

**ILLINOIS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH**

**FY 2011
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT APPLICATION**

**WORKING DRAFT FOR COMMENT AS OF
June 30, 2010**

The Illinois Department of Human Services Division of Mental Health invites public comment on the Working Draft of the FY 2011 Community Mental Health Services Block Grant Application that is being prepared for submission to the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS). The Division of Mental Health works with the Illinois Mental Health Planning and Advisory Council to develop the application each year. Please note that this document is a work in progress that is still being updated and modified, particularly the Performance Indicator Section. The Block Grant Application is formatted to be in compliance with SAMSHA requirements for submission. Public Comment may be made by sending an e-mail to dhsmh@dhs.state.il.us with a reference to Mental Health Block Grant Application in the Subject Line of the e-mail. This working draft will be posted for comment through August 5, 2010 in preparation for submission to SAMHSA CMHS in late August. DMH invites comment throughout the year however, and additional comments may be made after the final application is posted in early September 2010.

Attachment E

FACE SHEET
COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

 X FY 2011

STATE NAME: ILLINOIS

DUNS #: 6919071

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: Illinois ZIP: 60601

TELEPHONE: 312-814-4948 FAX: 312-814-2964

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

NAME: Michelle R.B..Saddler TITLE: Secretary

AGENCY Illinois Department of Human Services

ORGANIZATIONAL UNIT: Office of the Secretary

STREET ADDRESS: 401 South Clinton Street, 7th Floor

CITY: Chicago STATE: Illinois ZIP: 60607

TELEPHONE: 312-793-1533 FAX: 312-463-2060

III. STATE FISCAL YEAR

FROM: July 1st 20 10 TO: June 30, 2011

Month Year Month Year

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: Mary E. Smith, Ph.D TITLE: Associate Director, Decision Support, Research, and Evaluation

AGENCY: Illinois Department of Human Services

ORGANIZATIONAL UNIT: Division of Mental Health

STREET ADDRESS: 160 North LaSalle Street, 10th Floor

CITY: Chicago STATE: Illinois ZIP: 60601

TELEPHONE: 312-814-4948 FAX: (312) 814-2964

EMAIL: MaryE.Smith@illinois.gov

FY 2010 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. A variety of collaborative initiatives serve to increase coordination with other state agencies whose services are accessed by individuals receiving mental health services. The FY2010 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. DMH is actively transforming the mental health service delivery system in Illinois to one that is recovery-oriented. These efforts include increasing consumer and family involvement in planning and implementation activities and expanding the focus on planning and implementation of evidenced-based practices. 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 participate in these efforts. The anticipated outcome is the continued enhancement of activities that support the recovery-orientation of the mental health system and address the needs of consumers and their families.

Serious fiscal challenges are confronting the mental health service system in FY 2011. The DMH Fiscal Year 2011 community mental health services budget has been cut by approximately 90 million dollars. The impact of this reduction is described at various points in the plan narrative. The Division continues to work diligently to increase revenue from Medicaid and to seek grant funding to support programmatic efforts. In FY 2011, the emphasis will be on maintaining core services to individuals with serious mental illness.

During FY 2011, the efforts of the DMH remain focused on: (1) sustaining the significant accomplishments of recent years as much as possible, (2) continuing the maintenance and development of the public mental health service system through joint planning, coordination and implementation efforts, (3) emphasizing consumer education, recovery-orientation and enhanced consumer and family involvement in planning and evaluation activities, (4) planning efforts to continue transformation of the Illinois Mental Health service delivery system, and (5) continuing development and initiation of strategies to expand access to evidence-based practices. The format of this FY2011 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 presentation of the FY 2011 plan reflects this service integration and is organized in compliance with the SAMHSA CMHS format which calls for two separate plans---one for adults and one for children. This organization is reflected in the Narrative, as well as in the performance indicators that relate to the plan. To reduce redundancy where there are sections of narrative applicable to both adults and children these are in the Adult Plan and referenced in the Child plan. When different sections of the same plan cover the same subject, references are made to the section that has the more complete presentation of the material.

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

- Continuation of the **permanent supportive housing initiative** which has been designed to accommodate at least 600 consumers by the end of FY2011.
- A procurement process for an **Administrative Services Organization (ASO)** led to the selection, in Fall 2007, of a national behavioral health company to assist DHS/DMH in implementing a number of contractual objectives. The ASO, called the Illinois Mental Health Collaborative for Access and Choice (MHCAC), has been operational over the past three years and provides assistance encompassing a broad spectrum of administrative activity.
- DMH, working with the Mental Health Collaborative for Access and Choice (MHCAC), **has redesigned the management information system (MIS)** to include a data warehouse that houses eligibility, registration, billing/services information, a provider database, and service authorization in one place and updating key clinical and demographic fields used to track consumer outcomes over time.
- Access to the **Certified Recovery Support Specialist (CRSS)** credential is available through the Illinois Certification Board (ICB).. Individuals are certified as having met specific predetermined criteria for essential competencies and skills and are recognized for their ability to provide quality services.
- DMH funded child serving agencies are required to participate in the **web-based Clinical Outcomes Analysis System** from which reports showing data trends in service outcomes can be generated for feedback to clients and families, providers, and to DMH.C&A Services.
- **An education and training initiative for mental health providers in support of mental health trauma work** with children and families who have experienced trauma as a result of physical abuse, neglect, sexual abuse or domestic violence that has an effect on their behavior, performance and adjustment.
- Use of block grant dollars to promote **consumer-to-consumer outreach** and mentoring;
- The continuing investment of block grant dollars to increase and improve **psychiatric leadership and services**.
- Mental health services for children and adolescents have been enhanced by a variety of pilot projects such as **transitioning youth, tele-psychiatry in rural areas, early intervention, early childhood services**, and consultation on early childhood development and clinical intervention.
- Continuing to develop strategies to increase access to **evidence-based practices**;
- Establishing linkages with **jails, juvenile detention facilities, and the Courts** to serve adjudicated consumers.
- 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 FY 2011 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 in a separate section of each plan and referenced in the plan narrative. . 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. The 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 and have served as a basis for planning. Additional indicators are added as required to meet the priorities of mental health system development.

**ILLINOIS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH
FY 2010 DRAFT BLOCK GRANT APPLICATION
TABLE OF CONTENTS**

Face Sheet	2
Executive Summary	3
Part B: Administrative Requirements, Fiscal Planning Assumptions and Special Guidance	8
I. Federal Funding Agreements, Certifications and Assurances	9
(1) Funding Agreements	9
(2) Certifications	13
(3) Assurances	16
II. Set-Aside for Children’s Mental Health Services Report	19
III. Maintenance of Effort Report (MOE)	20
IV. State Mental Health Planning Council Requirements	21
(1) Membership Requirements	22
(2) State Mental Health Planning Council Membership List and Composition	29
(3) Planning Council Charge, Role and Activities	37
(4) State Mental Health Planning Council Comments and Recommendations	39
Public Comments on the State Plan	39
Section I-Description and Overview	40
ADULT- Overview of the State’s Mental Health System	40
ADULT- New Developments and Issues	42
ADULT-Legislative Initiatives and Changes	47
ADULT- Description of State Agency’s Leadership	48
CHILD – Overview of the State’s Mental Health System	55
CHILD – New Developments and Issues	56
CHILD – Legislative Initiatives and Changes	57
CHILD – Description of State Agency’s Leadership	57
Section II-Identification and Analysis of System Issues	59
ADULT- Service System Strengths and Weaknesses	59
ADULT- Unmet Service Needs	61
ADULT- Plans to Address Unmet Needs	61
ADULT- Recent Significant Achievements	63
ADULT- State’s Vision for the Future	65
CHILD – Service System Strengths and Weaknesses	66
CHILD – Unmet Service Needs	68
CHILD - Plans to Address Unmet Needs	69

CHILD – Recent Significant Achievements	70
CHILD - State’s Vision for the Future	71
Section III ACTION PLANS AND PERFORMANCE GOALS TO IMPROVE THE SERVICE SYSTEM	73
ADULT- Establishment of a System of Care (Criterion I)	73
ADULT- Available Services (Criterion I)	85
ADULT- Estimate of Prevalence (Criterion II)	102
ADULT- Quantitative Targets (Criterion II)	102
ADULT- Outreach to Homeless (Criterion IV)	105
ADULT- Rural Area Services (Criterion IV)	110
ADULT- Older Adults (Criterion IV)	112
ADULT- Resources For Providers (Criterion V)	114
ADULT- Emergency Services Provider Training	117
ADULT- Grant Expenditure Manner	119
DESCRIPTION OF TRANSFORMATION	120
ADULT- Goals, Targets, and Action Plans	127
CHILD - Establishment of System of Care (Criterion I)	149
CHILD - Available Services (Criterion I)	158
CHILD - Estimate of Prevalence (Criterion II)	167
CHILD - Quantitative Targets (Criterion II)	167
CHILD – System of Integrated Services (Criterion III)	170
CHILD – Geographic Area Definition (Criterion III)	181
CHILD - Outreach to Homeless (Criterion IV)	182
CHILD - Rural Area Services (Criterion IV)	184
CHILD - Resources For Providers (Criterion V)	185
CHILD - Emergency Services Provider Training	187
CHILD - Grant Expenditure Manner	187
CHILD - Goals, Targets, and Action Plans	189

PART B.

**ADMINISTRATIVE REQUIREMENTS, FISCAL PLANNING AND
SPECIAL GUIDANCE**

- I. FEDERAL FUNDING AGREEMENTS, CERTIFICATIONS AND ASSURANCES**
- II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES**
- III. MAINTENANCE OF EFFORT REPORT**
- IV. STATE MENTAL HEALTH PLANNING COUNCIL REQUIREMENTS**
- V. PUBLIC COMMENT ON THE PLAN**

Attachment A. COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2010

I hereby certify that Illinois Dept of Human Services 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 2009, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

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

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

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

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

(A) Services principally to individuals residing in a defined geographic area (referred to as a “service area”)

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

- (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 States 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.

Governor

Date

Governor's Designee: , Michelle R.B. Saddler Secretary, Illinois Department of Human Services

CERTIFICATIONS

- 1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION**
- 2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS**

3. CERTIFICATION REGARDING LOBBYING

**4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES
ACT (PFCRA)**

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

DISCLOSURE OF LOBBYING ACTIVITIES (FORM)

ASSURANCES NON-CONSTRUCTION PROGRAMS (PAGE 1)

ASSURANCES NON-CONSTRUCTION PROGRAMS (PAGE 2)

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).² Each year the State shall expend not less than the calculated amount for FY 1994.

State Expenditures for Mental Health Services

Reported by: State FY X Federal FY

Calculated FY 1994	Actual FY 2009	Estimated/Actual FY 2010
\$24,236,971	\$80,120,640	

Waiver of Children’s Mental Health Services

The Public Health Services Act stipulates that 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.

2. Section 1913(a) of the PHS Act

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.³ 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.

States are required to submit expenditures in the following format:

State Expenditures for Mental Health Services

MOE reported by: State FY X Federal FY _____

Actual FY 2008	Actual FY 2009	Estimated/Actual FY 2010
\$ 431,292,309	\$441,603,453	

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principal agency for authorized activities of a non-recurring nature and for a specific purpose.⁴

As in the past fiscal years, the MOE Exclusion is not applicable to Illinois this fiscal year.

3. Section 1915(b)(1) of the PHS Act

4. Section 1915(b)(2) of the PHS Act

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.

