DMH has started to collect data on service timelines, major diagnosis and interventions by co-location service providers. An evaluation of this data will be completed during FY 2008.

Objective A1.14. Jointly with the DHS Division of Alcoholism and Substance Abuse (DASA), continue to collaborate on planning services delivered to individuals with co-occurring disorders.

Indicators:

- Number of meetings between DMH and DASA staff

Objectives Related To National Outcome Measure Performance Indicators

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

Objective A1.15 (NOM): Continue efforts to increase the implementation of Evidence Based Practices.

Indicator:

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

As described above, the DMH has made significant progress in efforts to implement evidence-based practices in FY 2007. These efforts will continue in FY 2008.

Objective A1.16 (NOM): Continue efforts to decrease 30 day and 180 day readmission rates to DMH state hospitals.

Indicators:

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

The DMH continues efforts to decrease 30 day and 180 day readmission rates to DMH state hospitals. There was a decrease in 30 day readmission rates from FY 2005 (12.7%) to FY 2006 (11.4%). There was a slight decrease across the same time period for 180 day readmission rates (12.7% vs. 12% respectively). (Note: Data is not yet available for FY 2007)

Objective A1.17 (NOM): The percentage of consumers reporting positive outcome will increase in FY 2007 (See State Capacity Checklist in Appendix 2.)

Indicator:

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

Note: Consumer Access to Care is reported under Criterion 2 as a quantitative performance measure.

Additional Illinois Specific System Performance Indicators

The DMH has established the National Outcome Measures (as displayed above) along with additional system indicators to track mental health system service delivery and to aid in service planning. Each indicator is described in detail at the end of Section III. Operational definitions are provided, the use of the indicator is described, and the source of data that is used to compute indicator values is identified. Data is provided for FY 2004 through FY 2006, and projections have been made for FY 2007 and FY 2008. FY 2007 actual data will be provided in the FY 2007 Mental Health Block Grant Implementation Report.

Key System Performance Indicators – ADULT SERVICES	
Indicator Reference Number	Indicator Description
Criterion 1	
A1.1A (NOM)	Number of EBPs implemented in Illinois
A1.1B	Number of individuals receiving each EBP
A1.2 (NOM)	Percent of persons readmitted to a state hospital within thirty days of being discharged from a state hospital.
A1.3 (NOM)	Percent of persons readmitted to a state hospital within one hundred eighty days of being discharged from a state hospital.
A1.4	Percentage of adults engaged in full or part-time competitive employment
A1.5	Percentage of adults engaged in full or part-time employment in subsidized, supported or sheltered employment
A1.6	Percentage of adults living independently in the community
A1.7	Percentage of adults court ordered into outpatient treatment
A1.8	Percentage of adults reporting involvement with the criminal justice system (Department of Corrections)
A1.9	Percentage of adults with co-occurring mental illness and substance abuse disorders receiving service
A1.10	Percentage of ACT service hours provided in community settings
A1.11	Percentage of adults with diagnoses of 295 or 296 receiving case management services
A1.12	Percentage of persons presenting for admission to state hospitals who have received a face-to-face screening
A.1.13 (NOM)*	Client perception of Care – Percentage of adults reporting positive outcomes
A.1.14 (NOM) *	Increased/Retained Employment
A.1.15 (NOM)*	Decrease Criminal Involvement
A1.16 (NOM)*	Increased Stability in Housing
A1.17 (NOM)*	Increased Social Supports/Social connectedness
A1.18 (NOM)*	Improved Level of Functioning
Total Number of Adult System Indicators	18

***See Section 3: Goals, Targets and Action Plans**

Transformation Activities in FY2008: Achieving the Promise

Overall, the DMH vision for the community mental health system is one that is oriented towards fostering resilience and recovery, and one that is consumer and family driven. It is our belief that system transformation, as all constructive endeavors, must be based on an assessment of needs, available strengths from which to build and change, and a set of priorities which provide clear direction and lend structure to the process and the activities aimed toward positive results. The Report of the President's New Freedom Commission on Mental Health provides an important foundation for on-going planning efforts in this regard. In Criterion I, the FY2008 plan addresses four of the six New Freedom Commission goals. See Section 2 "Transformation Activities in FY 2008.

Illinois

Adult - Available Services

Adult - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing services;
Educational services;
Substance abuse services;
Medical and dental services;
Support services;
Services provided by local school systems under the Individuals with Disabilities Education Act;
Case management services;
Services for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities leading to reduction of hospitalization.

See Adult Plan Section II review of Available Services

Illinois

Adult - Transformation Efforts and Activities in the State in Criteria 1

Adult - Describes mental health transformation efforts and activities in the State in Criteria 1, providing reference to specific goals of the NFC Report to which they relate.

Transformation Activities in FY2008: Achieving the Promise

Overall, the DMH vision for the community mental health system is one that is oriented towards fostering resilience and recovery, and one that is consumer and family driven. It is our belief that system transformation, as all constructive endeavors, must be based on an assessment of needs, available strengths from which to build and change, and a set of priorities which provide clear direction and lend structure to the process and the activities aimed toward positive results. The Report of the President's New Freedom Commission on Mental Health provides an important foundation for on-going planning efforts in this regard. In Criterion I, the FY2008 plan addresses four of the six New Freedom Commission goals:

Americans understand that mental health is essential to overall health.

Affirming the state's vision of Recovery is an essential feature of this goal. DMH will do this by actively providing recovery oriented training to all interested stakeholders and supporting the role and credentialing of Certified Recovery Support Specialists (CRSS). (See Objective A1.3). DMH is continuing to advance and expand the public awareness campaign to reduce stigma associated with mental illnesses. (See Objective A1.8)

Mental health care is consumer and family driven.

Consistent with the priority noted above, the DMH Office of Recovery Services will continue enhancement of the statewide system to educate consumers of mental health services in leadership, personal responsibility and self-advocacy through participation in Consumer Conferences, the use of Wellness Recovery Action Plans (WRAP), and through the Consumer Education and Support Initiative. (See Objectives A1.1 and A1.2)

Early mental health screening, assessment, and referral to services are common practice.

DMH Forensic Services will continue to expedite, facilitate, monitor and coordinate services to persons with serious mental illnesses in the criminal justice system. Those found unfit to stand trial or not guilty by reason of insanity and treated in state operated mental health facilities require restoration of fitness to conclude court involvement and reentry to community services at the earliest possible time. Case finding, data coordination, planned linkages and services through Mental Health courts are being advanced to meet the mental health needs of persons detained in county jails and incarcerated in the Department of Corrections. (See Objectives A1.9 through A1.13)

Excellent mental health care is delivered and research is accelerated.

The DMH is continuing its work on advancing evidence-based practice in Illinois:

During FY 2008, training and implementation in the use of medication algorithms will be increased and expanded to additional agencies. Coordination of medication algorithms between Community Mental Health Centers and State Operated Hospitals for the purpose of continuity of care will be undertaken for the first time. Consistency in medication management practices can improve patient outcomes in the continuum of treatment that begins in state operated facilities and continues with community mental health providers.

An effort will be made to strengthen fidelity and support the provision of ACT services. DMH and DRS are committed to implementing and expanding supported employment. Planning to implement family psychoeducation continues. (See Objectives A1.4, A1.5, A1.6 and A1.7). Joint planning with DASA for services to persons with co-occurring disorders will build upon the lessons learned from the Integrated Dual Diagnosis Treatment (IDDT) project (See Objective A1.14).

DMH staff are engaged in active planning to begin implementation of Illness Management and Recovery (IMR) within the state.

Illinois

Adult - Estimate of Prevalence

Adult - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

Prevalence Estimate

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, is estimated that in FY 2007, there were 510,469 adults with serious mental illnesses residing in Illinois.

(Note: See Quantitative Targets for incidence)

Illinois

Adult - Quantitative Targets

Adult - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

Criterion 2: Mental Health System Data Epidemiology

Prevalence Estimate

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, is estimated that in FY 2007, there were 510,469 adults with serious mental illnesses residing in Illinois.

Quantitative Targets For FY2008

The DMH continues efforts to increase access to services by adults with serious mental illnesses. In FY 2004, 56.1% of adults receiving services met DMH criteria; in FY 2005, the percentage increased very slightly to 56.5% and in FY 2006 it was 56.6%. (Note: Data for FY 2007 will be provided in the implementation report.) This goal will be continue to be pursued in FY 2008.

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

Indicator:

- **Percentage of the DMH adult target population receiving services**

The definition of the DMH eligible population is somewhat broader than the definition for the target population. In FY 2004, 95.3% of adults receiving services met the eligible population criteria, while in FY 2005, the percentage was 94.8%; in FY 2006 there was a slight decrease to 94.2%. (Note: Data for FY 2007 will be provided in the implementation report.) We will continue to focus on this indicator in FY 2008.

Performance Indicator A2.2 Increased Access to Services by the DMH Eligible Population.

Indicator:

- **Percentage of the DMH adult Eligible Population receiving services**

Illinois Specific System Performance Indicators

The DMH has established the National Outcome Measure (as displayed above) along with additional system indicators to track mental health system service delivery and to aid in service planning. Each indicator is described in detail at the end of Section III. Operational definitions are provided, the use of the indicator is described, and the source of data that is used to compute indicator values is identified. Data is provided for FY 2004 through FY 2006, and projections have been made for FY 2007 and FY 2008. FY 2007 actual data will be provided in the FY 2007 Mental Health Block Grant Implementation Report.

Criterion 2	
A2.1 (NOM)*	Number Of Adults Served. Continue breakdown by Gender, Race/Ethnicity, and Age
A2.2	Percentage of individuals being served by DMH-funded community-based providers who meet the established criteria for “target population” at the time of entry into services.
A2.3	Percent of individuals being served by DMH-funded community-based providers who meet the established criteria for “eligible population” at the time of entry into services.

***Note:** See Section 3 – Goals Targets and Action Plans

Transformation Activities in FY2008: Achieving the Promise

The Report of the President’s New Freedom Commission on Mental Health provides an important foundation for on-going planning efforts in data epidemiology. In Criterion II, the FY2008 plan addresses two of the six New Freedom Commission goals. See Section II – Transformation Activities in FY 2008 for details.

Illinois

Adult - Transformation Efforts and Activities in the State in Criteria 2

Adult - Describes mental health transformation efforts and activities in the State in Criteria 2, providing reference to specific goals of the NFC Report to which they relate.

Transformation Activities in FY2008: Achieving the Promise

The Report of the President's New Freedom Commission on Mental Health provides an important foundation for on-going planning efforts in data epidemiology. In Criterion II, the FY2008 plan addresses two of the six New Freedom Commission goals:

Disparities in mental health services are eliminated.

The DMH continues efforts to increase access to services by adults with serious mental illnesses. In FY 2004, 56.1% of adults receiving services met DMH criteria; in FY 2005, the percentage increased very slightly to 56.5% and in FY 2006 it was 56.6%. Data for FY 2007 will be provided in the implementation report. This goal will continue to be pursued in FY 2008. (See Performance Indicator A2.1- Increased Access to Services by the DMH Target Population)

The definition of the DMH eligible population is somewhat broader than the definition for the target population. In FY 2004, 95.3% of adults receiving services met the eligible population criteria, while in FY 2005, the percentage was 94.8%; in FY 2006 there was a slight decrease to 94.2%. FY 2007 data for this indicator will be provided in the implementation report. We will continue to focus on this indicator in FY 2008. (See Performance Indicator A2.2 -Increased Access to Services by the DMH Eligible Population.)

Consistent with this important NFC goal, the DMH is continuing to track data on gender, race/ethnicity, and age as a means discovering, analyzing, and solving disparity issues. (See: Performance Indicators A2.1 (NOM)-Number Of Adults Served By Gender (Access to Services); A2,2 (NOM)- Number Of Adults Served By Race/Ethnicity. (Access to services); A2.3 (NOM)-Number Of Adults Receiving Services By Age (Access to services)

Technology is used to access mental health care and information.

DHS MIS staff are working with DMH staff to migrate to a web-based data collection platform. The first step in this initiative has been to convert the collection of PAS/MH data from a diskette-based reporting system to a web-based data reporting system. In FY2008, this work on this initiative will continue to expand.

As noted in Section 1, DHS/DMH is planning to reconstitute administrative services through an Administrative Services Organization (ASO) in FY2008. One of the major responsibilities of the ASO will be to implement a state-of-the-art management information system (MIS) which supports a range of data related functions including consumer enrollment, service utilization, provider claims submission, validation, processing, adjudication, and payment through reliable, valid, and expeditious data transmission among all appropriate federal, state, and local entities. The ASO will also provide for access to this data by developing a datamart that is accessible to DMH staff.

Illinois

Adult - Outreach to Homeless

Adult - Describe State's outreach to and services for individuals who are homeless

Criterion 4: Targeted Services to Homeless Populations, Targeted Services to Rural Populations, and Services to Older Adults.

The Homeless Population in Illinois

Emergency Food and Shelter (EF&S) Services Annual Report

The most reliable source, though not complete, for descriptive data of the homeless population is the IDHS Division of Human Capitol Development, Office of Family Support Services which administers the Emergency Food and Shelter (EF&S) program. This program was developed to provide immediate food and shelter to homeless persons and families or persons and families at imminent risk of becoming homeless. Between July 1, 2005 and June 30, 2006 there were 49,150 individuals that received shelter, food, and services to meet their emergency needs and help them regain self-sufficiency. During the year, organizations funded through the EF&S Program provided 2,079,319 nights of shelter, served 3, 329,617 meals and delivered 2,050,102 units of supportive services.

The FY2006 Report provides an interesting profile of the homeless population receiving services. See Section 2 for a summary of the report and EF&S services. The EF&S Report noted that 43 percent of those served by the EF&S program reported a disability in FY2006 (21,262 of 49,150 persons served). Substance abuse and alcohol abuse continued as the most common reported disabilities at 26% and 23% respectively. Mental illness comprised 16% of the disabilities reported in FY2006 and was reported by 7% (3,428) of the total number of persons served. It was the third most prevalent disability in FY2006 after 10% (4,957) reported a physical disability and 21% (10,368) reported substance and/or alcohol abuse. Prior to FY2006, Mental Illness had been the second most common disability in the homeless population served by EF&S (6% of the EF&S clients).

Outreach and Services to Homeless Adults

Homeless adults with serious mental illness require linkage to a wide array of services including outpatient and inpatient mental health services, housing, employment and other support services. The DMH has encouraged providers to develop working relationships and working agreements with neighboring shelters, soup kitchens and pantries in order to identify where outreach and engagement service needs were to be focused and to develop co-affiliation services for this population. The DMH continues to undertake efforts to provide intensive outreach to this population. Resources have been shifted to create additional case management positions to work with homeless individuals who present at sixteen homeless shelters across the Chicago area.

Number of Homeless Persons Receiving Services

System Performance Indicator A4.1 was created in FY 1999 to track the number of homeless adults entering community-based services funded by public mental health dollars. This indicator permits an initial evaluation of the ability to provide access to mental health services for those individuals who are homeless and have mental illnesses DMH plans to maintain or expand access to community mental health services by

persons with mental illness who are homeless. In FY 2006, there were 6,635 homeless adults receiving DMH funded services which represents a slight increase (8%) over the number of persons accessing service in FY 2005.

Project for Assistance in Transition from Homelessness (PATH)

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

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

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

Objective A4.1: By the end of FY2008, redirect \$236,000 in federal Project for Assistance in the Transition from Homelessness (PATH) funding to provide case management services to 185 additional persons who are PATH eligible.

Indicator:

- **Number of persons receiving case management services under the PATH initiative by the end of FY2008.**

Illinois

Adult - Rural Area Services

Adult - Describes how community-based services will be provided to individuals in rural areas

Adult Services In Rural Areas

Providing Mental Health Services to Residents of Rural Areas.

DMH continues to track the number of residents residing in rural areas that receive DMH funded services (see System Performance Indicator A4.2). Seventy-six counties have been identified as rural in Illinois with an adult population of 1,509,159 according to 2000 census figures, yielding a prevalence estimate of 81,494 (at 5.4%). In FY 1999, when this system indicator was first established, 25,127 individuals who lived in the 76 rural counties were reported as receiving services. By FY 2005, the number had increased to 28,510. During the last fiscal year (2006) a 5% (32,280) increase in the number of rural residents receiving services was noted.

The DMH Southern Region, whose service area is primarily rural, has previously conducted an analysis of the service needs of consumers within its geographic area to identify what resources are needed to reach the goal of having appropriate service provision available within a 25-mile radius of a consumer's home. Data gathered through this analysis permitted DMH Regional staff to strategically fund new services consistent with defined need. Agreements were also initiated to facilitate and increase access to Psychosocial Rehabilitation programs and supported housing arrangements. Informational mapping was undertaken and developed for each of the 16 community mental health centers and the counties served by these centers which identified the estimated number of persons with serious mental illness (SMI) residing in each service area; the number of persons with SMI served by each center; the service capacity for both youth and adults; and the average expenditure for persons at 200% of poverty. This mapping has provided a clear perspective and understanding of the gap between community mental health center capacity and prevalence of persons with SMI.

DMH Regional staff have also worked with the Southern Illinois Health Consortium to connect and integrate mental health services with existing federally qualified health centers (FQHCs).

Expansion of Services for Older Persons Residing in Rural Area

In rural areas, the older population often experiences the most difficulty in obtaining services that are geared to their needs. The Geropsychiatric Initiative, initiated by the DOA and DMH in FY 2001, is designed to meet that need and was piloted in the rural areas in DMH Southern and Metro-East Regions. Local coordinating councils have been established for all 27 counties in the pilot project service area. The primary purpose of these councils is to educate key stakeholders regarding services available, the process for accessing services, and identifying strategies for improving services. The councils include representatives from primary health care, consumers, aging area offices, mental health agencies, and senior citizen centers. Each Community Mental Health Center has a case manager assigned specifically to focus on service provision for older adults.

Use of Communication Technology as a Basis for Service Delivery

In FY 2008, as resources allow, newer technology such as advanced telecommunication systems will be used to improve access to expertise from professionals located in urban areas to persons residing in rural areas. Internet access, video conferencing, and other applications provide an opportunity to enhance the quality of care in rural mental health services. These approaches also provide substantial support to model programs with new designs for better integration of mental health and primary healthcare in rural areas.

Illinois

Adult - Older Adults

Adult - Describes how community-based services are provided to older adults

Services To Older Adults

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

Geropsychiatry Services

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

The Geropsychiatric Initiative focuses on three key areas: systems integration, mental health services/consultation and training/education. In FY 2007 there are five funded positions for Geriatric Specialists that cover 27 counties throughout the southern part of the state. The Geriatric Specialists provided treatment and education resources for mental health services to the aging throughout the state and gave presentations at the national American Society of Aging/National Coalition on Mental Health and Aging and assisted in the cross training of the Illinois Department on Aging staff regarding domains on the Comprehensive Case Management Assessment. Mental Health and Aging Forums were held in Chicago, Peoria and Granite City.

The Division of Mental Health and the Illinois Department of Aging also collaborated with resources and expertise to develop, market and present three conferences: the Annual Statewide Mental Health and Aging Conference; the Behavioral Health, Aging and Wellness Conference; and the Rural Aging Conference.

Objective A4.2. In collaboration with the Illinois Department On Aging (IDOA), convene meetings with stakeholders to improve access to treatment by older adults.

Indicator:

- Number of meetings convened in FY 2008

Illinois

Adult - Transformation Efforts and Activities in the State in Criteria 4

Adult - Describes mental health transformation efforts and activities in the State in Criteria 4, providing reference to specific goals of the NFC Report to which they relate.

Transformation Activities in FY2008: Achieving the Promise

The Report of the President's New Freedom Commission on Mental Health provides an important foundation for on-going planning efforts for adults who are homeless, those residing in rural areas, and improving services to the elderly. In Criterion IV, the FY2008 plan addresses three of the six New Freedom Commission goals:

Disparities in mental health services are eliminated.

The number of homeless adults accessing DMH-funded services has been tracked for many years. In FY 2006, there were 6,635 homeless adults receiving DMH funded services which represents a slight increase (8%) over the number of persons accessing service in FY 2005. We will continue to track this information in FY2008 (See System Performance Indicator A4.1)

The number of adults living in the 76 rural counties of Illinois who receive DMH-funded services is tracked on an ongoing basis and an increase in number has been evident. By FY 2005, the number had increased by 3,500 individuals since this system performance indicator was first established (28,510). During the last fiscal year (2006) a 5% (32,280) increase in the number of rural residents receiving services was noted. Tracking and efforts to increase the number of adults in rural areas receiving services will continue to be a priority. (See System Performance Indicator A4.2)

The DMH collaborates closely with the Illinois Department On Aging (IDOA) to improve access to mental health services by older adults. In FY2008, the DMH and the IDOA will convene meetings with stakeholders to plan services for older adults and expand treatment options such as the GeroPsychiatry program. (See Objective A4.3)

Early mental health screening, assessment, and referral to services are common practice.

By the end of FY2008, \$236,000 in federal Project for Assistance in the Transition from Homelessness (PATH) funding will be redirected to provide case management services to 185 additional adults who are homeless and who are PATH eligible. (See Objective A4.1)

Technology is used to access mental health care and information.

Consistent with Public Act 95-16, the DMH is moving forward to develop and solidify the infrastructure and introduce the technology necessary for the successful use of tele-psychiatry, particularly in rural areas in which there is a shortage of psychiatrists and other needed mental health clinicians. Internet access, video conferencing, and other applications provide an opportunity to enhance the quality of care in rural mental health services.

Illinois

Adult - Resources for Providers

Adult - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

The DHS Division of Mental Health continues to work towards an integrated system of care that includes both state hospitals and community-based providers, including those that are responsible for emergency health services regarding mental health.

Enhancing Financial Resources

Increased Financial Resources for Community Services

As we have noted previously, there has been a substantial increase in the proportion of the DMH budget spent on community mental health services across fiscal years. The DMH has undertaken a number of efforts to increase the financial resources available to support community-based mental health services in Illinois. Many of these initiatives have been discussed in Sections I and II of this application.

Service Enhancement Using Block Grant Funds

Despite the fact that the allocation of Mental Health Block grant funds to Illinois by SAMHSA has been reduced over the past two years, the DMH continues its efforts to utilize these funds to enhance service provision within the state. Block Grant funds continue to support such initiatives as the consumer engagement specialist initiative, the provision of wellness, action and recovery planning (WRAP), residential services and psychiatric leadership services.

Grant Development

The DMH continues to undertake efforts to increase the flow of Federal and other grant dollars to the state. Some of the grants awarded to DMH over the past few years include the SAMHSA CMHS System of Care Grants (one in Chicago and one in McHenry County), a SAMHSA CMHS evidence-based practices implementation grant for Integrated Dual Diagnosis Treatment, a Data Infrastructure Grant, a SAMHSA Disaster Response grant, a Johnson and Johnson/Dartmouth Grant focusing on Supported Employment, a NIMH Planning Grant to implement Supported Employment, a SAMHSA grant focusing on alternatives to restraint and seclusion, a social security grant related to work incentive planning and a grant funded by the Federal Anti-Drug Abuse Act administered by the Illinois Criminal Justice Authority for the DMH jail data-link project.

In FY 2007, the DMH worked with Healthcare and Family Services (HFS) to submit a “Money Follows the Person” grant to the Centers for Medicare and Medicaid Services (CMS). This grant was funded and planning has begun to implement the grant.

Increasing Financial Resources For The Adult Population

Financial resources for both the adult and children and adolescent populations come from General Revenue Funds (GRF) appropriated by the Legislature, Block Grant funds, and the redirection of dollars accrued from the reduced utilization of state hospital services and annualized income from previous initiatives. Through careful planning, previously established initiatives have proven to be beneficial to mental health consumers both in quality of care and increased financial resources.

In FY 2005, the DMH received an allocation of \$4.7 million for “Supportive

Mentally Ill Housing”. In FY 2006, additional Supportive Mentally Ill Housing funding was appropriated by the Legislature which brought the total for this specific Appropriation to \$6,150,000. These additional funds in FY 2006 allowed the Department of Human Services and the Division of Mental Health to contract with 13 supportive housing providers for the provision of new supportive housing services to individuals whom are either homeless, mentally ill, or both. In FY07 an additional \$4.2 million was added to the Supportive Mentally Ill Housing appropriation, to bring that appropriation total to \$10.35 million . This new funding for the Division of Mental Health addressed the addition of 11 new Division of Mental Health supportive housing projects that will provide supportive housing services to 134 consumers receiving services purchased by the Division of Mental Health. In FY08 there is a proposal once again to continue to add state funds to the Division of Mental Health appropriation to allow for additional new permanent supportive housing projects for both individuals who are homeless and persons with mental illnesses.

Increasing Federal Financial Participation (FFP)

Over the past seven years, the DMH has worked closely with community agencies on an aggressive plan to increase the claiming of Federal Medicaid funds to support community based mental health services. In FY 2003, DMH was able to support efforts to increase Medicaid Funding for the Illinois Mental Health Service System by simplifying and clarifying Medicaid policies and procedures (making necessary changes in the State Medicaid Plan, 59 Ill. Admin. Rule 132, the DMH Medicaid Handbook, and the DMH Program Book). Also during FY 2003, the structure for utilization of the Medicaid Trust Fund was established and implemented. The distinction and importance of this fund is that it is a federal trust fund based exclusively upon the anticipated federal revenues from Medicaid payments for community mental health services. As billing for Medicaid services increases, so do the resources in the fund. Medicaid reimbursement through the Trust Fund continues to increase across time. In FY 2003 Medicaid reimbursement through the Trust Fund was \$59 million; in FY 2006 it had risen to \$85,802,707. It is expected that there will be continuing increases in Medicaid billing as the mental health system continues to become more efficient in its billing and reporting practices. A focus on increasing Medicaid capture will continue in FY 2008.

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

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

Indicator:

- **Amount of FFP generated in FY 2008**

Medicaid Billing For The Adult Population

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

Enhancing Human Resources

Human resource development is critical in terms of supporting community-based services for adults with serious mental illness and children with serious emotional disturbance and their families.

Activities Related to Human Resource Development

As noted in Section II, Illinois has a long-standing history of public and academic collaboration with Departments of Psychiatry, Social Work, Psychology, and Nursing in universities across the state. DMH also continues to support human resource development through the following activities:

- Continued funding of the Illinois Nursing Institute which addresses competencies needed by DMH psychiatric nurses
- Providing training and consultation to community providers in the implementation of IDDT
- Recruiting and training consumers to become Recovery Specialists
- Establishment of the Certified Recovery Support Specialist credentialing process
- Recruiting and training consumers as WRAP facilitators
- Providing training and consultation to community providers around the implementation of medication algorithms with the DMH/University of Illinois Center for the Implementation of Medication Algorithms (CIMA)
- Initiatives in which psychiatric consultation is provided to community mental health providers in remote and rural areas in the state.
- Mental Health and Law Enforcement Training -The DMH regularly collaborates with law enforcement agencies and emergency services at general hospitals to facilitate appropriate and effective psychiatric intervention to persons in crisis.
- Provision of technical assistance and training to agencies to improve the efficiency of billing and agency operation
- Provision of technical assistance and training to DMH staff regarding FFS related issues
- Training of SRI consumer liaisons so that they are prepared to provide input into SRI activities.

Human Resource Development Related To Adult Services

Recovery Oriented Training

Training events that assist in the implementation of the Recovery Vision in Illinois continue to be a priority of DMH. This training is offered statewide through DMH Regions and through other venues to providers, consumers, family members and other interested stakeholders. DMH Recovery Services staff provide training on Recovery using a standardized training curriculum that was developed in FY 2002. Other initiatives, such as Recovery Specialist Training, and training in the WRAP model, as described in Sections II and III of this application, also support these efforts.

The DMH Nursing Institute

The DMH contracts with the University of Illinois in Peoria to fund Nursing Institute. The Institute provides targeted training and develops targeted deliverables based on an annual negotiation with DMH Staff. During FY 2007, the Institute completed development of a web-based application to provide training to psychiatric nurses on the competencies required to perform their job and responsibilities.

Illinois

Adult - Emergency Service Provider Training

Adult - Provides for training of providers of emergency health services regarding mental health;

Disaster Response: Emergency Health Services

As reported in Section II of this application, the Governor has designated the DMH as the lead State agency for disaster resource coordination, training and recovery functions related to mental health. Working in the collaborative context of the overall Statewide Disaster Plan, DMH is coordinating Illinois' disaster preparedness for state operated and state funded psychiatric service entities. The operational focus includes collaboration and training with other State agencies, monitoring and facilitating ongoing concordance with national policy, and assisting State funded agencies in the development of local response capability for issues of Mental Health. DMH also coordinates surge deployment of mental health services in response to disasters, be they natural or caused by terrorists. This is an ongoing effort that has been enhanced by a grant award from SAMHSA for \$200,000 for disaster response planning which began in FY 2004. The first two years of development have seen the establishment of a statewide coalition dedicated to disaster response, the planning and execution of statewide training in disaster preparedness, and the establishment of an understanding with the City of Chicago, as well as the Illinois Emergency Management Authority (IEMA). Following Hurricane Katrina, the Governor of Illinois made a commitment of rather wide scope, to assist the evacuees. As DMH is the lead State agency for disaster resource coordination, training and recovery functions related to mental health, a grant application was submitted to SAMHSA for a Crisis Counseling Grant that was subsequently funded and is still in operation. Working in the context of the overall Statewide Disaster Plan, DMH coordinated the program directly. The operational focus of work included statewide outreach, collaboration with other State agencies, monitoring and daily program operation. In FY 2006, over 2500 persons had been served. FY 2007 figures are not yet available.

Illinois

Adult - Grant Expenditure Manner

Adult - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

Allocation Of Block Grant Dollars In FY2008

The Illinois plan for the expenditure of the FY 2008 Community Mental Health Services Block Grant is directed at providing services in community settings for adults with serious mental illness and children and adolescents with serious emotional disturbances.

The Mental Health Block Grant is allocated based on the following criteria:

- 1) The funding must be available to all geographic areas of the State.
- 2) Funds are distributed based on population.
- 3) Geographic areas of high priority receive additional funding.

As in previous years, FY 2008 Mental Health Block Grant funding focuses heavily on the Chicago Metropolitan area where the population density is the greatest. The remainder of Mental Health Block Grant funds addresses both the semi-urban and rural areas of the State with all geographic regions represented in the list of agencies funded.

Block Grant Allocation FY 2008

The Illinois block grant fund amount for FY 2008, based on projections from FY 2007 is \$16,441,527. Allocations to specific agencies for service provision are displayed in Appendix 1. Please note however that the grant awards to community providers represent the best known information available as per their issuance in July of 2007. The state budget as appropriated and approved reflects the FY 2008 level of award continuing to be provided. Administrative expenses, which are capped at 5%, amount to \$822,076. Services for adults, children and adolescents are allocated as follows.

Block Grant Allocation - Adult Population

For adults, dollars will be directed toward those individuals with serious mental illness requiring supportive and supervised residential programs, community consumer support which is a component of psychosocial rehabilitation, and crisis care. These programs are designed to provide the necessary intermediate and ongoing support and supervision for individuals who are transitioning from a state hospital to the community. Funds have also been allocated to continue support of psychiatric leadership services for community programs. The adult service funding allocation is consistent with the State Mental Health Plan, especially the need to provide residential and other community-based services as alternatives to hospitalization so that the need for state hospitals is reduced. Utilizing the State Community Mental Health Services Block Grant for residential services, the State can make a significant impact on the use of inpatient state hospitals and psychiatric hospitalization, and maintain individuals in community settings with appropriate additional support services such as case management and psychosocial day programs.