2. State Mental Health Planning Council Membership List and Composition. (Per IMHPAC as of 5/18/10)

Table 1. List of Planning Council Members

Name	Type of Membership	Agency Or Organization Represented	Address, Phone, Fax & E-Mail
Anselmo, Frank		Community Behavioral Health Association (CBHA)	3085 Stevenson Drive Springfield, IL 62703 217-585-1600 fanselmo@cbha.net
Ayres, Cassie Council Secretary		IL Association of Rehabilitation Facilities	206 South Sixth St. Springfield, IL 62701 217-753-1190 217-525-1271 (FAX) cayres@iarf.org
Backstein, Cindy			26 Camberley Road Springfield, IL 62712 217-498-8774
Blank, Wendy		IL Dept. of Corrections (Criminal Justice)	Stateville CC 16830 South Rt. 53 Crest Hill, IL 60403 815-727-3607 ext.6220 630-450-2204 (cell) Wendy.Blank@DOC.Illinois.gov
Boyd, Cheryl		The H Group	902 West Main Street West Frankfort, IL 62896 618-937-6483 X-7200 618-937-1440 (Fax) Cheryl.boyd@hgroup.org
Buss, Donna			620 Dakota Street Crystal Lake, IL 60012 815-354-1577 815-455-2925 (fax) dbuss@mc708.org
Carmichael, Michele		Illinois State Board of Education	100 N. 1 st Street Springfield, IL 62777-0001 217/782-5589 mcarmich@isbe.net
N'Dana Carter			4915 S. Washington Park Court Chicago, IL 60615 (773) 624-6281 ergoqueen@hotmail.com
Connor, Ray			3 Creekside Lane Barrington, IL 60010 847-426-3692 847-649-8915(Fax) rayconnor@comcast.net

Name	Type of Membership	Agency Or Organization Represented	Address, Phone, Fax & E-Mail
Cooke, Andrea			1313 West 19 th Street Apt. 4B Chicago, IL 60608 708-224-1574 a-cooke@sbcglobal.net
Daum, Denise		Executive Director Community Resource Center	101 South Locust Centralia, IL 62801 618-533-1391 618-533-0012 (fax) ddaum@crconline.info
Daxenbichler, Cindy			116 Daddono Circle Bloomington, IL 61701 309-642-1080 Taurus@sprint.blackberry.net
Denson, Linda Co-Chair		Sankofa Organization of IL	7619 Parnell Chicago, IL 60660 312-805-1751 312-747-9380 773- 651-4882 (FAX) ldsankofail@aol.com
Feinberg, Ellen			Feinberg_ellen@yahoo.com
Ford-Whitsett Smith, Pamela			10719 S. LaSalle Street Chicago, IL 60628 (312)547-9791 (cell) 773-722-7900 X 4028 (Work) 773-722-0644 (Work Fax) pfordwhitsett@sbcglobal.net
Frazier, Sondra			6957 South Jeffery Blvd. Chicago, IL 60649-1521 773-324-6644 lasalf@aol.com
Friedman, Fred			6513 North Sacramento Chicago, IL 60645 773-274-2150 fred@nextstepsnfp.org
Heyrman, Mark		Legal Assistance Foundation University of Chicago	6020 S. University Ave. Chicago, IL 60637- 773-753-4440 773-702-2063 (Fax) m-heyрман@uchicago.edu
Hopkins, Dennis PsyD,		Iroquois Mental Health Center	323 West Mulberry Street Watseka, IL 60970 815-432-5241 dhopkins@imhc.net
Irving, Anne		AFSCME	29 N. Wacker, Ste 800 Chicago, IL 60601

Name	Type of Membership	Agency Or Organization Represented	Address, Phone, Fax & E-Mail
			312-641-6060 312-346-1016 (Fax) annei@afscmeillinois.org
James, Brian			210 Avenue "c" Danville, IL 61832 (217) 442-3200 Ext.132 (Work) hopebrianjames@yahoo.com
Kalra, Antar			211 Elgin Apt. 6J Forest Park, IL 60130 708-771-0472 antar7@sbcglobal.net
Koelliker, Marsha		Equip For Equality	20 N. Michigan Ave Suite 300 Chicago IL 60602 marsha@equipforequality.org
Kopera, Anthony		CEO Community Counseling Centers of Chicago	4740 North Clark Street Chicago, IL 60640 773-769-0205 tony.kopera@c4chicago.org
Lake, Virginia		Thresholds	202 North Schuyler Ave Suite 205 Kankakee, IL 60901 815-935-8886 vlake@thresholds.org
Larson, Nanette		Director of Recovery Support Services, Division of Mental Health	5407 University St. Peoria, IL. 61614 309-693-5228 Nanette.Larson@illinois.gov
Lindahl, Teri		McHenry County Mental Health Board	4100 Veterans Parkway. McHenry, IL 60050 815-353-9900 815-669-2570 tlindahl@familyservicemch.org
Martinez, Daniel MD		Child Psychiatrist Lutheran Social Services	4840 W. Byron St. Chicago, IL 60641 773-282-7800 dmartinez@discoverccs.org
Nance, Mike		Heritage Grove	365 East Waggoner St. Decatur, IL 62526-4695 217-423-4715 Mnance1284@yahoo.com
Nolen, Kim			1753 186 th Place Homewood, IL 60430-3806

Name	Type of Membership	Agency Or Organization Represented	Address, Phone, Fax & E-Mail
			708-798-2820 knolen@sbcglobal.net
O'Shea, Lynn		Association for Individual Dev.	309 West New Indian Trail Court Aurora, IL 60506 630-966-4001 630-844-9884 (Fax) loshea@the-association.org
Oulvey, Gene		Office of Rehabilitation Services (Vocational Rehabilitation)	618 E. Washington, 3 rd Fl Springfield, IL 62794 217-720-9378 217-524-7549 (Fax) Gene.Oulvey@illinois.gov
Patterson, Jerry			7905 9 th Street West Rock Island, IL 61201 309-787-0332 svfan92@yahoo.com
Peterson, Ann			521 Coventry Lane Crystal Lake, IL 60014 815-814-5008 (cell) annmpeter@yahoo.com
Pluta, William		IL Housing Development Authority Office of Housing Coordination Services	401 North Michigan Avenue, Suite 900 Chicago, IL 60611 312-836-5354 312-832-2191 (Fax) wpluta@ihda.org
Schneider, Beth			444 West Frontage Rd. Northfield, IL 60093-3009
Shustitzky, John Council Co-Chair		President and CEO, Pillars	333 North LaGrange Road LaGrange Park, IL 60526 708-995-3500 jshustitzky@pillarscommunity.org
Smith, Mary E., Ph.D *(not included in count)		Associate Director, Decision Support, Research and Evaluation - DMH	160 N. LaSalle 10 th Fl Chicago, IL 60601 (312) 814-4948 (312) 814-4832 (Fax) MaryE.Smith@illinois.gov
Sorrells, Anita			2009 Windsor St. Pekin, IL 61554
Jones, Lorrie PhD.		Director	160 N. LaSalle 10 th Fl

Name	Type of Membership	Agency Or Organization Represented	Address, Phone, Fax & E-Mail
* (not included in count)		Division of Mental Health	Chicago, IL. 60601 (312) 814-4856 (312) 814-4832 LorrieRickman.Jones@illinois.gov Connie.Mariscal@illinois.gov
St. Clair, Cathy			6301 N. Sheridan, #8D Chicago, IL 60660 (312) 630-0278 cstclair@centerforprogress.org
Thomas, Lisa			1775 Kings Gate Lane Crystal Lake, IL 60014 815-455-5396 Lrbthomas@comcast.net
Thomas, Lora Council Treasurer		NAMI	218 West Lawrence Springfield, IL 62704 217-522-1403 Thomas.lora@sbcglobal.net
Vyverberg, Bob, Ed.D. * Official DMH Representative		Chief of Staff Division of Mental Health	5407 N. University Peoria, IL. 61614 (309) 693-5228 Robert.Vyverberg@illinois.gov
Ware, Frank		CEO Janet Wattles Center	526 West State Street Rockford, IL 61101 815-968-9300 fware@janetwattles.org
Wells, Don P.			9524 Robinson Lane Mapleton, IL 61547 309-697-0090 donwellsok@aol.com
Willenborg, Melinda			157 County Road 700 North Neoga, IL 62447 217-273-5394 mindywillenborg@yahoo.com
Zych, Gilbert		Lyons Township Mental Health Commission	6404 Joliet Road Countryside, IL 60525 708-352-2992 708-354-7212 (fax) ltmhc@lyonsts.com

**TABLE 2. Planning Council Composition by Type of Member
(As of 5/18/10)**

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	46	
Consumers/Survivors/Ex-patients (C/S/X)	16	
Family Members of Children with SED	9	
Family Members of Adults with SMI	0	
Vacancies (C/S/X & family members)	0	
Others (Not state employees or providers)	7	
TOTAL C/S/X, Family Members & Others	32	62.26%
State Employees	6	
Providers	8	
Vacancies		
TOTAL State Employees & Providers	14	37.74%

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) advises the DMH on mental health issues. The Advisory Council is a body of 53 members, which includes consumers and representatives from public and private organizations that plan, operate, and advocate for mental health and support services for persons with serious mental illness. Established in 1992, the Advisory Council's participation in the analysis of Illinois' mental health system has yielded a significant public/private partnership that focused on restructuring public mental health services in Illinois and guided the development of a strategic plan for consumer-responsive, community-based, and cost-effective service delivery. The Council approved a set of By Laws at the end of FY2002 and revised them in FY2005.

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

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 Chairperson, Cathy St.Clair, which are included in this application. A copy of the letter from the MHPAC co-chairs endorsing the FY 2011 Illinois Mental Health Block Grant Application is attached.

Members of the IMHPAC participate in statewide planning meetings convened by the Division of Mental Health. Based on feedback provided by a wide range of stakeholders, key priorities for the mental health service delivery system are identified. These priorities include expanding work in the areas of: recovery, implementation of evidence-based practices, permanent supportive housing, children's mental health issues and mental health and justice system involvement.

State Mental Health Planning Council Comments and Recommendations

Comments and recommendations of the IMHPAC are reflected in the attached letters of support and comments received from members are noted below.

5. Public Comment on the FY 2010 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 meetings at which the plan is discussed and provide feedback and comments. (3) The Planning Committee of the MHPAC has reviewed the FY2011 Block Grant Plan during its development. The Block Grant Plan has also been discussed at all MHPAC meetings in the past year. Formal review of the Plan by the Council occurred on _____ pursuant to a report by the Planning Committee. Notice of the availability of the plan via the web was emailed to all Council members on _____ with a request for input and recommendations by _____ to inform the drafting process. (4) A Notice requesting public comment was posted on the DHS Website and successive drafts of the Plan were posted as they were completed. Detailed comments have been reviewed by the Planning

Committee and the Council and are on file at the DMH. (5) The final state block grant application and proposed plan will be posted on the web site for the Division of Mental Health (www.dhs.state.il.us) in September. The public can access this DHS DMH Internet site. Interested parties have been instructed to contact Dr. Mary E. Smith to provide comment. Contact information is provided on the website.

SECTION I:

DESCRIPTION OF STATE SERVICE SYSTEM

ADULT PLAN

OVERVIEW OF THE STATE'S MENTAL HEALTH SYSTEM

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

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

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

The Community-Based Mental Health Service System.

Community services are considered the cornerstone of the mental health delivery system. Services provided and purchased by the DMH are geographically based. The DMH is organized into five Comprehensive Community Service Regions (CCSRs). Through these Regions, the DMH operates nine state hospitals, contracts with 27 local hospitals and 149 community-based outpatient/rehabilitation agencies across the state. Comprehensive Community Service Regions are charged with the responsibility for managing care, developing the capacity and expertise of providers, monitoring service provision and

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

The DMH continually seeks input from consumers, family members, advocates, and representatives of public and private organizations through the framework of the Illinois Mental Health Planning and Advisory Council (IMHPAC) to aid in planning efforts. The DMH uses emerging developments at the local, state and national levels as a basis for strategically setting statewide parameters and goals, with the 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 that 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.

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

The Growth of Community-Based Services

Within Illinois there are numerous private practitioners, community mental health agencies, community hospitals providing inpatient psychiatric care, and community long-term care facilities providing services to individuals with serious mental illnesses. Over the past 30 years the locus of treatment for persons with mental illness has shifted from institutions to community-based settings. In FY1973, 8% of the DMH's budget was allocated for community services. Today more than 70% of DMH expenditures are allocated for community-based services. In FY2009, the DMH purchased community based services for more than 129,400 adults and 36,768 children and provided state hospital services for over 10,300 individuals.