Additional Illinois Specific System Performance Indicators

The DMH has established system indicators to track mental health system service delivery and to aid in service planning. Each indicator is described in detail at the end of Section III. Operational definitions are provided, the use of the indicator is described, and the source of data that is used to compute indicator values is identified. Data is provided for FY 2004 through FY 2006, and projections have been made for FY 2007 and FY 2008. FY 2007 actual data will be provided in the FY 2007 Mental Health Block Grant Implementation Report.

Criterion 5

A5.1 Total dollars billed to Medicaid for adults.

A5.2 Total dollars approved and paid by Medicaid.

The Report of the President's New Freedom Commission on Mental Health provides an important foundation for on-going planning efforts directed toward enhancing financial and human resources. In Criterion V, the FY2008 plan addresses two of the six New Freedom Commission goals.

Table 4.

The DMH is currently unable to report data for this table and awaits guidance from SAMHSA CMHS.

Table 4
FY 2008 – FY 2010 MHBG Transformation Expenditures Reporting Form
State: Illinois

Number	State Transformation Activity	FY 2008 MHBG Planned Expenditure Amount	FY 2008 Other State Funding Source Amount
1	Improving coordination of care among multiple systems		
2	Support for culturally competent services		
3	Involving consumers and families fully in orienting the MH system toward recovery		
4	Support for consumer- and family-operated programs, including Statewide consumer networks		
5	Services for co-occurring mental and substance use disorders		
6	Eliminating disparities in access to and quality of care		
7	Support for integrated electronic health record and personal health information systems		
8	Improving consumer access to employment and affordable housing		
9	Provision of Evidence Based Practices		
10	Aligning financing for mental health services for maximum benefit		
11	Supporting individualized plans of care for consumers		
12	Supporting use of peer specialist		
13	Linking mental health care with primary care		
14	Supporting school mental health programs		
15	Supporting early mental health screening, assessment, and referral to services		
16	Suicide prevention		
17	Supporting reduction of the stigma associated with mental illness		
18	Use of health technology and telehealth to improve access and coordination of mental health care		
19	Supporting workforce development activities		
20	Other (specify)		

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	122,329	129,567	129,000	129,000	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To monitor access to services.

Target: Maintain or increase access to services for adults with mental illnesses

Population: Adults with mental illnesses.

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

Indicator: Number of adults served.

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

Sources of Information: Reporting of Community Services (RoCS).

Special Issues:

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

Action Plan: DMH will continue to track the number of persons receiving services from DMH-funded community-based providers in FY 2008. The data will be submitted via the URS and will continue to be partitioned by gender, age and race/ethnicity.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	11.43	13.48	11	11	N/A	N/A
Numerator	1,076	1,537	--	--	--	--
Denominator	9,410	11,402	--	--	--	--

Table Descriptors:

- Goal:** To encourage assurance of sufficient clinical stabilization of individual from the state hospital through planning and preparation of post-hospital community-based mental health services prior to being discharged.
- Target:** Maintain or decrease readmissions within 30 to state hospitals.
- Population:** Adults with serious mental illness.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** Percent of persons readmitted to a state hospital within thirty days of being discharged from a state hospital.
- Measure:** Numerator: Number of adults readmitted to a state hospital within thirty days of being discharged from a state hospital.
Denominator: Number of persons discharged from a state hospital in a fiscal year.
- Sources of Information:** Inpatient Clinical Information System (CIS)
- Special Issues:**
- Significance:**
- Action Plan:** DMH will continue to monitor the number of adults readmitted to state hospitals within 30 days of discharge with a FY 2008 goal of maintaining or decreasing the level of re-hospitalization by maintaining services in the community that provide alternatives to re-hospitalization.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	9.77	13.48	11	11	N/A	N/A
Numerator	919	1,537	--	--	--	--
Denominator	9,410	11,402	--	--	--	--

Table Descriptors:

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

Target:

Population: Adults with Serious mental illnesses.

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

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

Measure: Numerator: Number of persons readmitted to a state hospital within 180 days of being discharged from a state hospital.
Denominator: Number of persons discharged from a state hospital in a fiscal year.

Sources of Information: Inpatient Clinical Information System.

Special Issues:

Significance:

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

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	4	5	5	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To increase the availability of EBPs within the state

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

Population: Adults with serious mental illnesses.

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

Indicator: Number of EBPs Implemented in Illinois

Measure: Number of EBPs Implemented in Illinois

Sources of Information: Structured program reports collected by DMH staff from community agencies.

Special Issues: EBPs are very difficult to implement requiring the dedication of many resources. Some EBPs take multiple years to implement.

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

Action Plan: DMH has a goal of increasing the number and type of EBPs provided within the state. During FY 2006, DMH has focused on Supported Employment (SE), Integrated Dual Diagnosis Treatment, Illness-Self-Management, and Medication Algorithms. Grant funding from SAMHSA and other sources has been largely used for these efforts. We will continue to maintain this focus in FY 2008. Currently we are working with NRI to develop a strategy for expanding the implementation of these practices. During FY 2008, we expect to finalize this planning.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Supported Housing (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	0	0	0	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Provide EBPs to adults needing these services

Target: None

Population: Adults with serious mental illnesses

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

Indicator: Number of adults with SMI receiving supported housing

Measure: Number of adults with SMI receiving supported housing

Sources of Information: None currently

Special Issues: Not yet implemented; Also waiting on release of Resource Implementation Kit by SAMHSA.

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

Action Plan: The DMH is currently working on developing a plan to implemented Supported Housing. Meeting have been held with key stakeholders and consultants such as the technical assistance collaborative and the supportive housing agencies in Illinois. This planning will be finalized during FY 2008.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Supported Employment (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	302	373	385	385	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Increase availability of Supported Employment

Target: Increase availability of SE by 3%

Population: Adults with serious mental illnesses

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

Indicator: Number of adults receiving supported employment

Measure: Number of adults receiving supported employment

Sources of Information: Reports submitted by 11 agencies as part of SE pilot projects

Special Issues: Data is not yet integrated into DMH reporting system; Data is being collected as part of a pilot project.

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

Action Plan: Continue to provide training to SE pilot agencies, including technical assistance/consultation.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Assertive Community Treatment (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	2,955	3,529	3,000	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Provide access to assertive community treatment

Target: No target is being provided for FY 2008 due to the fact that ACT is being revamped within the state to ensure that the EBP is being provided

Population: Adults with serious mental illnesses with multiple psychiatric hospitalizations

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

Indicator: Number of adults with SMI receiving ACT

Measure: Number of adults with SMI receiving ACT

Sources of Information: Reporting of community services system

Special Issues: The DMH is undertaking an effort to ensure that evidence-based assertive community treatment is being provided. There will be a focus on assessing the fidelity of the service. Many ACT teams are currently being converted to community support services by community agencies; therefore it is expected that the number of teams (currently 50) and the number of individuals receiving these services will be greatly reduced during the next fiscal year.

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

Action Plan: DMH will collect data during the next fiscal year to establish a new baseline for this indicator.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Family Psychoeducation (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	0	0	0	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Implement family psychoeducation

Target: No target; planning underway to implement

Population: Adults with serious mental illnesses.

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

Indicator: Number of adults with SMI receiving family psychoeducation

Measure: Number of adults with SMI receiving family psychoeducation

Sources of Information: Not currently collected.

Special Issues: Planning is occurring; not yet implemented

Significance:

Action Plan: Not currently implemented; planning is occurring (see capacity checklist).

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Integrated Treatment of Co-Occurring Disorders(MISA) (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	0	0	0	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Availability of IDDT

Target: Zero; still in process of implementing

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

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

Indicator: Number of Individuals receiving IDDT

Measure: Number of Individuals receiving IDDT

Sources of Information: Not currently collected

Special Issues: IDDT is one of the more difficult EBPs to implement. The DMH has been working on a pilot project to implement this EBP.

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

Action Plan: The DMH will continue its efforts to implement IDDT during FY 2008 (See capacity checklist).

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Illness Self-Management (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	0	0	0	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Availability of Illness Self Management

Target: Zero; Continuing efforts to implement this EBP

Population: Adults with SMI

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

Indicator: Number of individuals receiving Illness Self Management

Measure: Number of individuals receiving Illness Self Management

Sources of Information: Not currently collected

Special Issues:

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

Action Plan: The DMH will continue its work on planning for implementation of this EBP (See capacity checklist).

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Medication Management (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	0	0	0	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Availability of medication management

Target: Zero; The DMH will continue working on efforts to strengthen its work in this area

Population: Individuals with serious mental illnesses with specified diagnoses receiving psychotropic medication

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

Indicator: Number of individuals receiving medication management

Measure: Number of individuals receiving medication management

Sources of Information: None currently -- not collected

Special Issues:

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

Action Plan: The DMH will continues it work to implement medication algorithms in state hospitals and community agencies during FY 2008. (See capacity checklist).

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	76.27	75	77	N/A	N/A
Numerator	0	768	--	--	--	--
Denominator	N/A	1,007	--	--	--	--

Table Descriptors:

Goal: Increase perception of positive treatment outcomes

Target: Increase perception of positive treatment outcomes by 3 to 5%

Population: Adults with mental illnesses receiving mental health treatment

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

Indicator: Client Perception of Care

Measure: Number: Number of adults reporting positive perception of care using the MHSIP Adult Survey
Denominator: Number of adults completing the MHSIP Adult Survey

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

Special Issues:

Significance: Mental health services should result in positive outcomes

Action Plan: Implement consumer survey and complete in time for FY 2007 Implementation Report.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	0	0	0	N/A	N/A
Numerator	0	0	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

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

Target: None; change in employment not currently collected

Population: Adults with mental illnesses receiving treatment

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

Indicator: Increased/retained level of employment

Measure: Profile of adults consumers by employment status - Change in status

Sources of Information: Status at case opening is collected via Reporting of community services system

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

Significance: Employment is an important variable contributing to recovery

Action Plan: Continue to report employment status and develop plans to collect data across time (see capacity checklist).

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	0	0	0	N/A	N/A
Numerator	0	0	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

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

Target: None - not currently collecting this data

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

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

Indicator: Decreased criminal involvement

Measure: Decreased criminal involvement - Number of arrests is the measure that is of current focus.

Sources of Information: None - Don't currently collect this information systematically.

Special Issues: Many issues exist with regard to accessing administrative data related to this indicator, as well as defining criteria for collecting data across time.

Significance: There is an expectation that adults receiving mental health services who have been involved with the justice system will increase this involvement, however questions remain regarding the appropriate measure. NRI is hosting a workshop in September 2007 to address this issue.

Action Plan: There is an expectation that adults receiving mental health services who have been involved with the justice system will increase this involvement, however questions remain regarding the appropriate measure. NRI is hosting a workshop in September 2007 to address this issue. We will decide on an action plan following refinement of the measure (see capacity checklist).

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	0	0	0	N/A	N/A
Numerator	0	0	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

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

Target: None - DMH is not currently collecting data to assess change in living arrangements

Population: Adults with serious mental illnesses

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

Indicator: Increased stability in housing (percentage)

Measure: Numerator: Number of individuals with serious mental illnesses showing increased stability in housing between time 1 and time 2
Denominator: Number of individuals with serious mental illnesses receiving services

Sources of Information: None - don't currently collect this information across time; currently only collected at case opening

Special Issues: See issues related to change in employment status etc

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

Action Plan: The DMH will continue working with CMHS, NRI and the states to better define ways to collect this data (see capacity checklist). Status will be reported on Table 4 of the URS tables.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	0	0	0	N/A	N/A
Numerator	0	0	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Increased social support

Target: None - Developmental Measure

Population: Adults with serious mental illnesses

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

Indicator: Increase social supports/social connectedness

Measure: Numerator: Number of adults with serious mental illnesses showing an increase in social support/social connectedness from time 1 to time 2
Denominator: Number of adults with serious mental illnesses for whom data is reported.

Sources of Information: None - not currently collected. This information will be piloted as a component of the Adult MHSIP Survey

Special Issues: See issues related to employment etc. This indicator is developmental and still be defined and refined.

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

Action Plan: The DMH will continue to work with CMHS, NRI and the states to refine this indicator. We will also pilot the questions that have been developed in the next round of the Adult MHSIP Consumer Survey.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	0	0	0	N/A	N/A
Numerator	0	0	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Improved functioning for adults with mental illnesses receiving services

Target: None - Developmental Measure

Population: Adults with mental illnesses receiving treatment

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

Indicator: Improved level of functioning

Measure: Numerator: Number of adults receiving services reporting improved level of functioning from time 1 to time 2
Denominator: Number of individuals receiving services reporting on change in functioning

Sources of Information: None to be determined - Developmental Measure

Special Issues: See discussion under employment

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

Action Plan: Continue working with the NRI, CMHS and the states to refine/develop this indicator. (see capacity checklist)

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: ACT SERVICE HOURS IN COMMUNITY

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	68	65	65	65	N/A	N/A
Numerator	171,585	144,441	--	--	--	--
Denominator	252,117	221,360	--	--	--	--

Table Descriptors:

- Goal:** To assure that a significant portion of the service delivered within the (ACT) programs are provided in the most normalized settings possible in the individual’s community, rather than within the provider’s offices or clinics.
- Target:** Maintenance of the 65% level of ACT Services delivered in community settings.
- Population:** Adults with serious mental illnesses.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percentage of service hours for adults being served by the DMH-funded Assertive Community Treatment (ACT) Programs, who receive services outside of the provider’s offices or clinics.
- Measure:** Numerator: The number of hours of service provided by the DMH-funded (ACT) Programs which occur outside of the provider’s offices or clinics.
Denominator: The total number of hours of service provided by the DMH-funded (ACT) Programs.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:**
- Significance:** Although DMH does not conduct a complete fidelity assessment, the provision of service in the community versus the office is a key component of the ACT programs that are monitored. In FY 06, Over 65% of ACT service hours were provided in the community, suggesting fidelity to this key aspect of the ACT model.
- Action Plan:** DMH will continue to monitor service provision of ACT programs in order to maintain current levels of services delivered in community settings outside of the provider's offices or clinics.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: ACTUAL MEDICAID REIMBURSEMENT (FEDERAL FINANCIAL PARTICIPATION)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	64,514,230	74,799,820	75,000,000	75,000,000	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

- Goal:** To assure prudent administration of resources through appropriate matching of federally available dollars for mental health services.
- Target:** Maximize appropriate reimbursement through Federal Fund Participation (FFP)
- Population:** Adults with mental illnesses.
- Criterion:** 5:Management Systems
- Indicator:** Total dollars billed and paid by Medicaid.
- Measure:** Total dollars approved and paid by Medicaid.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:**
- Significance:** A measurement of the state's capacity to fund and provide mental health services. Resources must be maximized to support delivery of mental health services.
- Action Plan:** DMH aims to continue to enhance resources through matching federally available dollars for community mental health services. This effort will be enhanced through improved data collection and monitoring of service delivery and monitoring.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: CASE MANAGEMENT

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	48.44	48.60	0	0	N/A	N/A
Numerator	38,042	38,491	--	--	--	--
Denominator	78,350	79,245	--	--	--	--

Table Descriptors:

- Goal:** To maintain or expand access to case management services to individuals with specific serious mental illnesses being served in the DMH-funded community-based service system.
- Target:** DMHs' target is to maintain or expand case management services to about 50% of persons with the specified diagnoses.
- Population:** Adult's with mental illnesses.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percentage of adults being served by the DMH-funded community-based service system with an initial DSM-IV diagnosis of 295.xx or 296.xx who receive case management services.
- Measure:** Numerator: Adults being served by the DMH-funded community-based service system with an initial DSM- IV diagnosis of 295.xx or 296.xx receiving case management services.
Denominator: All adults being served by the DMH-funded community-based service system with an initial DSM-IV diagnosis of 295.xx or 296.xx.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:** DMH has recently revamped its Services taxonomy. There is an expectation that many case management services will be subsumed in "Community Support Services". Therefore, we will track the amount of case management services provided in FY 2008. No projection made.
- Significance:** There is a direct relationship between the amount of case management services provided and resilience and recovery rates for some diagnoses.
- Action Plan:** DMH will continue to track the amount of case management services provided but reestablish its baseline in FY 2008.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: CO-OCCURRING DISORDERS -ADULTS

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	11.50	12.10	12.10	12.10	N/A	N/A
Numerator	14,837	15,610	--	--	--	--
Denominator	128,732	129,564	--	--	--	--

Table Descriptors:

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

Target: Identification of percentage of adults with co-occurring disorders at time of intake and reported through the Reporting of Community Services (RoCS) data collection system.