The Illinois Mental Health Collaborative for Access and Choice

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

Most prominent among the goals for the Collaborative is to assist the DMH in continued efforts to transition the mental health system to a consumer/ family-centered recovery and resilience-oriented service system, and to assist in the transition from a pre-payment (grant-in-aid) financing system to a post-payment/fee-for-service (FFS) system. Other key objectives include: a) advancement of evidence-based practices, b) prior authorization for priority services, c) precise accountability mechanisms for providers, d) provider network development to insure provider viability and consumer access, e) efficient and effective claims processing/payment mechanisms and post-payment review that insures that the State is receiving what it is paying for, f) and a state-of-the-art information technology (IT) system capable of supporting implementation of these goals and objectives.

NEW DEVELOPMENTS AND ISSUES

Impact of the Economic Recession

Illinois is facing a \$13 billion deficit this year. The General Assembly has consistently rejected the Governor's proposals for an increase in the state income tax. The current budget, calls for continued downsizing of state government and reductions in spending General Revenue Funds. As of May, a \$90 million reduction to the mental health services budget is being considered for FY2011. The outlook for any new funding for mental health services is extremely bleak. In this environment, DMH is making every effort to maintain core mental health services for persons suffering with the most serious mental illnesses.

In FY2010 some of the programs previously described in the block grant such as: Qualified Mental Health Professional (QMHP) liaisons to DHS/DHCD Family Community Resource Centers, Screening Assessment and Support Service Flexible Funds, (discretionary funding for non-traditional support services such as special programming components of Wrap Around planning), the Multi-disciplinary Specialty Assessment program that funded specialty assessments such neurological testing and learning disability assessments, five of the ten Mental Health Transition pilot programs and five of the ten Mental Health Early Intervention pilots (See the Child-System of Integrated Services Section for further detail) were not funded. The current expectation is that more programs will not be funded in FY2011.

The Warm Line

The Collaborative has established a statewide “warm line”. The warm line is a cutting edge source of peer and family support. Staffed by five Peer and Family Support specialists, the toll-free number is operational Monday through Friday, 8am to 5pm except holidays and receives 60 to 120 calls per week. These professionals are persons in recovery, or family members of persons in recovery, who are trained to effectively support recovery in other individuals’ lives. They reaffirm, reconnect, and renew hope, and provide practical assistance for overcoming mental illnesses to persons who are striving to live, learn, work, and participate fully in their communities. Warm Line Peer and Family Support Specialists offer emotional support by listening and understanding; recovery education by providing and linking persons to new mental health recovery information; self-advocacy guidance by helping individuals learn to communicate effectively to ensure that their needs are met; and mentoring, through boosting the confidence of individuals as they progress toward their recovery goals. The warm line has already become a successful DHS/DMH investment by assuring the accessibility of a human connection at a time when it is needed now more than ever. Although warm lines are found throughout the U.S., Illinois is among the very few states known to operate statewide Warm Lines.

The Consumer and Family Care Line

In addition to the Warm Line, consumers and family members may contact the Collaborative toll-free Consumer and Family Care Line with compliments and complaints about the mental health services they receive. While the staff of the Collaborative can offer support and coaching if the individual wants to pursue the complaint directly, each complaint is reviewed by the staff, referred to the appropriate agency or authority for investigation or resolution, and followed up. Feedback is provided to consumers and family members in writing on the progress and resolution of their complaints and assistance is offered to obtain further review or to appeal a decision.

Mental Health Services to Veterans

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

Veterans Reintegration Initiative (VRI)

Veterans in the criminal justice system with mental illness and combat-related trauma disorders represent a growing population with unique service needs. Critical barriers to

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

The State of Illinois was one of six states awarded the Substance Abuse and Mental Health Services Administration Jail Diversion – Trauma Recovery (Priority to veterans). This grant, for approximately \$2 million over 5 years has enabled the Illinois Department of Human Services, Division of Mental Health (IDHS/DMH) to establish the *Illinois Veterans Reintegration Initiative (VRI)* to increase diversion for criminal justice-involved veterans with trauma histories in Cook and Rock Island counties. The VRI is expected to result in the delivery of trauma-informed, evidence-based treatment to 120 consumers per year over a 5-year program period, as well as specialized training for 1,000 police officers in street-level responses to veterans demonstrating mental illness. The VRI is a collaborative effort of stakeholders from the veterans, justice and treatment systems. The planning phase of the project included the participation of key stakeholders in Cook County and Rock Island County and culminated with a comprehensive strategic plan establishing a formal link between veterans' services and justice/treatment interventions in each of the project sites. VRI is expected to strengthen partnerships among justice agencies and service providers, expand diversion opportunities, and establish an infrastructure for intervention and service delivery that can be replicated across the State. With appropriate supports and ongoing systems collaboration, justice-involved veterans with mental illness can achieve successful community reintegration.

Mental Health Transformation

DMH and other state entities continue to work toward envisioning and organizing the Illinois transformation effort to meet New Freedom Commission goals. The DMH has convened meetings in which all agencies purchasing or providing mental health services have 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. DMH applied for a SAMHSA CMHS Transformation Grant in April 2010 and is waiting to find out whether a grant will be awarded.

Community Support Teams

Since FY2008 Community Support Teams (CST) have been operational as a core service to support recovery/resilience. Community Support Team services consist of therapeutic interventions delivered by a team that facilitate illness self-management, skill building, use of natural supports, and community resources to decrease crisis episodes and

hospitalizations, and assist the client to achieve rehabilitative, resiliency and recovery goals. Interventions and activities are delivered in natural settings and are targeted toward the management and reduction of symptoms as well as the promotion of stability and independence. The aim of Community Support is to build capacity by assisting the individual to do for self. Reimbursement is based on medical necessity requiring documentation of psychiatric disability (diagnosis), currently assessed need, an existing service plan with allowable interventions, and continuing assessment of progress toward achieving recovery and resilience goals.

Permanent Supportive Housing

Permanent Supportive Housing (PSH) refers to integrated permanent housing (typically rental apartments) linked with flexible community-based mental health services that are available to tenants/consumers when they need them, but are not mandated as a condition of occupancy. The PSH model is based on a philosophy that supports consumer choice and empowerment, rights and responsibilities of tenancy, and appropriate, flexible, accessible, and available support services that meet each consumer's changing needs. A growing body of knowledge has documented the effectiveness of PSH and helped generate the systems changes needed to create it. The Division of Mental Health is committed to develop an array of Permanent Supportive Housing consistent with the flexible needs of consumers and associated with other new initiatives, i.e., Money Follows the Person (MFP) demonstration project and supportive employment. A concerted redirection of energy and resources has been necessary to ensure that consumers have choice on housing alternatives and that this choice has a foundation based on principles of recovery thereby expanding options for consumers to live independently.

The PSH array includes new construction or acquisition/rehabilitation of units through new partnerships with housing developers, IHDA, and other housing stakeholders, as well as assisting consumers to lease scattered site rental housing, including studio/efficiency units, one bedroom units, and two bedroom, two-person_shared apartments. By increasing the supply of safe, decent, and affordable PSH units, -DMH will significantly improve its capacity to help consumers obtain permanent housing that meets their preferences and needs. Consumer choice is important because (1) certain housing features/amenities may support a consumer's recovery goals; and (2) choice in housing correlates with housing and community tenure. PSH can either be tenant based or site based models, with consumers holding leasing rights outlined in a lease agreement. Support services are flexible and by choice, and are not a requirement to maintain occupancy. In most cases and for most individuals the support services necessary to assure successful tenancy are already reimbursable by Medicaid under the Community Support service definition or under other Medicaid plan services (e.g., medication management, psychiatry, outpatient counseling). DMH has provided extensive training to DMH staff members who will serve as Regional Housing Support Facilitators (one for each Region), as well as all DMH community mental health providers, and participating subsidy administrators.

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

DMH continues to retain national experts from the Technical Assistance Collaborative, Inc. (TAC), and the Corporation for Supportive Housing (CSH), both nationally recognized organizations in developing and funding PSH housing models. Currently DMH has been allocated funding from an Illinois Hospital Tax Initiative to provide PSH to a targeted estimated 600 consumers of mental health services over a three-year period. Additionally, DMH funds have been utilized for the development of a web-based housing stock database to identify available housing stock in Illinois. This real time web-based housing search website (Ilhousingsearch.org) was activated as of 6/15/09 and is open to everyone in Illinois to search for housing opportunities.

Public Awareness (Anti-Stigma) Campaign

In FY2008 and FY2009, DMH established and implemented its public awareness initiative targeting adults and children by launching the **Say It Out Loud** campaign. **Say It Out Loud** is a statewide campaign to promote good mental health that is co-sponsored by IDHS/DMH and the Illinois Children's Mental Health Partnership. The campaign seeks to address the misperceptions associated with mental illnesses by giving people the opportunity to engage and share their experiences and knowledge and has used the stories of real people in advertisements distributed to newspapers and radio stations in every county of the state. The campaign's Web site: www.mentalhealthillinois.org. and related activities are continuing in FY2011. However new activities are on hold pending acquisition of funding. The campaign is continuing in a very basic maintenance mode with the existing website, materials, and resources.

LEGISLATIVE INITIATIVES AND CHANGES

Recently several legislative initiatives were passed that will have some impact on the landscape of mental health service delivery in Illinois.

Public Act 95-16 (July, 2007) permits rural Medicaid patients to receive treatment through telepsychiatry-primarily videoconferencing - to provide psychiatric care despite the distance. This addresses the shortage of psychiatrists working in rural communities, as well as long distances and limited access to transportation which make it difficult for rural persons to obtain adequate mental healthcare.

Public Act 96-0093, signed on July 27, 2009, created a Military and Veterans Court Task Force to study the creation of veterans' courts for veterans and active duty service personnel with substance abuse or other problems.

DESCRIPTION OF STATE AGENCY'S LEADERSHIP

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 integrating mental health services with other IDHS divisions and working closely at the state level with Illinois departments and organizations.

DMH and IDHS Service Areas

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

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

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

DMH and the Division of Alcoholism and Substance Abuse (DASA) have collaborated for many years to address services for individuals with co-occurring disorders. Initiatives have included the establishment of consortiums comprised of mental health and substance abuse providers to collaborate on treatment provision, cross-training of

providers from both service systems focusing on integrated treatment, and the funding of an institute to provide training to service providers across the state. The DMH and DASA jointly applied for and received, a SAMHSA grant for training providers and evaluation of the implementation of Integrated Dual Diagnosis Treatment (IDDT) that ended in FY2007 with positive results. However, state funding has not been available for continued implementation.

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.

Both divisions share leadership tasks in addressing the needs of persons with Autistic Spectrum disorders (ASD). 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. Since FY 2005, the Division of Developmental Disabilities (DDD) and the DMH have co-convened the Autism Task Force.

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.

DMH and DRS actively collaborate to increase the access of persons with serious mental illnesses to vocational rehabilitation services and to improve the coordination of psychiatric and vocational services. DMH, DRS, and DASA worked collaboratively with the Illinois Certification Board (ICB) during FY2007 to develop the Illinois Model for Certified Recovery Support Specialist (CRSS) that defines baseline criteria for CRSS professionals and provides a professional certification that is competency based. This credential became available in FY2008. DMH and DRS continue to jointly assess their service systems to determine what gaps exist locally and emphasize technical assistance for needed program modifications.