Population: Adults with mental illness.

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

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

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

Sources of Information: Reporting of Community Services (RoCS).

Special Issues:

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

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

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: ELIGIBLE POPULATION - ADULTS

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	94.79	94.20	95	95	N/A	N/A
Numerator	122,028	122,029	--	--	--	--
Denominator	128,732	129,564	--	--	--	--

Table Descriptors:

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

Target: Maintain/increase performance level of assuring that 95% of individuals being served by DMH community-based providers are within the population eligible to receive state funded mental health services.

Population: Adults with mental illnesses.

Criterion: 2:Mental Health System Data Epidemiology

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

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

Sources of Information: Reporting of Community Services (RoCS).

Special Issues:

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

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

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Employment

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	20.50	20.50	20.50	20.50	N/A	N/A
Numerator	26,388	26,491	--	--	--	--
Denominator	128,732	129,524	--	--	--	--

Table Descriptors:

Goal: Continue tracking employment status of consumers at case opening

Target: Track number of individuals employed at case opening

Population: Adults with mental illnesses

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

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

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

Sources of Information: Reporting of Community Services System (ROCS)

Special Issues:

Significance: Employment is a key issue relating to recovery and resilience. At intake in FY 2006, Employment rates were slightly below 20%. This descriptive data collected at intake – before services are initiated – is not expected to change. These low levels are consistent with national findings and indicate the importance of further developing employment and supported employment services.

Action Plan: DMH plans to continue tracking this data while developing specialized employment services.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: FACE-TO-FACE SCREENINGS-ADULTS

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	95.70	92	95	95	N/A	N/A
Numerator	10,606	N/A	--	--	--	--
Denominator	11,087	N/A	--	--	--	--

Table Descriptors:

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

Target: The target for FY 2008 is the provision of face to face screenings for 96% of patients presenting for admission to state hospitals.

Population: Adults with mental illnesses.

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

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

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

Sources of Information: Inpatient Clinical Information System.

Special Issues:

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

Action Plan: DMH plans to continue the provision of face-to-face screenings for people presenting for admission at state hospitals in order to reduce unnecessary hospitalizations. The vast majority of these individuals, close to 95%, have been screened in recent years, and a target of 95% has been set for FY 2008.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Forensic Outpatient

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	1.60	1.70	1.70	1.70	N/A	N/A
Numerator	2,004	2,244	--	--	--	--
Denominator	128,732	129,564	--	--	--	--

Table Descriptors:

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

Target: Track the forensic status of consumers accessing mental health treatment through the Reporting of Community Services (RoCS) data collection system.

Population: Adults with mental illnesses.

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

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

Measure: Numerator: Number of adults reported as unfit to stand trail, not guilty by reason of insanity or court ordered into treatment at the time of case opening.
Denominator: Total number of adults served in the fiscal year.

Sources of Information: Reporting of Community Services (RoCS).

Special Issues:

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

Action Plan: DMH plans to continue tracking forensic outpatient information at intake. DMH efforts to link mental health databases with county jails are ongoing and provide another means of identifying persons with current involvement in the criminal justice system, as well as facilitating service provision.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	2.39	2.30	2.30	2.30	N/A	N/A
Numerator	3,080	2,872	--	--	--	--
Denominator	128,732	129,564	--	--	--	--

Table Descriptors:

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

Target: Determine the forensic status of consumers accessing mental health services.

Population: Adults with mental illness.

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

Indicator: Percentage of adult clients reporting involvement with the Department of Corrections at the time of case opening.

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

Sources of Information: Reporting of Community Services (RoCS).

Special Issues:

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

Action Plan: DMH plans to continue tracking correctional history information at intake. DMH efforts to link mental health databases with county jails are ongoing and provide another means of identifying persons with current involvement in the criminal justice system, as well as facilitating service provision.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: HOMELESS PERSONS SERVED - ADULTS

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	6,498	6,635	6,500	6,500	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

- Goal:** To assure that individuals with mental illnesses who are also homeless are accessing the DMH-funded community-based mental health service system.
- Target:** A target number of 6500 is an estimate based on the number of homeless persons who were identified as receiving mental health services in previous fiscal years.
- Population:** Adults with mental illnesses.
- Criterion:** 4:Targeted Services to Rural and Homeless Populations
- Indicator:** Number of individuals being served by DMH-funded community-based providers who are reported as undomiciled or homeless at the time of entry into service.
- Measure:** Number of persons receiving community mental health services that reported being homeless at intake for mental health services.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:**
- Significance:** Individuals with mental illnesses should have access to affordable permanent housing.
- Action Plan:** DMH aims to maintain or expand access to the DMH-funded community-based mental health service system by persons with mental illnesses who are homeless.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Living Independently

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	63.60	65.10	65.10	65.10	N/A	N/A
Numerator	81,905	84,379	--	--	--	--
Denominator	128,732	129,564	--	--	--	--

Table Descriptors:

- Goal:** To track demographic information on living arrangements of adult clients.
- Target:** Track number of individuals living independently at case opening.
- Population:** Adults with mental illness.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percentage of adults living in private residences*, unsupervised, and considered to be living independently at the time of case opening.
- Measure:** Numerator: Number of adults living in private residence, unsupervised, and considered to be living independently at the time of case opening.
Denominator: Total number of adults served in the fiscal year.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:**
- Significance:** The proportion of individuals reported as living independently at intake has been close to 63% for several years. This demonstrates the need for ongoing attention to housing services for individuals with mental illnesses.
- Action Plan:** DMH will continue to assess living arrangements at intake as a means of having baseline data on this indicator regarding the individuals who access DMH funded services.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: MEDICAID BILLING - ADULTS

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	129,028,640	149,599,641	150,000,000	150,000,000	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

- Goal:** To assure prudent administration of resources through appropriate matching of federally available dollars for mental health services.
- Target:** Maximize billing for Medicaid services.
- Population:** Adults with mental illnesses.
- Criterion:** 5:Management Systems
- Indicator:** Total dollars billed to Medicaid for adults.
- Measure:** Total dollars billed to Medicaid for adults.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:**
- Significance:** A measure of the state's capacity to fund and provide mental health services. Resources must be maximized to support delivery of mental health services.
- Action Plan:** DMH has a goal of increasing Medicaid billing for community mental health services provided to adults in FY 2008.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: RURAL RESIDENTS SERVED - ADULTS

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	30,607	30,607	32,000	32,000	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

- Goal:** To assure that individuals with mental illnesses who reside in rural areas are accessing the DMH-funded community-based mental health service system.
- Target:** DMH has set a target of identifying and providing services to 32,000 persons with mental illness in rural areas of the state.
- Population:** Adults with mental illness.
- Criterion:** 4:Targeted Services to Rural and Homeless Populations
- Indicator:** Number of individuals being served by DMH-funded community-based providers who are residents of rural areas at the time of entry into services.
- Measure:** Number of individuals reported by DMH-funded community-based providers who are residents of rural areas at the time of entry into services.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:**
- Significance:** The geography of rural areas adds challenges to the timely and consistent access to services for both service providers and persons with mental illness.
- Action Plan:** DMH aims to maintain or expand access to community mental health services for persons residing in rural areas.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: TARGET POPULATION - ADULTS

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	56.52	56.60	57	57	N/A	N/A
Numerator	69,135	73,323	--	--	--	--
Denominator	122,323	129,564	--	--	--	--

Table Descriptors:

- Goal:** To assure resources and services are provided to the priority population of the publicly funded mental health system.
- Target:** Maintenance of or increase service level for persons with severe mental illness receiving mental health services in the publicly funded mental health system.
- Population:** Adults with serious mental illnesses.
- Criterion:** 2:Mental Health System Data Epidemiology
- Indicator:** Percentage of individuals being served by DMH-funded community-based providers who meet the established criteria for “target population” at the time of entry into services.
- Measure:** Numerator: Number of adults being served by DMH-funded community-based providers who meet the established criteria for “target population” at the time of entry into services.
Denominator: All adults being served by DMH-funded community-based providers.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:**
- Significance:** The target group of adults with serious mental illnesses (SMI) is the priority population for the delivery of community mental health services.
- Action Plan:** DMH will continue to monitor service provision to assure that individuals with severe mental illness receive priority services.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Vocational Placement

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	3.38	3	3	3	N/A	N/A
Numerator	4,005	3,880	--	--	--	--
Denominator	118,465	129,564	--	--	--	--

Table Descriptors:

- Goal:** To track demographic information on vocational placement for adult consumers.
- Target:** Target will remain at 3%.
- Population:** Adults with mental illnesses.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percentage of adults who have a vocational placement at the time of case opening.
- Measure:** Numerator: Number of adults reported as having a vocational placement at case opening
Denominator: Total number of adults served in the fiscal year.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:**
- Significance:** Employment is a key issue relating to recovery and resilience. At intake in FY 2006, vocational placement levels were at 3%. This descriptive data collected at intake – before services are initiated – is not expected to change. These low levels are consistent with National findings and indicate the importance of further developing employment services.
- Action Plan:** DMH plans to continue tracking this data while developing specialized employment services.

Illinois

Child - Establishment of System of Care

Child - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

SECTION III-B: CHILD AND ADOLESCENT (C&A) PLAN

Criterion 1. Comprehensive Community-based Mental Health System

Illinois has made substantive progress in developing a comprehensive mental health service system for individuals with serious mental illnesses (SMI) and for youth with serious emotional disturbances (SED) and their families. Illinois envisions a well resourced transformed mental health system that is consumer directed and community driven with a continuum of integrated and effective culturally inclusive programs, services (prevention, early intervention and treatment), and supports, that promote healthy lifelong development through equal access and that 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. The Illinois Vision for Mental Health is "The Expectation of Resilience and Recovery through Treatment, Accountability and Equal Access". Many of the activities in which the DMH is engaged are providing the foundation to make this vision a reality.

Organization of the Comprehensive System.

Central Office Structure

The Child and Adolescent Services office is led by a qualified Child Psychiatrist and consists of 25 FTE Statewide C&A Staff. Twenty are located in a Chicago office which has statewide responsibility, three are in Central Office, one in Region 3, and one in Region 2. With fewer staff available in the past year, contracting responsibilities have shifted to the Regional staff. C&A staff accompany regional staff and consult, but no longer carry any direct responsibility for contract work and monitoring. The model appears to be working well, reducing duplicated effort and allowing the Regions to draw upon C&A expertise to support their contract and monitoring role.

The CCSRs

The five geographic Comprehensive Community Service Regions (CCSRs) are responsible for contracting activities with 151 community-based outpatient/rehabilitation agencies which include 124 child serving agencies which are either specialized or are community mental health centers with children's programming. They also contract with 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 assigned staff specially designated to address child and adolescent and juvenile 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 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.

Family Participation

The participation of parents/caregivers and adolescents in planning and evaluating the quality of mental health services is an important aspect of the Illinois public mental health system. DMH has maintained this effort as a priority during fiscal year 2007. The activities directed toward increasing family voice and participation in the provision of C&A services statewide and in DMH Regions will continue in FY 2008. DMH continues to:

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

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

Family Resource Developers

DMH requires Family Resource Developers (FRDs) to be hired in SASS agencies. Increasing value has been placed on the expertise FRDs bring to the SASS teams. Of the 54 agencies providing SASS services, only three of the agencies have never hired a FRD. There is generally a modest level of turnover in the FRD staff, and at the point that the FY 2007 FRD survey was conducted 41 of 49 reporting agencies (84%) had FRDs employed. Thirty-one (76%) were FTE positions. Monthly meetings are held for the FRDs in order to provide education, resource development and support for the positions. FRDs from the federally funded Systems of Care demonstration grants also attend these meetings. Each System of Care sites has emphasized the importance and hiring of FRDs. While the survey results could not specify the number of FRD positions that were FY 2007 new hires, it was noted that their support role has expanded as some agencies are using FRDs to assist with Individual Care Grant application processes and service planning.

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

Indicators:

- **Number of FRDs hired by SASS programs to facilitate parent-to-parent support**
- **Percentage of FRD positions filled in FY 2008**

Teen Advisory Group

The Teen Advisory Group consists of youth who are currently, or have previously, utilized C & A services. The group consists of 8 members who meet monthly and publish a Newsletter. Meetings were held each month in FY 2007 to provide feedback to

the C & A network regarding quality of care. Members of the group are compensated for each meeting they attend. During FY2007, the group conducted a survey of mental health counselors in the system regarding their perceptions of the counseling services they provide the problems they encounter and their clinical roles. As part of the analysis and report to the C&A Advisory Council, they are comparing their own experiences with counseling to identify differing perceptions of issues involved in access and treatment. This objective will continue in FY 2008.

Objective C1.2.

Continue efforts to develop and enhance the role of the DMH C&A Teen Advisory Group.

Indicators:

- **Monthly meetings of the teen advisory group held in FY 2008**
- **Documentation of Teen Advisory Group participation and input into the larger DMH arena**

Focus on Evidence-Based Practices

DMH is not currently able to establish the Evidence Based Practices for children and adolescents which have been identified by SAMHSA. In order to broaden the application of solid and proven clinical practice with children, the DMH C&A Statewide Office is actively promoting Evidence Informed Practice (EIP). Evidence Informed Practiced is defined as “a collaborative effort by children, families and practitioners to identify and implement practices that are appropriate to the needs of the child and family, reflective of available research, and measured to ensure the selected practices lead to improved meaningful outcomes”.

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

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

A curriculum on EBP will be further refined and will form the basis for training of providers and stakeholders. The subcommittee also intends to partner with a University to apply for a NIMH IPRISP grant to further develop the ability of the system to utilize scientifically sound concepts in the children’s mental health system. Implementation of this plan began in FY07.

During FY 2007, the DMH/ Child and Adolescent Service System worked to increase the adoption of evidence-informed practices statewide in Illinois. A broad coalition of members of the Illinois C & A Advisory Committee has been assembled which includes community mental health providers (e.g. academic partners, university professors, consumer parents, advocacy groups, and a sister state agency - DCFS) to address the issue of implementing evidence-based practices within the Illinois children's mental health system. Training on evidence-informed practices was provided for community mental health providers, educators, and staff from other child-serving agencies involved to increase the effectiveness of the clinical services provided

The following objective will be a priority for FY 2008.

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

Indicators:

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

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 ICG program is family driven, meaning that families make the decision regarding whether they wish to utilize their grant for residential or community based services. These decisions are generally made with consultation from the mental health providers working with the family. Services provided include intensive, home-based support, treatment, and respite care that 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.¹

¹ Four categories of services are available to ICG recipients under the community-based model. These include:

1. Therapeutic Stabilization – *“An essential part of in-home services, providing a timely one-to-one relationship between the child and a contractual agent of the SASS agency for the purpose of facilitating age-appropriate, normalizing activities of the child.”* This intervention allows for up to 21 hours per week of service per child. The number of hours approved must be justified by the level of the child's functional impairment.

2. Behavior Management Intervention – *“A time-limited child and family training/therapy intervention focused toward amelioration or management of specific behaviors that jeopardize the child's functioning in the home/family setting. This intervention typically teaches/models techniques and skills that can be used by the parent/guardian and other family members.”* This intervention is typically used to purchase expertise to support a child that requires expertise above and beyond that generally available in the local community mental health agency, an example would be the services of a dietician or fitness trainer to address the needs of a child who has gained a great deal of weight while taking psychotropic medications, or de-escalation training for parents.

3. Child Support Services – *“Time-limited funding to cover costs that would otherwise be prohibitive to the parents for the child to participate in community activities when those activities are related to objectives in the child's current individual services plan.”* These services often include therapeutic recreation, music, art, after-school programs, or therapeutic summer camps.

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

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

The ICG program received and processed 1,201 applications in FY 2006, awarding 114 grants. In FY2006, there were 449 ICG residential placements, and 185 children and adolescents received community services under the ICG program. As of April, FY 2007, 876 applications were requested by families. Of those, 248 were reviewed for eligibility and 61 grants had been awarded. At that time there were 479 active ICG clients. Of this number, 267 were in residential care and 134 were in community-based care. By the end of FY2007, a total of 515 ICG clients had used ICG services during the year.

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

Indicator:

- **Number of children served through ICG community service options in FY 2008**

Anti-Stigma Campaign

The Report of the President's New Freedom Commission on Mental Health noted that the "stigma that surrounds mental illnesses is one of three major obstacles preventing Americans with mental illnesses from getting the excellent care that they deserve". Funds totaling \$300,000 have been allocated to implement strategies geared toward reducing the stigma families and children experience when afflicted with serious emotional disturbances and mental disorders.

4. Young Adult Support Services – "Time-limited funding for young adults to cover costs of services and supports, to aid the young adult in his or her transition to community living." These services may include a young adult taking a class in a community college to teach money management or cooking skills.

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

Indicators:

- **Materials developed that address stigma**
- **A list of campaign activities that enhance public awareness that were completed in FY2008.**

Transformation Activities in FY2008: Achieving the Promise

Overall, the DMH vision for the community mental health system is one that is oriented towards fostering resilience and recovery, and one that is consumer and family driven. It is our belief that system transformation, as all constructive endeavors, must be based on an assessment of needs, available strengths from which to build and change, and a set of priorities which provide clear direction and lend structure to the process and the activities aimed toward positive results. The Report of the President’s New Freedom Commission on Mental Health provides an important foundation for on-going planning efforts in this regard. In Criterion I, the FY2008 Children’s plan has addressed four of the six New Freedom Commission goals. A summary of these activities, as well as the strengths, priorities, and service needs under this criterion are provided at the end of Criterion I in Section 2.

C&A Performance Indicators – Criterion I

The DMH has established the National Outcome Measures (NOM) along with additional system indicators to track mental health system service delivery and to aid in service planning. Each indicator is described in detail at the end of Section III. Operational definitions are provided, the use of the indicator is described, and the source of data that is used to compute indicator values is identified. Data is provided for FY 2004 through FY 2006, and projections have been made for FY 2007 and FY 2008. FY 2007 actual data will be provided in the FY 2007 Mental Health Block Grant Implementation Report.

Key System Performance Indicators – Children and Adolescents	
Indicator Reference Number	Indicator Description
Criterion 1	
C1.1	Percentage of children/adolescents living with parents or other relatives in a private residence
C1.2	Percentage of children/adolescents court ordered into outpatient treatment
C.1.3	Percentage of children/adolescents reporting involvement with the juvenile justice system (Department of Corrections)
C1.4	Percentage of children/adolescents with serious emotional

	disturbances receiving case management services
C1.5	Percentage of service hours to children/adolescents receiving SASS services which occur in community settings outside of providers' offices or clinics.
C1.6	Percentage of children/adolescents presenting for admission to state hospitals who have received a face-to-face screening
<i>Total Number of C&A Services Indicators</i>	6

Illinois

Child - Available Services

Child - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing services;
Educational services;
Substance abuse services;
Medical and dental services;
Support services;
Services provided by local school systems under the Individuals with Disabilities Education Act;
Case management services;
Services for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities leading to reduction of hospitalization.

See Section II - Child for review of available services.

Illinois

Child - Transformation Efforts and Activities in the State in Criteria 1

Child - Describes mental health transformation efforts and activities in the State in Criteria 1, providing reference to specific goals of the NFC Report to which they relate.

Transformation Activities in FY2008: Achieving the Promise

Overall, the DMH vision for the community mental health system is one that is oriented towards fostering resilience and recovery, and one that is consumer and family driven. It is our belief that system transformation, as all constructive endeavors, must be based on an assessment of needs, available strengths from which to build and change, and a set of priorities which provide clear direction and lend structure to the process and the activities aimed toward positive results. The Report of the President's New Freedom Commission on Mental Health provides an important foundation for on-going planning efforts in this regard. In Criterion I, the FY2008 Children's plan addresses four of the six New Freedom Commission goals:

Americans understand that mental health is essential to overall health.

DMH is advancing a public awareness campaign to reduce the stigma experienced by children/adolescents, and their families associated with mental illnesses. Funding has been obtained through collaboration with the Illinois Children's Mental Health Partnership (See Objective C1.5.).

Mental health care is consumer and family driven.

DMH C&A Services is continuing to work with parents and parent-led organizations to facilitate parent-to-parent support through the use of Family Resource Developers (FRD's), to increase the number of FRD's employed in child-serving mental health agencies, and to encourage substantive feedback from parents and parent led organization on enhancing the quality of services at all levels of care. (See Objective C1.1) Efforts to enhance and integrate the role and contribution of the DMH C&A Teen Advisory Group will also continue. (See Objective C1.2.)

Early mental health screening, assessment, and referral to services are common practice.

Community service options in the DMH ICG program will be further strengthened in FY2008 and the number of youth served is expected to increase. (See Objective C1.4)

Excellent mental health care is delivered and research is accelerated.

As noted above, DMH committed to continuing to advance the implementation of evidence-informed practices in the child and adolescent service system through training events and the use of research and practice experience documented in a clearly laid out curriculum. (See Objective C1.3).

Illinois

Child - Estimate of Prevalence

Child - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

Prevalence Estimate For 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 lower limit at a level of functioning of 50 (LOF=50). The latest available information provided by CMHS estimates that 115,615 or a 6% children and adolescents aged 9 to 17 based on a 17.5% poverty rate have serious emotional disturbances.

Illinois

Child - Quantitative Targets

Child - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

Progress In Performance Measurement for Children and Adolescents with SED
The Division of Mental Health (DMH) utilizes a reporting system in which data that is collected is disseminated to all parties who might benefit from it in a format that maximizes its usefulness. The use of quantitative measures of organizational functioning through the use of key performance indicators permits comparison against established standards over time or between organizational units. Target levels for the performance indicators provide focus for evaluation and inform planning efforts. The DMH requires full reporting of client and service data by community providers.

Collaboration with Federal Initiatives

The DHS Division of Mental Health continues to build on previous work undertaken in collaboration with SAMHSA CMHS and other states to develop and implement performance measures and indicators. Over the years, the DMH has received SAMHSA grants to implement the MHSIP Consumer Oriented Mental Health Report Card and participated in the Five State Feasibility Study of Performance Measurement, and the Sixteen State Pilot Indicator Project and the Data Infrastructure Grant. These efforts are continuing under the current round of state data infrastructure grants for quality improvement. Efforts also continue to be undertaken to work with the Mental Health Planning and Advisory Council (MHPAC) to share information regarding the use and interpretation of performance indicators.

Access to Services- Quantitative Targets For FY2008

In FY 2004, the percentage of children and adolescents meeting the DMH target population criteria was 33.7%. This percentage decreased in FY 2005 to 30.4% and increased slightly in FY 2006 to 32%. Data for FY 2007 will be provided in the implementation report. Since FY2005 the data for this indicator is likely an underestimate due to the fact that the DMH still has no access to SASS data.

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

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

In FY 2004, the percentage of children and adolescents meeting the DMH eligible population criteria was 91.3%. The percentage decreased in FY 2005 to 89.5%, further decreasing to 86.5% in FY 2006. Data for FY 2007 will be provided in the implementation report. Since FY2005 the data for this indicator is likely an underestimate due to the fact that the DMH still has no access to SASS data.

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

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

C&A Performance Indicators - Criterion 2

The DMH has established the National Outcome Measures (NOM) along with additional system indicators to track mental health system service delivery and to aid in service planning. Each indicator is described in detail at the end of Section III. Operational definitions are provided, the use of the indicator is described, and the source of data that is used to compute indicator values is identified. Data is provided for FY 2004 through FY 2006, and projections have been made for FY 2007 and FY 2008. FY 2007 actual data will be provided in the FY 2007 Mental Health Block Grant Implementation Report.

Criterion 2

C2.1 Target Population - C & A: Percentage of individuals being served by DMH-funded community-based providers who meet the established criteria for "target population" at the time of entry into services.

C2.2 Eligible Population - C&A: Percent of individuals being served by DMH-funded community-based providers who meet the established criteria for "eligible population" at the time of entry into services.

Illinois

Child - Transformation Efforts and Activities in the State in Criteria 2

Child - Describes mental health transformation efforts and activities in the State in Criteria 2, providing reference to specific goals of the NFC Report to which they relate.

Transformation Activities in FY2008: Achieving the Promise

The Report of the President's New Freedom Commission on Mental Health provides an important foundation for on-going planning efforts in data epidemiology. In Criterion II, the FY2008 Child and Adolescent plan addresses two of the six New Freedom Commission goals:

Disparities in mental health services are eliminated.

The DMH continues efforts to increase access to services by children and adolescents with serious emotional disturbance. In FY 2004, the percentage of children and adolescents meeting the DMH target population criteria was 33.7%. This percentage decreased in FY 2005 to 30.4% and increased slightly in FY 2006 to 32%. Data for FY 2007 will be provided in the implementation report. Also, note that this is likely an underestimate due to the fact that the DMH is still unable to access SASS data. (See Performance Indicator C2.1- Increased Access to Services by the DMH Child/Adolescent Target Population)

The definition of the DMH eligible population is somewhat broader than the definition for the target population. In FY 2004, the percentage of children and adolescents meeting the DMH eligible population criteria was 91.3%. The percentage decreased in FY 2005 to 89.5%, further decreasing to 86.5% in FY 2006. Data for FY 2007 will be provided in the implementation report. (This is likely to be an underestimate due to the fact that the DMH is unable to access SASS data). See Performance Indicator C2.2- Increased Access to Services by the DMH Eligible C & A Population

Technology is used to access mental health care and information.

In FY2008, work will continue on the completion of the Child and Adolescent Outcomes Analysis program, a Web-based Clinical Outcomes Analysis system. As noted above, this system will feature the ability to generate immediate feedback at the individual, agency, and statewide levels.

As noted in Section 1, DHS/DMH is planning to reconstitute administrative services through an Administrative Services Organization (ASO) in FY2008. One of the major responsibilities of the ASO will be to implement a state-of-the-art management information system (MIS) which supports a range of data related functions including consumer enrollment, service utilization, provider claims submission, validation, processing, adjudication, and payment through reliable, valid, and expeditious data transmission among all appropriate federal, state, and local entities. The ASO will also provide for access to this data by developing a datamart that is accessible to DMH staff.

Illinois

Child - System of Integrated Services

Child - Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:

Social services;
Educational services, including services provided under the Individuals with Disabilities Education Act;
Juvenile justice services;
Substance abuse services; and

Health and mental health services.

Criterion 3. Children's Services

Inter-Agency Collaboration – Child Serving Systems

DMH staff continues to work in collaboration with other State departments, IDHS Divisions and private service providers to improve services to children and adolescents with severe emotional disturbance and other human service needs. These collaborations include the following:

DMH and DCFS. The focus of this collaboration is transition services for youth moving from child welfare services to adult mental health services.

DMH and the Children's Mental Health Partnership – DMH and the Children's Mental Health Partnership are collaborating on early intervention pilot projects, and on transition Services for youth with SED.

DMH and DASA – The focus of this collaboration is on infrastructure building to provide services for Children and Adolescents with co-occurring mental health and substance abuse problems.

DMH and ISBE- A Federal Department of Education Grant was awarded to increase the integration of school mental health services and community mental health centers.

Many other collaboration exist including a collaboration with the McHenry County 708 Board, and the University of Illinois - Rockford on a new System of Care SAMHSA grant C.A.R.E. Project described previously in this application. Other collaborations are described in Sections I and II of the application.

Through these collaborative efforts, DMH continues to ensure that a wide variety of community mental health services are available for children and adolescents and their parents. Some are described below.

Wraparound Services

The Wraparound service approach continues to be essential to the provision of case management services for children. These services, which are provided to families, offer traditional and non-traditional supports by using the local network of community providers and associations. In this approach, there is a definable planning process involving the child and family, which results in an individualized plan which focuses on strengths and needs across multiple settings. The DMH provides funds to SASS programs throughout the state to support wraparound services. Maintenance of funding for Wraparound Services will remain a priority in FY 2008. **(See System Performance Indicator C3.1).**

Services for Dually Diagnosed (MISA) Youth

DMH Regional C & A staff in collaboration with the DHS Division of Alcoholism and Substance Abuse (DASA) are continuing to explore staff training needs and to assess program capacity requirements for addressing the clinical needs of this population.

During FY 2007, DMH Child and Adolescent Services staff continued the collaboration with the DASA staff on a grant to build Infrastructure to serve children and adolescents with co-occurring mental health and substance abuse issues. This collaboration identifies and addresses opportunities to collaborate on the infrastructure building, cross training, parent consumer involvement and funding.

DMH routinely monitors the percentage of youth reported as having a co-occurring substance abuse and mental health disorder. **System Performance Indicator C3.2 tracks the number of MISA clients in the service population.**

Mental Health and the School System - System of Care- and Illinois

In FY-2003, the DMH Metro C&A Network applied for and received an award from SAMHSA for \$9.5 million for a period of six years to develop comprehensive community mental health services for children and their families. FY 2007 was the fifth year of this grant. The primary goal of this federally funded initiative is to promote the development of a system of care involving all child-serving systems and partnerships in the Chicago area. At the service delivery level, collaboration has been fostered through the implementation of the Positive Behavioral Interventions and Supports (PBIS) model as it has been adapted to the Chicago-PBIS model. Staff from mental health agencies participating in the project have actively partnered with staff of the seven participating schools to support the PBIS model that is universal (school-wide), targeted (special populations) and intensive (identified children and youth with serious emotional disturbance needing individualized supports) within the school setting. The SOCC Initiative met the majority of its established goals for FY 2007 and will work to strengthen its governance council and solidify a family organization and consumer groups in FY 2008. A Federal Department of Education Grant was awarded to increase the integration of school mental health services and community mental health centers.

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

policies to improve the mental health care system and will strategize on the development of a comprehensive system of care for McHenry County. The Governance Council includes professionals, family members and youth and will ensure that the project is family driven, youth guided and culturally competent.

The following objective for System of Care-Chicago (SOCC) objective was pursued in FY2007 and will continue in FY 2008:

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

Indicator:

- **Number of collaborative meetings attended by the five agencies to establish and enhance an integrative approach across service systems.**

Mental Health and Juvenile Justice

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

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

In FY 2006, 1,064 youth were referred to MHJJ programs; 924 were screened and 754 were found to be eligible for services and 684 were enrolled. Preliminary data for FY 2007 indicates that MHJJ services will surpass that provided in FY 2006. Thus far in FY 2007 (based on preliminary data), 1,249 youth have been referred to MHJJ programs; of these, 867 were screened and 767 were found to be eligible. Six hundred and eighty-four individuals had been enrolled as of this writing.

The table displayed below displays information for each of the indicators for the MHJJ objectives for FY 2006, as well as preliminary information for FY 2007.

Indicators	FY 2006	FY 2007*
Number of youth receiving MHJJ services	924	867
Number of youth linked to services	588	554
Number of youth re-arrested	181	118

A notable finding is that in FY 2007, based on preliminary data minority enrollment surpassed that of Caucasian enrollment for the first time in the history of the MHJJ program. This is a significant finding in light of data for previous years which identified disproportionate minority contact associated with MHJJ services.