Moving from Institution to Community: DHS 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 organized the Disabilities Services Advisory Committee (DSAC) 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 update are available on the DHS Website at <http://www.dhs.state.il.us/page.aspx?item=33842>

Relationship of the DMH to the Illinois Departments and Organizations

Illinois Housing Development Authority

The availability of safe, decent, and affordable housing is a necessary component of a comprehensive community support system. 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. DMH has worked at forging dialogue and partnerships with the Illinois Housing Development Authority (IHDA), a group with a legislative mandate to oversee and advise on Housing in Illinois, which includes the broader spectrum of state government in its membership, as well as local housing authorities, housing developers and other finance entities. Many DMH local contracted community mental health vendors have worked with HUD to develop housing opportunities for individuals who are homeless through the Shelter Plus Care Project and the 811 Project to pave the way for local housing development. DMH Regions continue to encourage local vendors to explore avenues for 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 all Department of Human Services Divisions, and the Attorney General to support the needs and rights of mental health consumers when there is community resistance to develop housing for persons with a history of mental illness.

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, as well as identifying model programs, best practices and staff competencies to serve this population. The committee has provided training, consultation and technical assistance in the area of mental health and aging and has promoted public awareness of geriatric mental health concerns. In FY 2009, the DMH, in coordination with the DOA, successfully convened its annual statewide 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

Suicide Prevention

In Illinois, more than 1,000 persons die by suicide each year and suicide fluctuates yearly between being the second or third leading cause of death for adolescents. Interest, organized efforts, and advocacy for suicide prevention in Illinois resulted in legislative action. In 2004, the Suicide Prevention, Education and Treatment Act (PA093-0907) was passed by the General Assembly and signed by the Governor directing the Illinois Department of Public Health (IDPH) to appoint the Illinois Suicide Prevention Strategic Planning Committee composed of representation of statewide organizations and local agencies that focus on the prevention of suicide and support services to survivors. The committee was charged with the development and implementation of a state Suicide

Prevention Strategic Plan and with convening a statewide conference on suicide prevention, conducting media and public awareness campaigns, formulating education initiatives, and contingent upon funding, setting up five pilot programs to provide training and direct service. As interest and advocacy grew, an alliance was formed between a coalition of stakeholders and the strategic planning committee that was recognized in law by the General Assembly in 2008. The mission of the Alliance as stated in the law is “to reduce suicide and its stigma throughout Illinois by collaboratively working with concerned stakeholders from the public and private sectors to increase awareness and education, provide opportunities to develop individual and organizational capacity in addressing suicide prevention, and advocate for access to treatment.” DMH is a member of the Alliance and has actively participated in the development of the 2007 Illinois Suicide Prevention Strategic Plan. The Plan may be found at: http://www.idph.state.il.us/about/chronic/Suicide_Prevention_Plan_Jan-08.pdf

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” Federal Demonstration

Illinois is to receive \$55.7 million dollars in federal Medicaid reimbursement over five years to assist individuals who have serious mental illnesses and who are living in non-IMD nursing facilities with seamless transition to community residential alternatives (non-group home settings) and necessary support services. The “Money Follows the Person”(MFP) demonstration will facilitate the transition of approximately 3500 persons, between the involved state Departments, into their home communities over the course of five years. Six hundred and eighty five individuals to be transitioned will fall within DMH’s identified priority population. The Department of Healthcare and Family Services, the lead agency for the initiative, is working closely with the IDHS divisions of Developmental Disabilities (DDD), Rehabilitation Services (DORS) and DMH, the Department on Aging, and the Illinois Housing Development Authority (IHDA) on the project. IDHS is committed to maximizing this funding in support of the goals of consumer self-direction, independence and community reintegration. Programs under the MFP are designed to: (1) Eliminate barriers or mechanisms that prevent Medicaid-eligible individuals from receiving support for appropriate and necessary long-term services in the setting of their choice; (2) Increase the ability of the state Medicaid program to assure continued provision of home and community-based long term care services to eligible individuals who choose to move from an institutional to a community setting; and (3) Ensure that procedures are in place to provide for continuous quality

improvement in these services for individuals receiving Medicaid home and community-based long-term care. A federally required operational protocol has been completed and accepted. DMH participates in the identification of appropriate candidates for transition to the community and contracts with provider agencies for the provision of services. As DMH continues to move forward into shared implementation of the initiative, policies and procedures are being developed to facilitate the provision of mental health clinical and support 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)

IDHS/DMH has assumed a leadership role in developing significant statewide initiatives for justice-involved individuals with mental illness at every stage, including street-level intervention, jail diversion, correctional programming, and offender reentry. IDHS/DMH has been instrumental in developing integrated processes of identification, reentry linkage, and service delivery between the criminal justice, mental health and substance abuse networks, and recovery support services, such as housing and employment. These efforts have laid the groundwork for a more comprehensive and effective diversion approach based on leveraging existing successful intervention models, enhancement of capacity, and increased availability of clinically appropriate services.

The following 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 (under Adult-Establishment of a System of Care).

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.

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.

DMH and Disaster Response Activities

The Robert T. Stafford Act of 1974 (Public Law 93-288) created the system in place today by which a Presidential Declaration of an emergency triggers financial and physical assistance through the Federal Emergency Management Agency (FEMA) thereby initiating an orderly and systemic means of federal natural disaster assistance for state and local governments in carrying out their responsibilities to aid citizens. The Governor has designated the DMH as the State agency to lead disaster resource coordination and recovery functions related to mental health. Working in the context of the overall State-wide Disaster Plan and the Illinois Emergency Management Administration (IEMA) as well as the State Emergency Operations Center (SEOC), DMH coordinates Illinois' disaster preparedness for state operated and state funded psychiatric service providers. Through the Comprehensive Community Service Regions, DMH assists in the development of local response capability for issues of Mental Health. The operational

focus includes collaboration with other state agencies, monitoring, and facilitating ongoing concordance with National Incident Command Systems (NIMS). DMH participates in Substance Abuse and Mental Health Services (SAMHSA) Grant applications and collaborates with qualified partners in providing training. DMH also develops plans and mechanisms to coordinate surge deployment of mental health services in response to disasters, be they natural or caused by terrorists.

A Statewide Mental Health Disaster Preparedness Plan has been developed which recognizes the concept of local response to disaster mental health needs of Illinois communities and which builds on the strengths of the communities. Each Region has designated a Disaster Resource Coordinator to identify and work with lead providers in their area (generally one in a county for most of the state).

In recognition of the potential for natural or terrorist caused disasters in the State, emphasis in disaster planning has been on developing and/or maintaining a local response capacity. This includes educational offerings and the availability of trained mental health professional and paraprofessional volunteers to respond to the needs of their community in time of crisis. A central list of Illinois mental health professionals who were willing to be deployed on an urgent (surge) basis is continually updated as a resource in the event of future terrorist aggression or disaster requiring a mental health response. As necessary, the Red Cross may draw down the volunteers in groups. DMH continues to provide training on disaster response in conjunction with other state agencies and entities.

CHILD AND ADOLESCENT SERVICE PLAN

CHILD-OVERVIEW OF STATE'S MENTAL HEALTH SYSTEM

Organizational Structure of the Illinois System of Care

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

Central Office Structure

The Child and Adolescent Services office is led by a board certified Child and Adolescent Psychiatrist and consists of approximately 20 FTE Statewide C&A Staff, some of whom are geographically located in each of five regions of the state. Contracting responsibilities have shifted to the Regional staff that are often accompanied by and/or receive consultation from C&A staff. The model appears to be working well, reducing duplicated effort and allowing the Regions to draw upon C&A staff expertise to support their contract and monitoring role. Specialty program grants specific to children and adolescents are managed by Central Office Child and Adolescent Services staff who have expertise in such areas as mental health services in schools, transition services for youth, early childhood services, and mental health prevention and early intervention for children and youth.

The CCSRs

The five geographic Comprehensive Community Service Regions (CCSRs) are responsible for contracting activities with 149 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 collaborate with and monitor local hospitals that provide psychiatric programs for youth. The localized integration of a comprehensive care system including mental health, substance abuse, child welfare, juvenile justice, and education is within their purview. Child and Adolescent Service expertise is provided to Regional staff by statewide C&A Services staff. Each CCSR has access to C&A staff specially designated to address child and adolescent and juvenile forensic services. The regionally based C&A Staff are primarily Consumer parents (Family Consumer Specialists) and serve the critical system role of connecting the Division of Mental Health's services to their communities, as well as providing the consumer family voice to the Division of Mental Health from their communities.

The Illinois Department of Human Services (DHS)

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

Mental Health Services Provided for Youth Through Other State Agencies

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

the control of their parents. By law, the program must be available in every area of the state, 24 hours a day.

CHILD-NEW DEVELOPMENTS AND ISSUES

See the ADULT- NEW DEVELOPMENTS AND ISSUES section for information on the impact of the economic recession, the Warm Line, the Consumer and Family Care Line, Mental Health Transformation, and the Public Awareness Initiative that are relevant to both adults and children.

Family Driven Care

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

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

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

Public Awareness Campaign

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

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

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

CHILD-LEGISLATIVE INITIATIVES AND CHANGES

A recent law clarifying the definition of “children with disabilities” 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.

DESCRIPTION OF STATE AGENCY’S LEADERSHIP

Collaboration with the IDHS Division of Community Health and Prevention

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

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

- A statewide perinatal mental health consultation service has been established for providers to use when a screening indicates that a pregnant or postpartum woman may be suffering from depression. This service is accessed by a toll free number and provides consultation with psychiatrists specializing in women’s health issues, information about medications that may be used in the management of perinatal depression during and/or after pregnancy, and referral and linkage to available mental health resources. This program was formed in collaboration with DCHP, HFS (Illinois Healthcare and Family Services), and DMH.
- Early Intervention Services provided through DCHP for children under three years of age who are experiencing delays in one or more of the following areas: cognitive development; physical development; language and speech development; psycho-social development; and self-help skills. Evaluations and assessments are provided at no cost to families. Families with eligible children receive an Individualized Family Service Plan (IFSP) listing the services and support that must be made available to the family. DMH Child and Adolescent Services is supporting this program through efforts to increase community mental health provider capacity to serve any mental health needs of the children identified through these screenings; capacity-building programs include collaboration in the Illinois’ Children’s Mental Health Partnership’s Early Childhood Consultation project providing early childhood mental health consultants to participating community mental health agencies, and the addition this year of the Devereaux Early Childhood Assessment tools to the DMH Child and Adolescent Services web-based outcomes system for children ages 0-5 served in the community

mental health services system.

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

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 FY2000 and expanded statewide by the end of FY2002. 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.

Schools -Illinois State Board of Education (ISBE) and the Chicago Public Schools

The DMH has pursued the Positive Behavioral Interventions and Supports (PBIS) model of collaboration between education and mental health through work on our States' current three System of Care Grants and through collaborative efforts with the Children's' Mental Health Partnership. The Division of Mental Health is funding 6 school-based Mental Health programs in collaboration with ISBE and the Illinois Children's Mental Health Partnership, and these have been successful in implementing the three-tiered model of schools-based mental health and development collaborations, helping not only students in all three tiers of the model, but schools staff such as teachers, and parents as well. Work is continuing to expand the education/mental health partnership of these schools and mental health programs. 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. This workgroup has produced a position paper in the past year based on their survey findings assessing the roles of different persons in school mental health services throughout the school system. The workgroup will use this data to further assess the state of mental health services and needs throughout the State, as well as to further plan expansions of or development of schools and mental health programming.

Child Welfare

DMH continues to work closely with DCFS, the child welfare agency, on a number of initiatives including the Screening, Assessment, and Support Services (SASS) Program, which is an interagency collaboration between DMH, DCFS, and HFS (Healthcare and Family Services). This SASS program provides 24/7 access to children, youth, and their families in crisis in the State and is accessed through a 1-800 CARES line number statewide. DMH is currently collaborating with DCFS to create inpatient psychiatric care guidelines for community hospitals that provide care to DCFS wards. This effort has been based on Practice Guidelines from each of the major clinical care fields involved in such settings, such as for child psychiatrists and psychiatric nurses, and is currently being reviewed with statewide stakeholders.