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

- Increase the clinical services provided to youth that have been found to be most strongly associated with positive outcomes. Such services include: Individual therapy, school consultation, psychiatric hospitalization, psychiatric medication and case management services.
- Increase the number of service sessions provided, particularly for Black and Hispanic youth (note: in FY 2006, the average number of treatment sessions provided to Black and Hispanic youth was less than the number of sessions provided to Caucasian youth (16.77 and 16.16 versus 22.75). Finding from a 2006 evaluation of the program revealed that number of service sessions is associated with positive outcomes. FY 2007 data will be reviewed to determine if this trend continues.
- Increase the number of minority youths referred to the MHJJ program (Note: In FY 2006, Referrals of minority youth were significantly below that of White youth (FY '06: White = 488, Black = 283, Hispanic =58).). FY 2007 data will be reviewed to determine if this trend continues.

Objective C3.2. Increase the number of youth receiving services through the Mental Health Juvenile Justice Initiative (MHJJ)

Indicators:

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

Other DMH Child and Adolescent Initiatives - FY 2008

Illinois Children's Mental Health Partnership

Social Emotional Learning

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

Initiatives Supported and Funded Through ICMHP

In addition to this school-based approach, the ICMHP has been successful in garnering state funds for children's mental health needs. The DMH Child and Adolescent Office works closely with the ICMHP in planning how the funds are to be used and implementing those plans. In FY2008, ICMHP is anticipating a \$6.5 million budget which will include expansion of three key projects already undertaken by DMH and the partnership in FY2007.

Transitional Services

In FY2008 DMH and ICMHP are introducing a new pilot project in each DMH Region to provide transitional services for older adolescents (16-17 years old) transitioning from C&A services to adult services and for any youth with SED transitioning from correctional services to the community. Each of the five pilot projects will be funded at \$100,000 upon successful completion of a competitive RFP (Request For Proposal) process. Including the pilot project introduced in FY2007, each will now have two projects for a total of \$1,000,000 in statewide funding. The projects will provide direct basic services and will serve to build the infrastructure for continuing expansion and service effectiveness. The outcomes of these programs will provide vital information as to the kind of models which work best in serving these population groups.

Objective C3.3: In each Comprehensive Community Service Region, initiate an additional transitional service program for youth aging into the adult mental health service system and for those transitioning from correctional settings. Evaluate early outcomes of the programs which were initiated in FY2007.

Indicators:

- **Amount of money expended for the programs in FY2008.**
- **Number of operational programs by the end of FY2008.**
- **Total number of transitioning youth served by the end of the fiscal year.**
- **An initial report documenting outcomes, lessons being learned, gaps and challenges in the service structure, and the innovations which are successful in working with transitioning youth is drafted, reviewed, approved, and disseminated.**

Early Intervention

The Early Intervention Initiative is a granting opportunity to DHS agencies in the regions. The aim is to identify children at risk, especially those at risk of depression, and to intervene early. Case-finding needs to go on in venues which are outside the normal service paths for children with serious disturbances. In FY2007, \$500,000 was awarded to five agencies. One agency in each of the five regions was selected by an open and competitive Request For Proposal (RFP) process to receive a \$100,000 award to provide early intervention services. Flexibility was emphasized as each agency develops its own plan and approach to early intervention based on the unique geographic, cultural, and interagency service environments in each region. In FY2008, another five agencies will be funded in the same way so that two agencies in every region will be in a position to coordinate early intervention services. By the end of FY2008, \$1 million will have allocated for this program.

Objective C3.4: By the end of FY2008, ten early intervention programs will be funded and operational in Illinois.

Indicators:

- **Amount of money expended for the programs in FY2008.**
- **Number of operational programs by the end of FY2008.**
- **Total number of children and families served by the end of the fiscal year.**
- **An initial report documenting outcomes, lessons being learned, gaps and challenges in the service structure, and the innovations which are successful in early intervention services to children and families is drafted, reviewed, approved, and disseminated.**

In addition to this program, an Early Childhood Consultation program was expanded statewide in FY2007. This program began as a joint venture of the Illinois Children's Mental Health Partnership and Michael Reese Hospital's Early Childhood program. The consultation and treatment program was very successful in Chicago but Michael Reese's funds were limited to Chicago. The Illinois Children's Mental Health Partnership obtained sufficient funds to extend the program to seven agencies in the state in FY2007. A total of \$500,000 is being budgeted to cover 10-12 agencies in FY2008. These dollars are provided to consultants who travel to the selected agencies and provide case consultation, education in early childhood issues, and training to identified agency staff for a period 12-18 months. One of the priorities of C&A Services is the further expansion of services to this age group and the evaluation of the process. Agencies successfully completing the training and consultation program will receive funds to expand their

services and provide support to other agencies in their area which are developing this specialization.

Objective C3.5: By the end of FY2008, expand early childhood consultation to twelve agencies statewide. Evaluate the consultation process and the initial results.

Indicators:

- **Amount of money expended for the programs in FY2008.**
- **Number of agencies participating in the consultation process by the end of FY2008.**
- **Number of early childhood assessments completed successfully by the participating agencies by the end of the fiscal year.**
- **An initial report documenting outcomes, lessons being learned, gaps and challenges in the consultation process, any successful innovations, and a plan for specific next steps and the long term vision for continuing expansion of this consultation is drafted, reviewed, approved, and disseminated.**

C&A Performance Indicators – Criterion 3

The DMH has established the National Outcome Measures (NOM) along with additional system indicators to track mental health system service delivery and to aid in service planning. Each indicator is described in detail at the end of Section III. Operational definitions are provided, the use of the indicator is described, and the source of data that is used to compute indicator values is identified. Data is provided for FY 2004 through FY 2006, and projections have been made for FY 2007 and FY 2008. FY 2007 actual data will be provided in the FY 2007 Mental Health Block Grant Implementation Report.

Criterion 3	
C3.1 (NOM)	Percentage Of Caregivers Reporting Positive Outcomes Of Treatment For Children/Adolescents Receiving Services.
C3.2 (NOM)	Percent of children/adolescents readmitted to a state hospital within thirty days of being discharged from a state hospital.
C3.3 (NOM)	Percent of children/adolescents readmitted to a state hospital within 180 days of being discharged from a state hospital.
C3.4 (NOM)	Number Of Children/Adolescents Served. (Increased Access To Services). Continue breakdowns by Gender, Race/Ethnicity, and Age.
C3.5 (NOM)	Use of Evidence-Based Practices. (This Indicator was not reported upon in FY2007.)

C3.6	C&A Wraparound Support-Funds spent through Screening Assessment and Support Services (SASS) agencies to support interagency wraparound plans with specialized mental health services.
C3.7	Number of Child and Adolescents (C&A) served with a MISA based diagnostic category*.
C3.8 (NOM)	Return to/Stay in School
C3.9 (NOM)	Decreased Involvement with the Juvenile Justice System
C3.10 (NOM)	Increased Stability in Housing
C3.11 (NOM)	Increased Social Supports/Social Connectedness
C3.12 (NOM)	Improved Level of Functioning

***See Goals, Targets, Action Plans for all indicators including NOMS**

Illinois

Child - Geographic Area Definition

Child - Establishes defined geographic area for the provision of the services of such system.

Geographic Area Served

The Comprehensive Community Service Regions

The five geographic Comprehensive Community Service Regions (CCSRs) are responsible for contracting activities with 151 community-based outpatient/rehabilitation agencies which include 124 child serving agencies which are either specialized or are community mental health centers with children's programming. They also contract with 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 assigned staff specially designated to address child and adolescent and juvenile 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 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

Child - Transformation Efforts and Activities in the State in Criteria 3

Child - Describes mental health transformation efforts and activities in the State in Criteria 3, providing reference to specific goals of the NFC Report to which they relate.

Transformation Activities in FY2008: Achieving the Promise

The Report of the President's New Freedom Commission on Mental Health provides an important foundation for on-going planning efforts in service integration for children and adolescents. The service system priority continues to be one of collaboration to provide a seamless system of care, given the multiple problems of children and adolescents, as well as their families, who are involved with overlapping service systems. An additional priority on which DMH is focusing is the implementation of evidence-based practices for children. In Criterion III, the FY2008 Child and Adolescent plan addresses two of the six New Freedom Commission goals:

Early mental health screening, assessment, and referral to services are common practice.

In FY2008, the DMH will collaborate with Chicago Public Schools, the Illinois State Board of Education (ISBE), University of Illinois at Chicago, and the Illinois Department of Children and Family Service (IDCFS), to continue development of an integrative approach for providing a range of prevention, early identification, and intervention activities as components of the emerging "mental health in schools" model. (See Objective C3.1.) In collaboration with the Illinois Children's Mental Health Partnership, DMH is initiating ten new early intervention programs and expanding early childhood consultation to twelve agencies statewide (See Objectives C3.4 and C3.5). These initiatives will be evaluated. An initial report documenting outcomes, lessons being learned, gaps and challenges, any successful innovations, and a plan for specific next steps and the long term vision for continuing expansion of these initiatives will assist in instituting the service.

Excellent mental health care is delivered and research is accelerated.

In FY2008, an additional transitional service program for youth aging into the adult mental health service system and for those transitioning from correctional settings in each of the five CCSRs which will bring the number of programs statewide to ten. Outcomes of the programs that were initiated in FY2007 will be evaluated to learn what is needed to provide effective programs for individuals in this age group and in similar situations. This initiative is an effort to establish the groundwork required to develop a service model and the necessary infrastructure to replicate and expand these services statewide. (See Objective C3.3)

The Mental Health Juvenile Justice (MHJJ) initiative will continue work to increase the number of juvenile detainees with serious mental illnesses who are identified, screened, and linked with appropriate community-based services. Evaluation of the MHJJ program has found that these services result in overall clinical improvement, decreased functional impairment and reduced rates of recidivism for youths enrolled in the program. Based upon evaluation findings, the program will work on increasing the clinical services that have been found to be most strongly associated with positive outcomes, increasing the number of service sessions provided for Black and Hispanic youth, and increasing the number of minority youth referred to the MHJJ program. (See Objective C3.2).

Illinois

Child - Outreach to Homeless

Child - Describe State's outreach to and services for individuals who are homeless

The Homeless Population in Illinois

The most reliable source, though not complete, for descriptive data of the homeless population is the IDHS Division of Human Capitol Development, Office of Family Support Services which administers the Emergency Food and Shelter (EF&S) program. This program was developed to provide immediate food and shelter to homeless persons and families or persons and families at imminent risk of becoming homeless. It provides meals, beds and supportive services through not-for-profit organizations to homeless individuals and families to assist them to return to self-sufficiency. The General Revenue Fund (GRF) allocation for the EF&S Program in FY2006 totaled approximately \$8.9 million. Appropriations by the General Assembly allowed the Department to provide needed shelter and services to homeless persons throughout the state. Between July 1, 2005 and June 30, 2006 there were 49,150 individuals that received shelter, food, and services to meet their emergency needs and help them regain self-sufficiency. During the year, organizations funded through the EF&S Program provided 2,079,319 nights of shelter, served 3, 329,617 meals and delivered 2,050,102 units of supportive services.

Although the data should not be construed to represent the total homeless population in Illinois, because not all homeless persons are served by the EF&S program, the program

issues an annual report that reviews trends in services provided to homeless persons in Illinois. After experiencing decreases in the number of people served by the EF&S program in 2004 and 2005, the number of participants increased by more than 10,500 to 49,150 in FY2006. Sixty percent of the participants in FY2006 were males. The number of total households (the measurable unit of family composition) increased from 26,340 in 2005 to 33,400 in 2006, an increase of 7,060 households. It is to be noted here that of these, single males comprised 20,525 households and single females, 5,712. The remainder were: couples with no children (311), couples with children (812), a single male with children (209) and a single female with children (5,831). The increase is seen as due primarily to improved reporting of the City of Chicago.

The 6, 852 households with children noted above accounted for 14,122 participants under the age of 18 (29% of the total served) of which 50% (7,062) ranged from newborn infants through five years of age. Combined with the 18 through 21 year old group (3,029) nearly 35% (34.89) of the homeless persons served by the EF&S program were under the age of 22. In comparison, only 2.16% of those served (1,063) were over the age of 62 while those 41-61 (32%) and those 22-40 (31%) were similar in numbers, thus currently dispelling the myth that homelessness is predominantly an issue for older adults.

Outreach To Homeless Youth

Providing Mental Health Services to Homeless Youth

The DMH continues to provide funding to maintain and enhance services to homeless youth. These services have been described in detail in Section II of this application. System Performance Indicator C4.1 was created in FY 1999 to track the number of homeless youth entering community-based services in the public mental health service system. This system performance indicator permits an initial evaluation of the system's ability to provide access to mental health services for runaway youth and children in families who are homeless and who have serious emotional disturbances. In FY 2005, 401 youth were identified as undomiciled or homeless at their initial assessment; this number decreased in FY 2006, with 365 youth reported as homeless. See also Section II for descriptions of several programs which provide outreach services.

Illinois

Child - Rural Area Services

Child - Describes how community-based services will be provided to individuals in rural areas

Available Services In Rural Areas

Team Illinois

DMH participates in a broader DHS initiative addressing the multiple challenges posed by providing services in rural areas. Team Illinois continues to be a priority initiative of Illinois Governor Rod Blagojevich and his administration. The goal of the program is to demonstrate that by partnering with local residents, elected officials, and other stakeholders in communities that face multiple challenges, and by concentrating its resources in these communities, the State can help communities build stronger infrastructures, achieve economic turnaround and create a foundation for future growth. Team Illinois is an unprecedented effort to pool and focus Illinois resources, create public-private partnerships and collaborate with local citizens and community stakeholders in areas with a demonstrated need for infrastructure and economic development. Virtually every State agency is a partner in Team Illinois and has something to offer communities in need of intensive services. In each community, representatives of several state agencies participate in workshops, meetings, interviews and one-on-one discussions with local citizens and leaders as part of a needs assessment and to exchange ideas for addressing these needs. The state resources and partnerships put in place by Team Illinois will be long-term and the initiative will remain in the community as long as necessary.

Mental Health Services to Youth Residing in Rural Areas

We continue to track the number of rural youth served (**see System Performance Indicator C4.2**) in the public mental health. The C&A population of the 76 Illinois counties designated as rural was 471,894 according to 2000 census figures, yielding a mental health prevalence estimate of 33,032 (at 7%). In FY 1999, 9,294 individuals under 18 years old who live in the above 76 rural counties received DMH funded services. Nine thousand seven hundred and forty-four (9,744) youth received services in FY 2004, 10,247 youth received services in FY 2005 and 11,014 in FY 2006---so there appears to be a trend toward increased access of services by this population. One initiative of the DMH is to focus on increasing access to child psychiatry for children/adolescents residing in rural areas.

Child Psychiatry Consultation Program

DMH Central and Southern regional staff have worked closely with community providers to enhance child expertise and to reconfigure SASS (Screening, Assessment and Support Services) to meet the needs of children and adolescents residing in rural areas. The reconfiguration of services has focused on the provision of services by providers closely tied to these communities, and the use of a consultative model to ensure that a Child Psychiatrist is available to the community psychiatrist when no child psychiatric services are available. Two strategies have been undertaken to address the shortage of child psychiatrists: (1) Both Regions have applied for designation as professional shortage areas for child psychiatry and (2) The statewide DMH Deputy Director for child and adolescent services, who is a Child Psychiatrist, has been working with the American

Academy of Child Psychiatry to recruit board eligible child psychiatrists to provide services in these regions.

Providing consultative services to local program staff has provided an innovative vehicle for supporting the delivery of services in the state's foremost rural regions while efforts to recruit psychiatric staff are underway. The Child and Adolescent Training Institute at the University of Illinois in Chicago implemented a program of child psychiatry consultation through the use of video-conferencing. This program, which began in March of 2002, matches three child and adolescent psychiatrists from urban areas to three rural community mental health centers that have very limited access to child and adolescent psychiatrists. Over the course of fiscal years 2003, 2004, and 2005, staff at the University of Illinois have performed many psychiatric consultations. This program is highly valued by participating community mental health centers.

In FY2008, DMH has budgeted approximately \$300,000 for a pilot project which will allow six agencies to each purchase \$50,000 of qualified psychiatric consultation time to be provided through a Tele-Psychiatry approach which will range from informal case discussions to formal case reviews, and a telemedicine approach in which the child will be present for assessment. In July 2007, the Governor signed legislation providing for the use of telepsychiatry to provide psychiatric care to individuals living in rural areas. The legislation requires the Illinois Department of Healthcare and Family Services (the Illinois Medicaid Agency) to reimburse psychiatrists and Federally Qualified Health Centers for mental health services provided via telepsychiatry.

Objective C4.1: Implement a telepsychiatry pilot project in six rural sites in Illinois.

Indicator:

- **Number of projects implemented in FY 2008**
- **Dollars allocated for telepsychiatry pilot in FY 2008**

C&A Performance Indicators – Criterion 4

The DMH has established the National Outcome Measures (NOM) along with additional system indicators to track mental health system service delivery and to aid in service planning. Each indicator is described in detail at the end of Section III. Operational definitions are provided, the use of the indicator is described, and the source of data that is used to compute indicator values is identified. Data is provided for FY 2004 through FY 2006, and projections have been made for FY 2007 and FY 2008. FY 2007 actual data will be provided in the FY 2007 Mental Health Block Grant Implementation Report.

Criterion 4	
C4.1	Number of children being served by DMH-funded community-based providers who are reported as undomiciled or homeless at the time of entry into services.
C4.2	Number of children being served by DMH-funded community-based providers who are residents of rural areas at the time of entry into services.

Illinois

Child - Transformation Efforts and Activities in the State in Criteria 4

Child - Describes mental health transformation efforts and activities in the State in Criteria 4, providing reference to specific goals of the NFC Report to which they relate.

Transformation Activities in FY2008: Achieving the Promise

The Report of the President's New Freedom Commission on Mental Health provides an important foundation for on-going planning efforts for youth with serious emotional disturbance who are homeless and those residing in rural areas. In Criterion IV, the FY2008 plan addresses three of the six New Freedom Commission goals:

Disparities in mental health services are eliminated.

Since FY 1999 the number of homeless youth entering community-based services in the public mental health service system has been tracked permitting an initial evaluation of the system's ability to provide access to mental health services for runaway youth and children in families who are homeless and who have serious emotional disturbances. In FY 2005, 401 youth were identified as undomiciled or homeless at their initial assessment; this number decreased in FY 2006, with 365 youth reported as homeless. (See System Performance Indicator C4.1)

The DMH continues to track the number of rural youth served (see System Performance Indicator C4.2) in the public mental health system. There appears to be a trend toward increased access of services by this population. In FY2004, 9,744 youth received services in FY 2004, 10,247 youth received services in FY 2005 and 11,014 in FY 2006.

Technology is used to access mental health care and information.
and

Excellent mental health care is delivered and research is accelerated.

In FY2008 a telepsychiatry pilot project focusing on child psychiatry consultation will be implemented in six rural sites in Illinois. An initial allocation of \$300,000 will support the purchase of child psychiatry time and permit thoughtful study and evaluation of the process, equipment, and infrastructure necessary to expedite this service. (See Objective C4.1)

Illinois

Child - Resources for Providers

Child - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

The DHS Division of Mental Health continues to work towards an integrated system of care that includes both state hospitals and community-based providers, including those that are responsible for emergency health services regarding mental health.

Enhancing Financial Resources

Increased Financial Resources for Community Services

As we have noted previously, there has been a substantial increase in the proportion of the DMH budget spent on community mental health services across fiscal years. The DMH has undertaken a number of efforts to increase the financial resources available to support community-based mental health services in Illinois. Many of these initiatives have been discussed in Sections I and II of this application.

Service Enhancement Using Block Grant Funds

Despite the fact that the allocation of Mental Health Block grant funds to Illinois by SAMHSA has been reduced over the past two years, the DMH continues its efforts to utilize these funds to enhance service provision within the state. Block Grant funds continue to support such initiatives as the consumer engagement specialist initiative, the provision of wellness, action and recovery planning (WRAP), residential services and psychiatric leadership services.

Grant Development

The DMH continues to undertake efforts to increase the flow of Federal and other grant dollars to the state. Some of the grants awarded to DMH over the past few years include the SAMHSA CMHS System of Care Grants (one in Chicago and one in McHenry County), a SAMHSA CMHS evidence-based practices implementation grant for Integrated Dual Diagnosis Treatment, a Data Infrastructure Grant, a SAMHSA Disaster Response grant, a Johnson and Johnson/Dartmouth Grant focusing on Supported Employment, a NIMH Planning Grant to implement Supported Employment, a SAMHSA grant focusing on alternatives to restraint and seclusion, a social security grant related to work incentive planning and a grant funded by the Federal Anti-Drug Abuse Act administered by the Illinois Criminal Justice Authority for the DMH jail data-link project.

In FY 2007, the DMH worked with Healthcare and Family Services (HFS) to submit a “Money Follows the Person” grant to the Centers for Medicare and Medicaid Services (CMS). This grant was funded and planning has begun to implement the grant.

Increasing Financial Resources For The Child And Adolescent Population

The DMH and its partners have been successful in increasing financial resources to provide/purchase services for children and adolescents and their families through several sources. For example, the System of Care Chicago grant that has brought major new funds targeting the child and adolescent population into the state. This grant, which was funded at \$9.5 million over a six year period, will continue for one more year. The system of care grant awarded by SAMHSA CMHS to McHenry County in FY 2005 was also funded at \$9 million dollars per year over a six year period. The McHenry SOCC

will continue through FY 2011. In FY 2008, \$6.5 million dollars has been allocated for mental health services for children and adolescents through a partnership with the Illinois Children's Mental Health Partnership.

Increasing Federal Financial Participation (FFP)

Over the past seven years, the DMH has worked closely with community agencies on an aggressive plan to increase the claiming of Federal Medicaid funds to support community based mental health services. In FY 2003, DMH was able to support efforts to increase Medicaid Funding for the Illinois Mental Health Service System by simplifying and clarifying Medicaid policies and procedures (making necessary changes in the State Medicaid Plan, 59 Ill. Admin. Rule 132, the DMH Medicaid Handbook, and the DMH Program Book). Also during FY 2003, the structure for utilization of the Medicaid Trust Fund was established and implemented. The distinction and importance of this fund is that it is a federal trust fund based exclusively upon the anticipated federal revenues from Medicaid payments for community mental health services. As billing for Medicaid services increases, so do the resources in the fund. Medicaid reimbursement through the Trust Fund continues to increase across time. In FY 2003 Medicaid reimbursement through the Trust Fund was \$59 million; in FY 2006 it had risen to \$85,802,707. It is expected that there will be continuing increases in Medicaid billing as the mental health system continues to become more efficient in its billing and reporting practices. A focus on increasing Medicaid capture will continue in FY 2008.

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

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

Indicator:

- **Amount of FFP generated in FY 2008**

Medicaid Billing For The Children And Adolescent Population

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

Enhancing Human Resources

Human resource development is critical in terms of supporting community-based services for adults with serious mental illness and children with serious emotional disturbance and their families.

Activities Related to Human Resource Development

The DMH has contracted with the University of Illinois at Chicago Department of Psychiatry to oversee the implementation of a Statewide Child and Adolescent Training Initiative. Three training modules have been presented at seven locations in the State with over 2000 attendees. Two significant outcomes have resulted: (1) telepsychiatry consultation has been introduced in some of the states rural areas (See Criterion 4) and (2) work with community mental-health trade organizations and the University of Illinois at Chicago on the development of a curriculum geared towards the needs of persons with Bachelors and Masters degrees was completed. In FY 2004, the curriculum was promoted and marketed to both the academic and provider communities. The DMH C&A staff continue to collaborate with the University of Illinois on these efforts as well as others. Another initiative to help enhance the competencies of C&A service providers has occurred as a part of the System of Care Chicago Grant. The initiative includes the provision of education and training in Evidenced Informed Practices and consultation to child and adolescent providers. A training initiative for mental health providers on working with children who have experienced trauma is currently being developed in collaboration with the Department of Children and Family Services. These efforts are expected to continue and expand during FY 2008.

Illinois

Child - Emergency Service Provider Training

Child - Provides for training of providers of emergency health services regarding mental health;

Disaster Response: Emergency Health Services

As reported in Section II of this application, the Governor has designated the DMH as the lead State agency for disaster resource coordination, training and recovery functions related to mental health. Working in the collaborative context of the overall Statewide Disaster Plan, DMH is coordinating Illinois' disaster preparedness for state operated and state funded psychiatric service entities. The operational focus includes collaboration and training with other State agencies, monitoring and facilitating ongoing concordance with national policy, and assisting State funded agencies in the development of local response capability for issues of Mental Health. DMH also coordinates surge deployment of mental health services in response to disasters, be they natural or caused by terrorists. This is an ongoing effort that has been enhanced by a grant award from SAMHSA for \$200,000 for disaster response planning which began in FY 2004. The first two years of development have seen the establishment of a statewide coalition dedicated to disaster response, the planning and execution of statewide training in disaster preparedness, and the establishment of an understanding with the City of Chicago, as well as the Illinois Emergency Management Authority (IEMA). Following Hurricane Katrina, the Governor of Illinois made a commitment of rather wide scope, to assist the evacuees. As DMH is the lead State agency for disaster resource coordination, training and recovery functions related to mental health, a grant application was submitted to SAMHSA for a Crisis Counseling Grant that was subsequently funded and is still in operation. Working in the context of the overall Statewide Disaster Plan, DMH coordinated the program directly. The operational focus of work included statewide outreach, collaboration with other State agencies, monitoring and daily program operation. In FY 2006, over 2500 persons had been served. FY 2007 figures are not yet available.

Illinois

Child - Grant Expenditure Manner

Child - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

The Illinois plan for the expenditure of the FY 2008 Community Mental Health Services Block Grant is directed at providing services in community settings for adults with serious mental illness and children and adolescents with serious emotional disturbances.

The Mental Health Block Grant is allocated based on the following criteria:

- 1) The funding must be available to all geographic areas of the State.
- 2) Funds are distributed based on population.
- 3) Geographic areas of high priority receive additional funding.

As in previous years, FY 2008 Mental Health Block Grant funding focuses heavily on the Chicago Metropolitan area where the population density is the greatest. The remainder of Mental Health Block Grant funds addresses both the semi-urban and rural areas of the State with all geographic regions represented in the list of agencies funded.

Block Grant Allocation FY 2008

The Illinois block grant fund amount for FY 2008, based on projections from FY 2007 is \$16,441,527. Allocations to specific agencies for service provision are displayed in Appendix 1. Please note however that the grant awards to community providers represent the best known information available as per their issuance in July of 2007. The state budget as appropriated and approved reflects the FY 2008 level of award continuing to be provided. Administrative expenses, which are capped at 5%, amount to \$822,076. Services for adults, children and adolescents are allocated as follows.

Block Grant Allocation - Child and Adolescent Population

For FY 2008, block grant funds will be directed toward the following community-based services for youths with serious emotional disturbances: psychiatric services, residential and crisis services. A list of the agencies and the awards projected for FY 2008 is provided in the Appendix. These projections are based on FY 2007 awards. The child and adolescent funding allocation of mental health block grant dollars is consistent with the State Mental Health Plan for Children and Adolescents.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	32,118	35,270	35,270	35,270	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To monitor access to services

Target: We are

Population: Children and adolescents with emotional and serious emotional disturbances

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

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

Measure: Number of child/adolescentsreceiving services from DMH-funded community-based providers.

Sources of Information:

Special Issues:

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

Action Plan: DMH will continue to collect and track available data for FY 2008.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	5.17	1.94	1.90	1.90	N/A	N/A
Numerator	6	2	--	--	--	--
Denominator	116	103	--	--	--	--

Table Descriptors:

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

Target: Reduce or maintain readmission rates of children and adolescents to state hospitals

Population: Children and adolescents with serious emotional disturbances.

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

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

Measure: Numerator: Number of children/adolescents readmitted to a state hospital within thirty days of being discharged from a state hospital.
Denominator: Number of children/adolescents discharged from a state hospital in the fiscal year.

Sources of Information: Inpatient Clinical Information System.

Special Issues: *FY 2006 data not yet available--will serve as baseline

Significance:

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

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	6.90	6.80	6.70	6.70	N/A	N/A
Numerator	8	7	--	--	--	--
Denominator	116	103	--	--	--	--

Table Descriptors:

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

Target: Maintain or reduce readmissions to state hospitals.

Population: Children and adolescents with serious emotional disturbances.

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

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

Measure: Numerator: Number of children/adolescents readmitted to a state hospital within 180 days of being discharged from a state hospital.
Denominator: Number of children/adolescents discharged from a state hospital in the fiscal year.

Sources of Information: Inpatient Clinical Information System.

Special Issues:

Significance: Provision of treatment in the least restrictive setting

Action Plan: Data from FY 2006 served as the baseline for this indicator. DMH will continue to monitor the number of Children and adolescents readmitted to state hospitals within 180 days of discharge with a FY 2008 goal of maintaining or decreasing the level of re-hospitalization by maintaining services in the community that provide alternatives to re-hospitalization.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	0	0	0	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

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

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

Population: Children with serious emotional disturbances

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

Indicator: Number of Child/Adolescent EBPs implemented

Measure: Number of Child/Adolescent EBPs implemented

Sources of Information: Reporting of Community Services System

Special Issues:

Significance:

Action Plan: DMH is not currently implementing the EBPs that are part of the National Outcome Measures (see capacity checklist)

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Therapeutic Foster Care (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	0	0	0	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Implement EBPs for children and adolescents with serious emotional disturbances

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

Population: Children and adolescents with serious emotional disturbances.

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

Indicator: Number of children and adolescents receiving therapeutic foster care

Measure: Number of children and adolescents receiving therapeutic foster care

Sources of Information: Reporting of Community Services

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

Significance:

Action Plan: The DMH has no current plans to implement therapeutic foster care as this service would be administered by the state child welfare agency (see capacity checklist).

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Multi-Systemic Therapy (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	0	0	0	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Implement and provide multisystemic family therapy to children and adolescents needing this service

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

Population: Children and adolescents requiring multisystemic therapy

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

Indicator: Number of children/adolescents receiving multisystemic therapy

Measure: Number of children/adolescents receiving multisystemic therapy

Sources of Information: Reporting of Community Services

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

Significance:

Action Plan: The DMH is not currently implementing multisystemic therapy. Rather it is focusing on evidence-informed practices (see capacity checklist).

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Family Functional Therapy
(Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	0	0	0	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To provide family functional therapy to children and adolescents with serious emotional disturbances requiring this service.

Target: None. the DMH is not currently implementing this EBP.

Population: Children and adolescents with serious emotional disturbances.

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

Indicator: Number of children/adolescents receiving family functional therapy

Measure: Number of children/adolescents receiving family functional therapy

Sources of Information: Reporting of Community Services

Special Issues: DMH is focusing on evidence informed practices

Significance:

Action Plan: The DMH has no plans at this time to implement family functional therapy as it is focusing its effort on evidence-informed practices.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	48.61	0	49	50	N/A	N/A
Numerator	35	0	--	--	--	--
Denominator	72	N/A	--	--	--	--

Table Descriptors:

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

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

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

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

Indicator: Percentage of caregivers reporting positive outcomes of treatment for their children/adolescents who receive mental health services.

Measure: Numerator: Number of caregivers reporting positive outcomes of treatment
Denominator: Total number of caregivers responding to the MHSIP Consumer perception of care survey.

Sources of Information: MHSIP survey from Table 11, the Summary Profile of Client Evaluation of Care, the Illinois Uniform Data Report.

Table 11, the Summary Profile of Client Evaluation of Care, was reported in the Illinois Uniform Data Report.

Special Issues:

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

Action Plan: DMH aims to increase the percentage of caregivers reporting positive outcomes for the Child and Adolescent services. The survey was not conducted during FY 2007. It is in process and expected to be completed by the submission of the implementation report (see capacity checklist).