Pilot Programs for Prevention and Early Intervention and Specialty Populations Services

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. The ICMHP has been successful in garnering state funds for children's mental health needs. DMH Child and Adolescent Service System staff members actively participate in the ICMHP, are active partners in promoting its vision, and work closely with the ICMHP in planning how the funds are to be used and implementing those plans. In FY2008, ICMHP obtained a \$6.5 million budget which included funding for the expansion of pilot programs in services to transitioning youth, early childhood consultation, early intervention and the initiation of clinical pilot programs for children ages 0-5. The programs continued successfully through FY2009, but, as funding was limited to a three-year period, some programs funded in FY2007 were discontinued for FY2010 due to the lack of any additional funds for their continuation. See Section III-System Integration (Criterion 3) for a discussion of these pilot programs.

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

ADULT SERVICES PLAN:

ADULT SERVICE SYSTEM'S STRENGTHS AND WEAKNESSES

Important strengths of Illinois' community-based mental health system in relation to each of the four criteria for adults are described below. It is important to note that while we aptly describe our strengths, significant challenges continue to confront the public mental health service system. Fiscal constraint in the past few years has resulted in limited growth and implementation of a number of the initiatives described below and in Section III of this plan. With the creativity and innovation of the past several years, there has also been increasing awareness of the lack of sufficient resources with which to actualize and transform the service system to fully and rapidly achieve the vision articulated below. In FY 2011, the system is facing serious fiscal challenges and is anticipating further reduction instead of growth. DMH efforts are currently geared towards finding practical solutions to challenges and sustaining gradual and incremental progress where possible.

Criterion I: The Comprehensive Community Based Mental Health System:

- ✓ The array of core services 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.
- ✓ Involvement of consumers in planning, implementing and evaluating the initiatives and ongoing activities of the public mental health system.
- ✓ Successful efforts to reduce hospitalization. Screening and crisis services that contribute to this success remain a high priority for DMH, as well as extensive case management services, community support and ACT.
- ✓ Collaborations with other divisions of the IDHS and with other state agencies have been a successful strategy for improving and enhancing services throughout the system.

Criterion 2: Mental Health System Data Epidemiology

- ✓ Joint work with the Illinois Mental Health Collaborative towards implementing a new Management Information System (MIS) and establishing a data warehouse to provide improved and expanded access to data which is vital to support decision making.
- ✓ Through external resources, such as the Data Infrastructure Grant, federally funded studies, and DMH initiatives, our databases and analytic capabilities have steadily grown to an extensive array of computerized information that provides an important resource for analyzing service provision and service needs

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

- ✓ Continuing commitment to develop and implement service models for persons with mental illnesses who are homeless, such as the innovative use of PATH funds. Illinois has continually increased services including expanded intensive outreach to homeless individuals with serious mental illnesses.
- ✓ Active collaboration and effort to develop and evaluate approaches to improving housing services such as Permanent Supportive Housing (PSH) and successful advocacy for appropriations from the state legislature to support these promising approaches.
- ✓ The 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, and works with nearby universities to develop and evaluate programs designed for the needs of rural residents. Direct services that include crisis/emergency services, outpatient services, psychiatric services, care management, PSR, and residential services are provided in rural areas across the state.
- ✓ The State recognizes the value of advanced technology in communication to give Illinoisans living in rural communities increased access to psychiatric care. Public Act 95-16 signed by the Governor in July, 2007 requires the Illinois Department of Healthcare and Family Services to reimburse psychiatrists and federally-qualified health centers (FQHCs) for mental health services provided via telepsychiatry.
- ✓ The DMH Geropsychiatry program has been nationally recognized. It is targeted toward the needs of older adults with mental illness, especially in rural areas.

Criterion 5. Management Systems

- ✓ The DMH has made a substantial, successful and sustained commitment toward 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.

ADULT-UNMET SERVICE NEEDS

The FY 2011 Illinois Mental Health Block Grant Plan has been developed taking into account service needs and critical gaps within the current mental health system. As of May 2010, budget proposals include serious reduction in funds and the anticipated transition of the current system to one in which Medicaid-Eligible individuals will continue to receive all the services which are approved for reimbursement from Medicaid while individuals who are not Medicaid –Eligible will receive only those services affordable through very limited grant funding from state General Revenue Funds (GRF). Even though funding may be seriously reduced, DMH remains committed to maintaining, as far as possible, the core services required to meet the needs of individuals with serious mental illnesses. The identification of service needs and the tracking of progress in meeting these needs using both quantitative and qualitative information is detailed in the Adult Plan sections. The need to address issues such as the adoption and implementation of evidence-based practices, to address the needs of individuals (adults and youth) involved with the justice system, to provide access to services to adults and children residing in rural areas of the state are also described in the Adult Plan sections.

ADULT- PLANS TO ADDRESS CHALLENGES AND UNMET SERVICE NEEDS

The following are the priorities for enhancing the adult service system in FY2011:

Criterion I: The Comprehensive Community Based Mental Health System Priorities and Service Needs:

- Core services for ongoing clinical care and support of individuals with serious mental illnesses who are not Medicaid-Eligible in a period of fiscal constraint remain an important DMH priority, especially those services and activities that address individuals who are experiencing psychosis for the first time can reduce hospitalization (such as crisis services, face-to-face screening prior to hospital admission, case management services, including the use of ACT and Community Support teams).
- Increasing the range of housing opportunities is essential as housing is considered the #1 need of consumers transitioning into the community, of those who have found themselves homeless, and of consumers who are living in substandard environments. The viable development and establishment of the Permanent Supportive Housing initiative continues to be a primary area of interest and effort.
- Expansion of the scope and quality of consumer and family participation continues to be of paramount importance in Illinois.
- Furthering work on the recovery vision in Illinois.
- The advancement of the Certified Recovery Support Specialist (CRSS) credential by expanding educational opportunities to meet the requirements and obtain the credential as well as creating employment opportunities in provider agencies.
- Enhancement and expansion of evidence based practices is required to provide consumers increased access to proven quality services in family psychoeducation, medication management, ACT, supportive employment and permanent supportive housing.

- The expansion of WRAP programs.
- Family involvement in the development and implementation of treatment plans is important.
- Collaborative initiatives which respond to ongoing consumer needs such as work with the criminal justice system, with providers of alcoholism and substance abuse services, with providers of vocational and employment services, and with the Department on Aging on the mental health needs of older persons will continue as a priority.

Criterion 2: Mental Health System Data Epidemiology

- Continuing improvement of DMH management information systems (MIS) to meet the challenges ahead. This work has been valuably supported by the requirements and activities undertaken through the Data Infrastructure Grant.

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

- Adoption of models of service provision which can best meet the needs of special populations such as integrated service models that can be adapted and utilized for the many homeless persons who have co-occurring mental illnesses and substance abuse problems.
- Bringing mental health services to persons isolated by distance and shortages of clinical professionals through approaches such as video-conferencing and Tele-psychiatry is a matter of urgent importance.
- Collaboration with IDOA on the Gero-psychiatry program in rural areas. 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.

Criterion 5. Management Systems Priorities and Service Needs:

- Increasing revenue from federal Medicaid funds is necessary to offset the fiscal problems Illinois has experienced in recent years that have led to decreases in allocations for human services.
- The development of alternative cost efficient training supports remains a priority. Although the DMH does not have dedicated resources for a training department of its own some of these responsibilities are being picked up the MHCAC (the Collaborative).
- 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.
- DMH has recognized the urgency of a statewide mental health plan for response to terrorist activities, as well as natural and other disasters.

ADULT-RECENT SIGNIFICANT ACHIEVEMENTS

Update on Areas Needing Attention in FY 2010 Plan - Significant Achievements

This section provides a brief summary of areas identified as needing attention in FY2010 and notes significant achievements in these areas.

Consumer Participation and Involvement

The DMH has 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 continued to be provided.

DMH has recognized the need for providing consumers with 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 FY 2010, eight pre-arranged conference calls were conducted with consumers in all parts of the State by the end of May 2010 with an average of 350 participants per call. These calls provide a forum for discussion of service information, performance data, new developments, and emerging issues to promote consumers' awareness, knowledge, and the tools they need to cogently and effectively participate in the development and evaluation of the service system.

In collaboration with the Illinois Certification Board (ICB), the Divisions of Mental Health, Rehabilitation, and Alcoholism and Substance Abuse developed the Illinois Model for Certified Recovery Support Specialist (CRSS). This Model defines baseline competencies and skills for CRSS professionals. Access to this new credential first became available through the ICB in July of 2007 and since then, 132 individuals have achieved their CRSS certification and are in good standing with the ICB. Information regarding this new credential and on sources of education and training for it, has been continuously disseminated to interested stakeholders at conferences and through other venues.

Under the leadership of the DMH Director of the Office of Recovery Support Services, the Wellness Recovery Action Plan (WRAP) model has been adopted by Illinois. A statewide WRAP steering committee meets on a monthly basis to plan and review progress on the WRAP initiative. Through the establishment of WRAP classes in community agencies and the introduction of the principles of WRAP at consumer forums and conferences, thousands of consumers throughout the state have benefited from receiving orientation and education in the principles and components of this emerging best practice in recovery-based services. Since the inception of the Wellness Recovery Action Plan (WRAP) Initiative in Illinois in FY2003, over 250 individuals (including consumers currently receiving services) received Certificates as WRAP Facilitators through their completion of a 40-hour intensive course. Refresher/Continuing Education courses are held in each region bi-annually for Certified WRAP Facilitators.

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. Six regional conferences have been held across the state during FY2010 attended by more than 1,000 participants including consumers, family members, providers, DMH staff and other state agency staff.

Evidence-Based Practices

During the year, the DMH continued major initiatives to adopt and implement evidence-based practices in various areas across the state. Significant work has been done to implement Evidence Based Supported Employment (EBSE). Work continues on planning and implementing 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.

DMH continues to address SAMHSA'S National Outcome Measure of Implementing Evidence-Based Practices and strives to make EBPs available throughout the state by providing training and technical assistance to mental health agencies, and by involving mental health consumers and families in the expansion of such practices in Illinois. In April 2010, the DMH convened a third annual statewide conference on EBPs, entitled From Vision To Action: Evidence-Based Practice in Illinois. Presentations focused on the practical and philosophical aspects of organization, financing, and implementation issues to be considered in planning for implementation of EBPs. More than 200 individuals (consumers, family members, advocate, providers and state agency staff) attended the two-day conference.

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.

Information Technology

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

Grants

DMH received continuation grants for the following areas: Data Infrastructure for Quality Improvement; Work Incentive and Planning Assistance Services for SSI/SSDI Beneficiaries, and Supported Employment. DMH has partnered with staff of the Illinois Department of Healthcare and Family Services (DHFS) in implementing a federal Medical Emergency Room Diversion (ERD) Grant from CMS. The grant provides \$2 million over a two-year period to improve access and the quality of primary health care services. Illinois was one of six states awarded the Substance Abuse and Mental Health Services Administration Jail Diversion – Trauma Recovery (priority to veterans) grant. This grant, for approximately \$2 million over 5 years has enabled the establishment of the Illinois *Veterans Reintegration Initiative (VRI)* to increase diversion for criminal justice-involved veterans with trauma histories in Cook and Rock Island counties.

ADULT-STATE'S VISION 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 and transformed mental health system that is consumer directed and community driven providing a continuum of culturally inclusive programs which are integrated and effective, a range of direct and support services (including prevention, early intervention, treatment and supports), that support healthy lifelong development through equal access and promote recovery and resilience. The Illinois Vision for Mental Health is that:

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

-The expectation is recovery

-The consumer is central

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

CHILD AND ADOLESCENT SERVICES PLAN:

CHILD-SERVICE SYSTEMS STRENGTHS AND WEAKNESSES

Important strengths of Illinois' community-based mental health system in relation to each of the five criteria for children/adolescents are described below. It is important to note that while we aptly describe our strengths, significant challenges continue to confront the public mental health service system. Fiscal constraint in the past few years has resulted in limited growth and implementation of a number of the initiatives described below and in Section III of this plan. With the creativity and innovation of the past several years, there has also been increasing awareness of the lack of sufficient resources with which to actualize and transform the service system to fully and rapidly achieve the vision articulated below. In FY 2011, the system is facing significant fiscal challenges and is anticipating further reduction instead of growth. DMH efforts are currently geared towards finding practical solutions to challenges and sustaining gradual and incremental progress where possible.