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

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

Target: Not reported - see capacity checklist

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

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

Indicator: Increased school attendance

Measure: Derived from Table 19 URS

Sources of Information: None currently

Special Issues: This data is not currently available.

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

Action Plan: The DMH will likely collect this information through caregiver consumer perception of care surveys (see capacity checklist).

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Decreased Juvenile Justice Involvement for children/adolescent who have forensic issues and who are receiving mental health treatment

Target: The DMH is not currently collecting this information.

Population: Children/adolescents with serious emotional disturbances who are involved with the justice system and who are receiving mental health services

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

Indicator: Profile of involvement in the juvenile justice system

Measure: Profile of involvement in the juvenile justice system

Sources of Information: Not currently available

Special Issues:

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

Action Plan: The DMH does not currently collect this information which would be input in Table 19 in the URS. It is likely that this information will be collected via caregiver perception of care surveys.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Developmental Measure
Target: Developmental Measure
Population: Children/adolescents with serious emotional disturbances
Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
 3:Children's Services
Indicator:
Measure: To be determined
Sources of Information: To be determined
Special Issues: Development still in process
Significance:
Action Plan: Developmental measure (see capacity checklist).

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Developmental Measure
Target: Developmental Measure
Population: Children and adolescents with emotional/serious emotional disturbances
Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
 3:Children's Services
 4:Targeted Services to Rural and Homeless Populations
Indicator: Developmental Measure
Measure: Developmental Measure
Sources of Information: Developmental Measure
Special Issues:
Significance:
Action Plan: Developmental Measure (see capacity checklist).

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: CASE MANAGEMENT-C & A

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	15.26	14.90	N/A	N/A	N/A	N/A
Numerator	1,579	1,672	--	--	--	--
Denominator	10,345	11.23	--	--	--	--

Table Descriptors:

- Goal:** To maintain case management services as a key core service to children with serious emotional disturbances being served in the DMH-funded community-based service system.
- Target:** A target is not set because the data source does not capture complete information.
- Population:** Children and adolescents with serious emotional disturbances
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Reporting of Community Services (RoCS).
- Measure:** Numerator: Children identified as members of the DMH “target” population being served by the DMH-funded community-based service system who receive case management services.
Denominator: All children receivingDMH-funded community mental health services.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:** In prior fiscal years DMH funded agencies providing SASS services, which includes case management services as a key component, reported these services directly through the DMH community reporting system (ROCS). Several years ago, community providers began reporting services directly to the state Medicaid agency. As a result, we are unable to accurately determine the total number of children/adolescents receiving case management services because we do not have access to this data. This loss of data is reflected in the reported value of this performance indicator.
- Significance:** During FY 2005, 10,345 children in the DMH target population were reported in the DMH ROCS system as receiving services; of these individuals, only 15.3% are reported as having received case management services which is a gross underestimate. The DMH initiated efforts to re-acquire this data in FY 2006, but was unsuccessful; thus we do not anticipate that we will be able to fully report on this indicator this or next fiscal year.
- Action Plan:** DMH will retain this indicator, however, we anticipate that the information will continue to underrepresent the percent of children and adolescents receiving services.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: CORRECTIONS HISTORY - C&A

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	1.30	1.04	1.04	1.04	N/A	N/A
Numerator	429	380	--	--	--	--
Denominator	33,080	35,104	--	--	--	--

Table Descriptors:

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

Target: Forensic population expected to remain relatively constant at approx. 1.4%.

Population: Children and Adolescents with serious emotional disturbances.

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

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

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

Sources of Information: Reporting of Community Services (RoCS).

Special Issues:

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

Action Plan: Community mental health staff track the number of children and adolescents who are forensic outpatients (0.8%), as well as those who are on probation or parole at the time of case opening (a little over 1%). This data is collected as part of clinical assessments. DMH will continue to track these percentages in FY 2008.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Co-Occurring Disorders C&A

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	1.10	1.15	1	1	N/A	N/A
Numerator	389	403	--	--	--	--
Denominator	33,080	35,104	--	--	--	--

Table Descriptors:

- Goal:** To increase community-based mental health service for persons who have co-occurring disorders of mental illnesses and substance use.
- Target:** The target for this indicator is expected to remain under 2%.
- Population:** Children and adolescents with mental illness and a co-occurring substance use disorders.
- Criterion:** 3:Children's Services
- Indicator:** Percentage of Child and Adolescents (C&A) served with a mental illness and substance use diagnosis.
- Measure:** Numerator: Number of clients served in the community with a substance abuse diagnosis.
Denominator: Total number of all child and adolescents receiving services.
- Sources of Information:**
- Special Issues:** There is underreporting for this population.
- Significance:** Many individuals with serious mental illnesses and emotional disturbances have co-occurring substance abuse disorders.
- Action Plan:** DMH will continue to track this information in Fy 2008 with a goal of increasing the capacity for identification of dually diagnosed youth.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: ELIGIBLE POPULATION - C&A

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	89.50	86.50	85	85	N/A	N/A
Numerator	29,614	30,353	--	--	--	--
Denominator	33,080	35,104	--	--	--	--

Table Descriptors:

- Goal:** To assure resources and services are provided to children and adolescents in the priority population of the public mental health system.
- Target:** Maintenance or increase of a service level of 85% of children and adolescents receiving mental health services who meet eligibility requirements.
- Population:** Children and adolescents with serious emotional disturbances
- Criterion:** 2:Mental Health System Data Epidemiology
- Indicator:** Percent of children and adolescents being served by DMH-funded community-based providers who meet the established criteria for “eligible population” at the time of entry into services.
- Measure:** Numerator: Number of children and adolescents being served by DMH-funded community-based providers who meet the established criteria for “eligible population” at the time of entry into services.
Denominator: All children and adolescents being served by DMH-funded community-based providers.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:**
- Significance:** This indicator is part of the monitoring process to insure that mental health services are accessible and accessed by those who need them most.
- Action Plan:** DMH has a goal to maintain or increase the proportion of children and adolescents served who meet the criteria for the eligible population.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: FORENSIC OUTPATIENT-C&A

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	.71	.80	.80	.80	N/A	N/A
Numerator	226	280	--	--	--	--
Denominator	31,859	35,104	--	--	--	--

Table Descriptors:

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

Target: Identification of children and adolescents with involvement in the juvenile justice system.

Population: Children and adolescents with serious emotional disturbances.

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

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

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

Sources of Information: Reporting of Community Services (RoCS).

Special Issues:

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

Action Plan: DMH will continue to track these percentages in FY 2008.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: HOMELESS YOUTH SERVED

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	450	365	350	350	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

- Goal:** To assure that children with emotional disturbances who are also homeless are accessing the DMH-funded community-based mental health service system.
- Target:** Reduction in the number of children and adolescents who have serious emotional disturbances and who are homeless through appropriate delivery of mental health services.
- Population:** Children and adolescents with serious emotional disturbances that are also homeless.
- Criterion:** 4:Targeted Services to Rural and Homeless Populations
- Indicator:** Number of children being served by DMH-funded community-based providers who are reported as undomiciled or homeless at the time of entry into services.
- Measure:** Number of children being served by DMH-funded community-based providers who are reported as undomiciled or homeless at the time of entry into services.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:**
- Significance:** Children and adolescents with serious emotional disturbances should have a stable living environment.
- Action Plan:** DMH aims to maintain or expand access to the DMH-funded community mental health service system by children and adolescents who are homeless at intake.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: LIVING ARRANGEMENTS-C&A

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	93.40	92.90	93	93	N/A	N/A
Numerator	30,897	32,613	--	--	--	--
Denominator	33,080	35,104	--	--	--	--

Table Descriptors:

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

Target: Identification of children and adolescents with mental emotional disturbances who may need housing supports.

Population: Children and adolescents with mental illness.

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

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

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

Sources of Information: Reporting of Community Services (RoCS).

Special Issues:

Significance: Community mental health staff track living arrangements at intake for children and adolescents to assess service needs. At the time of case opening in FY 2006, the vast majority of children and adolescents lived with parents or other relatives in a private residence (92.9%). Nevertheless, services are needed to help those children who do not reside with their families.

Action Plan: DMH will track these percentages in FY 2008.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: MEDICAID BILLING - C&A

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	19,960,808	22,005,772	22,000,000	22,000,000	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

- Goal:** To assure prudent administration of resources through appropriate matching of federally available dollars for mental health services.
- Target:** Maximize billing for Medicaid services.
- Population:** Children and adolescents with serious emotional disturbances
- Criterion:** 5:Management Systems
- Indicator:** Total dollars billed for children and adolescents (C&A).
- Measure:** Total dollars billed for children and adolescents (C&A).
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:**
- Significance:** A measure of the state's capacity to increase funding for mental health services. Resources must be maximized to support delivery of mental health services.
- Action Plan:** DMH has a goal of increasing Medicaid billing for fees for community mental health services provided to children and adolescents in FY 2008.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: PRE-ADMISSION SCREENINGS - C&A

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	100	N/A	N/A	N/A	N/A	N/A
Numerator	129	N/A	--	--	--	--
Denominator	129	N/A	--	--	--	--

Table Descriptors:

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

Target: Maintain FY 2005 100% performance level.

Population: Children and adolescents with serious emotional disturbances.

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

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

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

Sources of Information: Inpatient Clinical Information System.

Special Issues:

Significance: The number of persons under age 17 who present for admission to a state hospital has been decreasing, from 255 in FY 2002 to 129 in FY 2005. Staff conduct face-to-face screening with virtually all of these individuals, with 100% being screened in FY 2005.

Action Plan: DMHs' goal is to maintain this level of community-based service provision for FY 2008*.
*Data not yet available for FY 2006 and 2007.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: RURAL RESIDENTS SERVED - C&A

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	10,247	11,014	10,500	10,500	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

- Goal:** To assure that children with emotional disturbances who reside in rural areas are accessing the DMH-funded community-based mental health service system.
- Target:** DMH has set a target of identifying and providing services to 10,500 children and adolescents with emotional disturbances residing in rural areas of the state.
- Population:** Children and adolescents with emotional disturbances who live in rural areas of the state.
- Criterion:** 4: Targeted Services to Rural and Homeless Populations
- Indicator:** Number of children being served by DMH-funded community-based providers who are residents of rural areas at the time of entry into services.
- Measure:** Number of children being served by DMH-funded community-based providers who are residents of rural areas at the time of entry into services.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:**
- Significance:** The geography of rural areas adds challenges to the timely and consistent access to services for both service providers and persons with mental illness.
- Action Plan:** DMH aims to maintain or expand access to community mental health services for children and adolescents residing in rural areas.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: SASS SERVICE HOURS IN COMMUNITY

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	68	N/A	N/A	N/A	N/A	N/A
Numerator	69,185	N/A	--	--	--	--
Denominator	100,865	N/A	--	--	--	--

Table Descriptors:

- Goal:** To assure that a significant portion of services delivered within the SASS programs are provided in the most normalized settings possible in the individual’s community, rather than within the provider’s offices or clinics.
- Target:** A target is not set because the data source does not capture complete information at this point in time.
- Population:** Children and adolescents with serious emotional disturbances.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percentage of children identified as members of the DMH “target” population being served by the DMH-funded community-based service system who receive SASS services.
- Measure:** Numerator: Number of hours of service provided by the DMH-funded SASS Programs which occur outside of the provider’s offices or clinics.
Denominator: Total number of hours of service provided by the DMH-funded SASS Programs.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:** This data is no longer reported directly to the DMH. Data was not available for FY 2005, FY 2006, and FY 2007. We will retain this indicator as a placeholder because of its importance. We hope to reacquire the information in FY 2008.
- Significance:** SASS programs aim to provide services in the most normalized settings possible in the individual’s community, rather than within the provider’s offices or clinics.
- Action Plan:** DMH is working to retrieve this information for FY 2007 and FY 2008 retainING this indicator as a place holder pending re-quirement of this data as it is important to monitor delivery of these critical services.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: TARGET POPULATION - C & A

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	30.40	32	32	32	N/A	N/A
Numerator	10,063	11,225	--	--	--	--
Denominator	33,080	35,104	--	--	--	--

Table Descriptors:

- Goal:** To assure that resources and services are provided to children and adolescents in the priority population of the public mental health system.
- Target:** To maintain or increase the percentage of child and adolescent mental health clients who have serious emotional disturbances receiving services.
- Population:** Children and adolescents with serious emotional disturbances.
- Criterion:** 2:Mental Health System Data Epidemiology
- Indicator:** Percentage of individuals being served by DMH-funded community-based providers who meet the established criteria for “target population” at the time of entry into services.
- Measure:** Numerator: Number of children and adolescents being served by DMH-funded community-based providers that meet the established criteria for “target population” at the time of entry into services.
Denominator: All children and adolescents being served by DMH-funded community-based providers.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:**
- Significance:** Children and adolescents with severe emotional disturbances (SED) are the priority target for mental health services.
- Action Plan:** DMH aims to maintain or increase the proportion of children and adolescents served who meet the criteria for the target population.

Illinois

Planning Council Letter for the Plan

Upload Planning Council Letter for the Plan

Ms. Lou Ellen Rice
Grants Management Office
Division of Grants Management, OPS, SAMHSA
1 Chkoe Cherry Road
Rockville, MD 20857

Dear Ms. Rice:

As Co-Chairs to the Illinois Mental Health Planning and Advisory Council we would like to express our support of the Department of Human Services, Division of Mental Health's Community Mental Health Services 2008 Block Grant application. This application has been thoroughly reviewed by the Planning Committee.

The IMHPAC meets bi-monthly (6 times per year). Standing Committees meet during interim months resulting in a process that allows an active role in Block Grant planning. The IMHPAC is comprised of 53 members adult & adolescent consumers of mental health services, family members (including parents of children who experience SED), mental health service providers, community leaders and representatives of several state agencies.

This year's grant will again be focused on evidence-based practices and the expanding role of peer support in natural settings as they relate to community mental health services (including persons served thru the Criminal Justice System).

Sincerely

Linda Denson
CEO, Sankofa Organization of Illinois, Inc.
P O Box 607294
Chicago, IL 60660

Mark J. Heyrman
Chair, Public Policy Committee
Mental Health America, Illinois
70 East Lake Street
Suite 900
Chicago, IL 60601

Lutheran Social Services of Illinois

August 21, 2007

Linda Denson, Co-Chair
IL Mental Health Planning and Advisory Council
Sankofa Organization of Illinois
7619 Parnell
Chicago, IL 60660

Mark Heyrman, Co-Chair
IL Mental Health Planning and Advisory Council
University of Chicago
6020 S. University Ave.
Chicago, IL 60637

Dear Ms. Denson and Mr. Heyrman:

As Co-Chairs of the IL Mental Health Planning and Advisory Council (IMHP AC) Planning Committee, we are writing to endorse the Illinois 2008 Division of Mental Health Block Grant Application. This document was reviewed on August 2nd, 2007 by the Planning Committee comprised of consumers, provider agencies and key state agency representatives.

The Planning Committee reviewed the FY 2008 Illinois Federal Block Grant Objectives which included the implementation of evidence-based practices (Supported Employment, Medication Algorithms, Integrated Dual Diagnosis Treatment, etc.), consumer conferences, Wellness Recovery Action Plans, and Consumer Education and Support services. New initiatives include a retreat/meeting scheduled for September 27th 2007. The purpose of this retreat is to further educate IMHP AC members on the block grant system in Illinois. Ultimately, we seek to advance the mission and vision of the IL Division of Mental Health.

During the past year, the Planning Committee has continued to increase its role in working with the Division of Mental Health in block grant development and monitoring. We recommend your support of the Illinois 2008 Division of Mental Health Block Grant Application.

Daniel B. Martinez, M.D. Co-
Chair, Planning Committee

Thomas Troe
Co-Chair, Planning Committee

Illinois

Appendix A (Optional)

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

State Capacity Checklist and Block Grant Allocation by Agency were mailed to Lou Ellen Rice.

The WEBBGAS Program would not upload this word file.