Criterion I: The Comprehensive Community Based Mental Health System

- ✓ The array of core services that is available to youth with serious emotional disturbances and their families.
- ✓ The commitment to evidence informed practices and the dissemination of information regarding the implementation of evidence-informed practices that lead to resilience.
- ✓ The consistent commitment and ongoing efforts to divert children and adolescents from inpatient and residential treatment to services in their home communities as exemplified by the SASS (Screening, Assessment and Support Services) program and the DMH Individual Care Grant (ICG) Programs. These individualized ICG or SASS services include intensive home-based support, treatment and respite care which allow the child to remain at home.

- ✓ Planning for family driven care which is based on the goals identified by the President's New Freedom Commission, the foundation for current and future planning efforts.
- ✓ Family Resource Developer positions have been created and maintained across the state and have also been an active component of the System of Care initiatives.
- ✓ Collaborative efforts, pilot projects, and vocational/employment supports to address the needs of youth with serious emotional disturbance transitioning to adulthood, including those transitioning from correctional settings and the child welfare system.
- ✓ The state health care coverage program that offers comprehensive, affordable health insurance for children in Illinois assures that every uninsured child, regardless of income or medical condition has access to health care, including mental health services. Additionally healthcare coverage is extended to parents living with their children 18 years old or younger and relatives who are caring for children in place of their parents.

Criterion 2: Mental Health System Data Epidemiology

- ✓ Maintenance and further expansion of the clinical outcomes analysis system for children/adolescents that can generate multi-level data reporting.
- ✓ Joint work with the MHCAC on a data warehouse will provide improved and expanded access to data to support decision making in children's services.
- ✓ Through external resources, such as the Data Infrastructure Grant, federally funded studies, and DMH initiatives, our databases and analytic capabilities have steadily grown to an extensive array of computerized information that provides an important resource for analyzing service provision and service needs

Criterion 3: Children's Services

- ✓ Collaboration with IDHS Divisions and state agencies to ensure continuity of care and service integration is a multifold strength of the DMH service delivery system for children and adolescents.
- ✓ The on-going collaboration with the Children's' Mental Health Partnership has been fruitful in providing the resources needed to advance several vitally needed initiatives including services to youth in transition, early intervention, and the promotion of Evidence Informed Practices.
- ✓ The statewide Mental Health Juvenile Justice (MHJJ) program brings services to youth in county detention centers across the State in collaboration with juvenile justice.
- ✓ Long-standing collaborations are in place with the DCFS, the ISBE and the DASA. The DMH has partnered with these agencies to implement the wraparound approach to the delivery of children's services as well as to provide or coordinate delivery of mental health services. More recently, collaboration with DCFS and DHFS expanded the provision of SASS services.
- ✓ The Mental Health in Schools Model, that strives 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.

Criterion 4: Targeted Services To Homeless, and Rural Populations.

- ✓ In reference to 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 22 shelters on the south, north, and west sides of Chicago. Services focus on the identification of untreated mental illness, developmental delays, substance abuse, needs assessment, advocacy, coordination services and follow-up supportive services.
- ✓ The IDHS Homeless Youth program has existed for many years and 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.
- ✓ Public Act 95-16 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 Tele-psychiatry. DMH has moved forward to provide child psychiatry consultation and services through Tele-psychiatry in Regions 4 and 5, both extensively rural.
- ✓ **Criterion 5. Management Systems**
- ✓ The DMH has made a substantial, successful and sustained commitment to increasing the portion of the DMH funds allocated to community-based treatment for children and adolescents with serious emotional disturbance and their families.
- ✓ In recognition of the increasing role played by federal Medicaid funds, the DMH has worked successfully to increase this revenue source to benefit children's services.
- ✓ The DMH has maintained a strong joint public and academic program which continues to include Departments of Psychiatry, Social Work, Psychology, and Nursing in universities across the State as evidenced by specialization and curricula appropriate to children with SED.

CHILD-UNMET SERVICE NEEDS

As stated for Adults, the FY 2011 Illinois Mental Health Block Grant Plan has been developed taking into account service needs and critical gaps within the current mental health system. As of May 2010, budget proposals include serious reduction in funds and the anticipated transition of the current system to one in which Medicaid-Eligible individuals will continue to receive all the services which are approved for reimbursement from Medicaid while individuals who are not Medicaid -Eligible will receive only those services affordable through very limited grant funding from state General Revenue Funds (GRF). Even though funding may be seriously reduced, DMH

remains committed to maintaining, as far as possible, the core services required to meet the needs of individuals with serious mental illnesses. The identification of these needs and tracking of the progress in meeting these needs using both quantitative and qualitative information are detailed in the Child Plan sections. The need to address issues such as the adoption and implementation of evidence-informed practices, to address the needs of youth involved with the justice system, to provide access to services to children residing in rural areas of the state are also described in the Child Plan sections.

CHILD-PLANS TO ADDRESS CHALLENGES AND UNMET SERVICE NEEDS

Criterion I: The Comprehensive Community Based Mental Health System Priorities and Service Needs:

- Core services for ongoing clinical care and support of youth with the most serious emotional disturbances who are not Medicaid-Eligible and their families in a period of fiscal constraint remain an important DMH priority.
- 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 collaborative initiatives for children of all ages is a major priority of the Statewide C&A Services Office and includes early intervention, transitional care, and the promotion and growth of early childhood consultation and programming in the State to strengthen services for very young children and their families.
- The enhancement of family involvement in the development and implementation of individualized treatment plans for children and adolescents who receive mental health services continues to be a primary concern.
- Inter-agency collaborations have been an important support and strategy for the DMH in improving services for children and adolescents. These initiatives respond to ongoing needs and remain a priority.
- Activities aimed at reducing hospitalization and out of state residential treatment have been successful. Screening through the SASS program, crisis services, case management services, Wraparound services, and ICG/MI community services 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: Mental Health System Data Epidemiology

- 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: Children’s Services

- The service system priority continues to be one of collaboration to provide a system of care as seamless as possible, 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.
- 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: Targeted Services To Homeless and Rural Populations.

- One third of the homeless population (which were served by the DHS Emergency Food & Shelter Program) were under the age of 18. New and expanded service models and implementation are required to meet the needs of this population. Existing programs and service models such as Beacon Therapeutic School’s Shelter Outreach Service require statewide replication and continuing expansion.
- A broader partnership among state agencies is required to address major concerns across rural counties for transportation and for “one-stop” services shopping.
- 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 Tele-psychiatry are assertively advanced and increasingly utilized.

Criterion 5. Management Systems

Priorities and Service Needs:

- Like many states, funding for mental health services is bleak in Illinois. 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. Although the DMH does not have dedicated resources for a training department of its own some of these responsibilities will be picked up the MHAC (the Collaborative).
- 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.

CHILD-RECENT SIGNIFICANT ACHIEVEMENTS

Family Participation

C&A Services focused on family participation by increasing the availability of family resource developers (FRDs). There is generally a modest level of turnover in the FRD staff, and at the point that the FY 2008 FRD survey was conducted 84% of the SASS agencies had FRDs employed. 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. Five Family Consumer Specialists (FCS) were hired as C & A staff members of DMH in each region of the state.

Systems Integration

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

Information Technology

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

Grants

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

In 2009 Illinois was one of six states that received a SAMHSA award which paid expenses to participate in a policy academy focused on Family Driven Care. This project has supported collaboration with other child serving systems and supporters (DCFS, ISBE, CHP, DJJ, DASA, IFF, ICMHP) to address the extent to which the system is Family Driven.

CHILD-STATE'S VISION FOR THE FUTURE

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

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

ADULT SERVICES PLAN

Criterion 1. Comprehensive Community-based Mental Health System
--

ADULT-ESTABLISHMENT OF A SYSTEM OF CARE

Consumer Involvement and 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. A variety of initiatives have been implemented to support consumer participation.

On the Mental Health Planning Advisory Council

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

WRAP Initiative.

The Wellness Recovery Action Plan (WRAP) model has been established in Illinois. Through WRAP classes in community agencies and the introduction of the principles of WRAP at consumer forums and conferences, thousands of consumers throughout the state have benefited from receiving orientation and education in the principles and components of this emerging best practice in recovery-based services. Since the inception of the Wellness Recovery Action Plan (WRAP) Initiative in Illinois, more than 250 individuals (including consumers currently receiving services) have received Certificates of Achievement as WRAP Facilitators, through their completion of a 40-hour intensive course. Refresher/Continuing Education courses are held in each region bi-annually for Certified WRAP Facilitators. Seven quarterly regional WRAP refresher trainings were conducted between July 1, 2009 and May 31, 2010. The average number of participants per session was 20.

Regional Consumer Conferences

Consumer education is provided through a variety of venues in the state. DMH Recovery Support Specialists work with stakeholders to design, plan and convene annual consumer conferences in each DMH region. These conferences often have a well-known and /or national speaker who delivers the keynote address and who sets the "tone of recovery" for

the conference. Six regional consumer conferences have been held between July 1, 2009 and May 31, 2010. More than 1,000 consumers, family members, providers, DMH and other state agency staff attended these conferences.

Consumer participation objectives for FY 2011 support the DMH priority for furthering work on the recovery vision in Illinois, by encouraging consumers and family members to participate in decision-making and service planning. Some of these objectives are continuations of efforts initiated in prior fiscal years.

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 and the use of Wellness Recovery Action Plans (WRAP).

Indicators:

- **Number of Regional consumer conferences held.**
- **Number of participants in the regional WRAP continuing education/refresher trainings conducted in FY2011.**

Consumer Education and Support Initiative.

Dissemination of accurate information regarding services for consumers is the primary focus of the Consumer Education and Support Initiative. DMH has recognized the need for providing consumers with the tools they need to cogently and effectively participate in the development and evaluation of the service system. The goal of this project is to ensure that consumers of mental health services receive current, accurate and balanced information regarding changes in the service delivery system, empowering them to take an active, participatory role in all aspects of service delivery. In FY2010, eight statewide consumer education calls have been held between July 1, 2009 and May 31, 2010. There was an average of 350 participants for each consumer education teleconference. These calls provided a forum for discussion of service information, performance data, new developments, and emerging issues to promote consumers' awareness and knowledge.

FY 2011 Consumer Education and Support Teleconferences:

Objective A1.2: In FY2011, the DMH Office of Recovery Support Services will conduct a series of conference calls designed to disseminate important information to consumers across the State.

Indicators:

- **Number of conference calls completed in FY 2011.**
- **Number of participants in Consumer Education / Support teleconferences.**

Recovery oriented training

In addition to the statewide consumer education calls, held monthly, 37 recovery oriented training sessions were held for all interested stakeholders in FY2009. Audiences for these sessions included diverse stakeholder groups, educating consumers of mental health services, family members of consumers, mental health and addiction professionals, advocates, college students, occupational therapy professionals, and many others. Topics

for these sessions have included the foundational principles of mental health recovery, Wellness Recovery Action Planning (WRAP), mentoring, advocacy, crisis planning, recovery support, spirituality, and others.

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

As a means of disseminating information regarding this new credential, the DHS/DMH has developed a brochure entitled “Employing Persons with the CRSS Credential.” Additionally, the ICB has provided staff presence at each of the regional consumer conferences, to distribute information and respond to questions. Individuals attending consumer conferences, statewide consumer education and support teleconferences, and regional WRAP Refresher trainings, receive CEU’s toward achieving or maintaining their credential through the ICB. There have been nine recovery oriented training sessions provided to stakeholders between July 1, 2009 and May 31, 2010. A total of 130 individuals received competency training for the CRSS credential and are preparing for application and examination with the Illinois Certification Board (ICB).

As of May 1, 2010, 132 individuals had achieved their CRSS certification, and all are in good standing with the Illinois Certification Board (ICB). DMH worked together with the Mental Health Collaborative for Access and Choice to design a study guide for individuals seeking to obtain their certification. This study guide was completed and published online in November 2009.

In FY2011, the Office of Recovery Support Services will continue to work with other system partners, including the ICB and the Mental Health Collaborative for Access and Choice (MHCAC), to develop training and study materials for those seeking to obtain their CRSS. Additional information regarding this cutting edge approach in credentialing for mental health peer specialists can be found at http://www.iaodapca.org/forms/crss/CRSS_Model.pdf

Objective A1.3: In FY 2011, continue to provide recovery-oriented training to all interested stakeholders and support the role of Certified Recovery Support Specialists (CRSS) and their statewide deployment.

Indicator:

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

DMH Public Awareness 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. From FY2007 through FY2009, the Division of Mental Health allocated \$200,000 every year to implement a public awareness campaign targeting adults. The DMH developed public service brochures, and T-shirts, buttons, and a variety of other items that carry the anti-stigma message and DMH phone and web contact information to access services. The Division also distributes materials developed and supported by SAMHSA for the national "What a Difference a Friend Makes" anti-stigma campaign. DMH contracted with a public relations firm to assist in the ongoing development of the campaign, oversee public service announcements and utilize opportunities to distribute public awareness information at large public entertainment events and through mass media outlets. The Department of Human Services has also expanded exposure of the public awareness message by insuring that the materials are distributed at the conferences and other public activities that are sponsored by other DHS Divisions. Due to severe fiscal constraints in FY2010, funding for the Campaign was very limited. However, direct coordination by DMH staff and a Web-based approach were utilized to maintain the Campaign through the fiscal year. The campaign's Web site: www.mentalhealthillinois.org. and related activities are continuing in FY2011. New activities are on hold pending acquisition of funding. The campaign is continuing in a very basic maintenance mode with the existing website, materials, and resources.

The campaign was targeted to the general public and a broad cross section of 'experts' or 'influencers' (providers), including Mental Health providers, Employers, Clergy, Pediatricians, Educators, etc in a position to assist consumers and families and provide them with greater information about up-to-date treatment regimens; screening mechanisms for early identification of persons at risk of developing mental illnesses, and listings of available resources with instructions for making referrals to mental health service providers. Authentic 'first person stories' were solicited for each of the target audiences with photo, story and promotional materials developed for each for inclusion on all subsequent distribution, media, venues, or marketing.

DMH developed an outcome survey and engaged an independent vendor to complete the survey with a pool of Internet users. Initial survey data indicates that the campaign's strategy and messaging were effective in motivating changes in the knowledge and

awareness about mental health issues and in the perceptions of persons with mental illnesses and their families. In addition, individuals who saw and heard the campaign's ads were more likely to express an intention to engage in behaviors consistent with the campaign's explicit calls to action.

Forensic Services and Mental Health and Justice Activities (Adult)

Forensic Services oversees and coordinates all forensic mental health services for the 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 also implemented adult initiatives related to the criminal justice system with key stakeholders in order to address concerns regarding the large number of non-mandated individuals with mental health needs who are involved with the criminal justice system. The key initiatives in this respect are the Jail Data Link Project and the Transformation Transfer Initiative. In addition to these active initiatives two federal grant applications have been submitted in FY10. One application is a BJA MIOTCRA grant to extend mental health court services in suburban Cook County. The second application is the Second Chance Act Reentry Demonstration Program: Targeting offenders with Co-occurring Substance Abuse and Mental Health Disorders. The latter grant provides pre and post release recovery oriented services for IDOC deemed to be high risk due to their mental health and substance abuse problems.

The Transformation Transfer Initiative

In FY2009 DMH was awarded a second SAMHSA Transformation Transfer Initiative grant for \$105,450. This second grant will fund three initiatives. The initiatives will include pilot testing the mental health court database in the Winnebago and Cook County courts, continuing the planning efforts of the Statewide Mental Health and Justice Advisory group, and supporting the development of peer to peer support for justice involved individuals with serious mental illness.

Jail Data Link Project: The Division of Mental Health's Jail Data Link Project's inception was in 1999 as a result of Bureau of Justice Assistance and other national experts that published findings that 6.1% of male and 15% of female detainees in the Cook County Jail, suffered from mental illness. Phase I of the Project was limited to Cook County and 14 pilot mental health community providers.

The project itself, which blends technological advancements and clinical systems integration, provided any County Jail and their respective community mental health providers with information as to which detainees have a history of mental illness, both inpatient and outpatient as documented by the Division of Mental Health. This cross match, is provided on a automated technology basis and is performed on a daily basis, based on the jail's current census.

Phase 2, with grant awards provided by the Illinois Criminal Justice Information Authority, the system graduated both technologically (now an SSL Internet based platform) and expanded to the Illinois counties of Will, Jefferson, Peoria and Marion. An additional three (3) community mental health providers were participatory.

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

In conjunction with the above, the platform for the Jail Data Link Project has been expanded to encompass all Mental Health Court data collection initiatives. This expansion, in the early phase of development has been supported the Council of State Governments and the Illinois Mental Health Court Association. The Division is awaiting response on pending grant from the Bureau of Justice Assistance, Mental Health Collaboration submission in order to implement the data collection model and expand the specialized linkage management model to the Cook County Mental Health Courts of West Suburban and Skokie. Numerous partners and stakeholders are included in this submission.

Jail Linkage Evaluation

The final evaluation of this Project, funded by the Illinois Criminal Justice Information Authority and performed by the University of Illinois (Southern) is completed and posted on the ICJIA website. Findings recommend this project should be expanded throughout the State of Illinois. Although not reducing recidivism as anticipated, the Division of Mental Health is working on preliminary data reflecting the reduction of inpatient hospital bed days for the individuals served by this project. Cook County Jail linkage continues to need dedicated case managers. Will, Peoria, Jefferson, Marion County, and Cook-Proviso are continuing to link individuals into community services. Three new counties have been added to data-link and begin technology aided linkage activities in FY2010. In the first three quarters of FY10 there were 51,826 jail admissions in the participating counties. Of these admissions 4261 detainees or 8% were determined to be eligible for linkage.

In the first three quarters of FY2010, 587 detainees or 13% of those eligible were linked to services within thirty days of release from jail. 172 of those individuals linked, or 29% of the linked detainees remained in treatment after thirty days. In FY11 data on continuation in treatment after 60 days will be included in the evaluation of linkage

outcomes. Low linkage percentages reflect limited case management staffing in each county jail. Also in view of the data on treatment compliance after 30 days, in 2011 JDL will be evaluating the types of services provided in the community to determine what factors help sustain linked individuals in treatment.

Objective A1.4: In FY2011, maintain linkage services for individuals with serious mental illness released from Illinois jails.

Indicators:

- **Percentage of eligible individuals linked to services.**
- **Percentage of Linkages still in treatment at 30 days.**
- **Percentage of Linkages still in treatment at 60 days.**

Community Monitoring of Persons Adjudicated as NGRI

Forensic Services is mandated by law to monitor the community-based treatment services and status of individuals who have been court-ordered into treatment due to a finding of Not Guilty by Reason of Insanity (NGRI). Currently, two tracking systems are being maintained. One follows those NGRI consumers who have been conditionally released from DHS facilities by court order. The second tracking system monitors those NGRI consumers who are ordered directly into outpatient treatment by the Court.

A total of 108 (75 Males, 33 Females) individuals adjudicated as NGRI were maintained in the community on Conditional Release (CR) status in FY2010. Seventeen persons (12 males, 5 females) were adjudicated as NGRI and released and maintained in the community during the year. During this FY, DHS 21 individuals were removed from the tracking system for various reasons such as discharge by the Court after reaching their maximum commitment date or early discharge from conditional release. A total of 7 individuals (5 males, 2 females) were subject to revocation of conditional release by the Courts and return to inpatient status. As of May 30, 2010 there were 82 “active files” being maintained in the tracking system. Agency compliance with court reporting and service delivery requirements for this population has been 87%.

Objective A1.5. Maintain the tracking system for persons adjudicated Not Guilty by Reason of Insanity (NGRI) who have been conditionally released from DHS inpatient programs to the community.

Indicator:

- **Number of persons adjudicated as NGRI who have been released and maintained in the community.**
- **Number of persons adjudicated as NGRI who have completed conditions of release.**
- **Number of persons adjudicated as NGRI who been subject to revocation of conditional release.**

During FY 2010, a total of 44 individuals (**31 males, 13 females**) were ordered by the Courts into Outpatient NGRI treatment of these a total of 13 (10 males, 3 females) were removed from the tracking database due to a change in their legal status. Agency

compliance with court reporting and service delivery requirements for this population has been at 89%.

Objective A1.6: Maintain the tracking system for persons adjudicated Not Guilty by Reason of Insanity (NGRI) who have been court ordered into Outpatient treatment.

Indicators:

- **Number of persons adjudicated as NGRI who have been court ordered into Outpatient treatment.**
- **Number of persons removed from the monitoring database due to change in legal status.**
- **Agency compliance with timely reporting**

Outpatient Fitness Restoration Service Monitoring and Expansion.

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

During FY 2010, a total of 110 individuals (60 Adults and 50 Juveniles) received Outpatient Fitness Restoration Services. There were 48 new cases referred for Outpatient Fitness Restoration Services during FY2010. The compliance rate for Community Service Provider Agency timeliness of reporting was 93% and rate of service provision was 100%.

Objective A1.7. Maintain a tracking system for persons receiving outpatient fitness restoration services.

Indicators:

- **Number of adult persons receiving outpatient fitness restoration services in FY 2011.**
- **Number of juveniles receiving outpatient fitness restoration services in FY2011.**
- **Number of new cases referred for outpatient fitness restoration.**
- **Agency compliance with timely court reporting.**
- **Agency compliance with providing fitness restoration services for UST patients in FY2011.**

Monitoring of Persons with UST Status Returning to the Community

Forensic services tracks individuals discharged from DMH hospitals after inpatient fitness restoration services. In FY2010 Forensic Services continues to follow up on discharged UST consumers and work collaboratively to improve the flow of information between DHS, courts, corrections, law enforcement and local providers in order to increase the number of discharged UST consumers who follow up on continuity of care referrals.

Of the 296 individuals (242 males, 54 females) discharged from Inpatient UST status as “fit for trial” during FY 2010, 155 were reported by the referred Agency as following through with appointments, while 15 were reported as remanded into correctional custody.

Objective A1.8: Provide continuity of care for individuals found unfit to stand trial (UST) that have been 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.
- Number of discharged UST reported in correctional custody.

Monitoring Length of Stay

Monitoring the length of stay for inpatient restoration services in DHS facilities is required in order to maintain an adequate number of inpatient beds specialized to this service and to reduce the amount of time that a consumer with a UST finding needs to remain in this more restrictive level of care. Benchmarking was undertaken in FY2009 in to collect data with which to monitor length of stay. The performance measurements to address the objective below were developed with input from staff from all hospital forensic programs and central office quality management staff. Forensic performance measures have been completed and data collection will be initiated in FY2010.

Objective A1.9. Reduce the length of stay in DMH hospital forensic programs 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.

Initial baseline data has been collected on forensic program LOS. Please see the following table. All data reflects periods in days.

Reporting period end of second Quarter FY10	Alton	Chester	Elgin	Mcfarland	Choate
Court Order /Admission	9.5	38.7	59.6*	26.8	No Report

Admission/Rec. Fitness	76.9	120.9	94.2*	30.4	No Report
Rec. Fitness /Discharge	19.6	23.4	17.9*	18.9	No report

*Third quarter data

Most notable in the data is the extended admission time for Elgin. Extended Jail waiting time after a court order delays access to necessary hospital treatment and increase potential DHS exposure to contempt of court. Much of the delay can be contributed to inadequate bed capacity and slow movement of long-term NGRI patients.

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 the state and local levels. The Division of Mental Health (DMH) and the Division of Alcohol and Substance Abuse (DASA) have worked diligently over the years to collaborate, develop and implement initiatives focusing on consumers with co-occurring disorders. These collaborations included co-location projects that continued through FY2009 at four state hospitals; Elgin, Chicago Read, Madden, and McFarland. Sharing service delivery site resources allowed DASA funded providers to perform screening and assessment for consumers on-site, and to provide consultation to DMH staff regarding the substance abuse treatment needs of consumers when these services were warranted. Sharing facilities has resulted in the development of more hospital staff training and expanded the role of the DASA providers to perform linkage and engagement activities. In the past year, funding for these efforts has not been available.

However, DMH continues highlight the clinical importance of integrated treatment for individuals who are dually diagnosed. Several sessions at the April 2010 EBP conference were focused on IDDT as an EBP sorely requiring further development in Illinois. Treatment funded by DHS/DASA in Illinois emphasizes services that are consumer-oriented, geographically accessible, comprehensive, bridging continuing care responsibilities between all levels of an integrated system of care. Specialized training, technical assistance and case consultation are available from the Illinois MISA Institute to assure the highest quality of integrated care is provided.

Assessing Consumer Perception of Care

The DMH uses the National Outcome Measures (NOMS) along with additional system indicators to track mental health system service delivery and outcomes to aid in service planning. A number of the National Outcome Measures (NOMS) are currently collected through the MHSIP Consumer Survey that has been completed annually since FY2007. The measures reported through the survey are: Client Perception of Care, Decreased Criminal Justice Involvement, Increased Social Supports/Social Connectedness, and Improved Level of Functioning.

The Adult Consumer Survey is part of the Mental Health Statistics Improvement Program (MHSIP) Quality Report performance measures. The surveys address two goals of the Division: data-based decision-making in a continuous quality improvement environment and to enhance and expand the involvement of consumers in the review, planning, evaluation and delivery of mental health services. Variables included in the analysis are: severity of emotional disturbance, race/ethnicity, and length of time in treatment. The information compiled in this report can be used for management, planning, quality improvement and feedback to providers, consumers and family members regarding state and federally funded services. The survey will be conducted again in FY2011.

Objective A1.10 (NOM): The percentage of consumers reporting positive outcomes through the Adult Consumer Survey will increase in FY2011.

Indicators:

Percentage of consumers reporting positively about outcomes with reference to the following national outcome measures:

- **Client Perception of Care (Outcomes Domain)**
- **Decreased Criminal Justice Involvement**
- **Increased Social Supports/Social Connectedness**
- **Improved Level of Functioning**

ADULT-AVAILABLE SERVICES

Health, Mental Health and Rehabilitation Services

Health Services

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, mental health practitioners are usually cognizant of the medical issues being faced by their clients and are prepared to refer them to the appropriate medical specialties. 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 applications for Medicaid benefits as one means of assuring that access to health services are available. The establishment of relationships between Federally Qualified Health Centers (FQHCs) and DMH funded community mental health agencies has also been emphasized. Programs implemented by the Department of Health Care and Family Services (DHFS) follow a Disease Management model. Illinois Health Connect is a statewide Primary Care Case Management (PCCM) Program for most persons covered by DHFS medical programs. People who are enrolled in Illinois Health Connect have a "medical home" through a Primary Care Provider who coordinates and manages their care. This program can benefit many consumers of public mental health services both children and adults. 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. DHFS, in partnership with DMH, applied for and received a \$2,000,000 Medical Emergency Room Diversion (ERD) Grant, one of twenty grants to twenty states for two-year projects with the goal of reducing the use of hospital emergency rooms by Medicaid beneficiaries for non-emergent reasons. The anticipated outcomes of these grant-funded projects are improved access to, and quality of, primary healthcare services, improved beneficiary health status and demonstrated program cost savings.

The Array of Core Mental Health Services

The array of core mental health services purchased on behalf of Illinois citizens with mental illnesses are based on the tenets of the Community Support Program (CSP) and Child and Adolescent Support Services (CASSP) models. They are described in the DMH Provider Handbook maintained by the Mental Health Collaborative and can be accessed at: http://www.illinoismentalhealthcollaborative.com/provider/prv_manual.htm. 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 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 - 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 1
- Medication-related Services; and

1 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. Funds are used in recruitment and retention of qualified psychiatrists, and to further collaboration with medical schools. 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.

- PAS/MH Services (Long Term Care screening and assessment service).

Rehabilitation Core Services

Rehabilitation core services 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.
- 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 Funds (GRF) have been budgeted yearly to increase accessibility to psychiatric medications. The program targets 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.

Employment Services

Supported Employment Services are based on integration of the DHS Division of Rehabilitation Services (DRS) funded vocational services and resources with DMH funded mental health treatment and supportive services. DMH and DRS have collaborated closely in this joint effort to increase access to Individual Placement and Support (IPS) supportive employment for persons with serious mental illnesses and to improve the coordination of psychiatric and vocational services. Locally, services are obtained through joint planning and service efforts by community mental health centers (CMHCs) and local offices of DRS. This collaboration addresses the needs of both adults and youth.

Evidence Based Supported Employment (EBSE)

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 and the DHS/Division of Rehabilitation Services (DRS) are actively collaborating to implement this evidence-based practice initiative and have been supported by two grants: a NIH/SAMHSA Planning grant to address state infrastructure issues (which ended in September, 2007) and a Johnson & Johnson/Dartmouth Community Mental Health Program Grant to support implementation at four pilot sites ended in June 2009. In FY2009 the number of mental health agencies working to implement EBSE increased from 13 to 17. Twelve of those agencies reached fidelity to standards of EBSE based upon the Individual Placement and Support (IPS) model. One agency provides the service at 8 sites and another at 2 sites. Thus, the total number of locations where fidelity EBSE services were accessed was 20. There were four additional locations working to reach fidelity.

July 1, 2008 through June 30, 2009 (fidelity agencies only):

	7/1 –9/30, 2008	10/1 –12/31, 2008	01/1–3/31, 2009	4/1-6/30, 2009
Number of agencies at fidelity	11	11	12	12
Number of locations at fidelity	18	19	20	20
Number of consumers receiving supported employment	1,209	1,218	1,182	1,144
Number employed in competitive jobs	322	343	328	320
Number of days persons enrolled in EBSE held competitive jobs	22,082	24,933	22,182	22,199
Number of hours worked per week by persons currently enrolled	7,396	8,533	7,363	7,526
Number of working people transitioned off the IPS Caseload	216	241	210	57
Number of new enrollees	239	239	258	210

Objective A1.11: Continue to expand the implementation of Evidence Based Supportive Employment.

Indicators:

- **Number of consumers receiving supported employment in FY2011. (National Outcome Measure)**
- **Number of consumers in supported employment who are employed in competitive jobs in FY2011.**
- **Number of technical assistance sessions provided to the IPS sites to increase fidelity to the SE model.**

In FY2010, 534 hours of technical assistance were provided to the IPS sites to increase fidelity to the IPS Supported Employment Model between October 1, 2009 and March 31, 2010. In the last quarter of calendar year 2009 1,039 consumers received supported employment and 321 consumers were employed in competitive jobs. During the first quarter of 2010, 1,055 received EBSE services and 318 were competitively employed.

Some accomplishments during FY2010:

- Consumers on all fidelity reviews helping to craft recommendations
- Two consumer think tanks on how recovery supports and the CRSS can be used to improve employment outcomes for IPS programs.
- NAMI IL Conference plenary session on the role of employment in recovery, IPS, and Work Incentives Planning and Assistance. NAMI has decided to have a full day track on IPS at their state conference in October 2010.
- Thru the IPS Family Project, NAMI IL received permission from the Family-to-Family Course author to develop a unit on the role of work in recovery and IPS. This was piloted in IL. CT & VT have now decided to adopt. This winter, the Family-to-Family IL state trainers built this unit into their training for new Family-to-Family facilitators. From now on all new facilitators will receive this.
- Two new sites reached fidelity.
- Three new sites began implementation.
- Two new sites are asking for assistance with implementation despite projected budget issues.
- In CY2009 IPS outcomes increased by 4% even though the state's unemployment rate increased by 3.6% during that same period. In other words, IPS is producing better outcomes than the general public with obtaining employment.
- In CY2009 211 people were transitioned off the IPS caseload while successfully employed in jobs that were consistent with their interests, strengths, and preferences.
- In November, our IPS technical assistance team was trained in a new method of teaching job development. In December we began using this method to teaching job development to IPS sites. (This focus was determined by aggregating our data from fidelity reviews to see where we needed the most help to improve our outcomes.)

Concerns/challenges

IPS is paid via a braided funding model. The DRS portion of the model is outcome driven i.e., providers are paid milestone payments when a person has been successfully working in a job that fits their preferences for 15 days, 45 days, and 90 days. Thus, a major portion of the funding for IPS is contingent on producing good employment outcomes. The DMH portion of the funding for IPS comes in the form of capacity grants and FFS dollars that are non-Medicaid. Thus, the complete loss of capacity grants for IPS and the complete loss of the use of the vocational services that can not be provided

under Rule 132 will likely result in the loss of this EBP. Maintenance of some of these resources would result in Illinois' capacity to continue to build and keep its knowledge of how to provide this very recovery-oriented system-transformational EBP.

Housing for Adults

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

Permanent Supportive Housing

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

The success of this effort is based on the DMH Bridge Subsidy Initiative that provides tenant-based rental assistance opportunities to eligible consumers who are capable of living in their own housing units within the community. The Bridge rental subsidy is designed to act as a "bridge" between the time the consumer is ready to move into his or her own housing unit until the time he or she can secure a permanent rental subsidy, such as Section 8 Housing Choice Voucher or comparable permanent rental subsidy. To facilitate transition to a permanent voucher from the Bridge Subsidy Program as seamlessly as possible, the requirements and guidelines for the program are consistent with those of the Housing Choice Voucher (HCV) Program and the consumer must either already be on a Public Housing Authority (PHA) waiting list for a Section 8 HCV or agree to register/apply for a HCV or comparable subsidy and to accept the subsidy whenever the opportunity is available. Consumers who have a serious mental illness or a co-occurring mental illness and substance abuse disorder whose household income is at or below 30% of Area Median Income (AMI) as defined by HUD are eligible to apply to

the program. DMH is targeting a defined population of consumers, including: those in long term care facilities or at risk of being in a nursing facility, long-term patients in state hospitals, young adults aging out of the ICG/MI program or out of DCFS guardianship, residents of DMH funded supported or supervised residential settings, and those who are determined by DMH to be homeless.

In FY2009 DMH utilized approximately \$5 million of newly dedicated funding to new Permanent Supportive Housing expansion and 229 eligible consumers were approved for PSH in the Bridge Subsidy Initiative in the first two application rounds opened by DMH. These consumers are securing PSH opportunities on a statewide basis. DMH has partnerships (contractual as well) with seven (7) service providers for the provision of Subsidy Administration duties. These seven Subsidy Administrators currently cover the entire state of Illinois. The DMH Permanent Supportive Housing (PSH) Bridge Subsidy Initiative is open and available to all DMH service providers currently under IDHS/DMH contract. At the conclusion of FY2009 about 100 agencies (about 60%) had applied for access to this Initiative on behalf of the consumers they represented.

The Permanent Supportive Housing Initiative has continued to make noteworthy progress during FY2010. As of 5-6-10 the DMH Permanent Supportive Housing Bridge Subsidy Initiative has approved 776 DMH bridge subsidies, and as of 5-6-10 490 consumers have utilized their subsidy and moved into a unit. DMH utilized approximately \$7 million of dedicated funding to this Permanent Supportive Housing expansion.

**Individuals Approved and Eligible for PSH Housing By Priority Population Group
(As of April 15, 2010)**

Priority Group	Number Approved
Resident of DMH Funded Residential	269
Homeless Individuals	193
Resident of Long Term Care Facilities*	201
At Risk of Placement in Long Term Care	45
Discharge from State Hospital	6
Aging Out ICG Recipient	3
Aging out DCFS Ward	4
Total	721

*Included in the "Resident of long term care" category listed above, 91 persons are from the Money Follows the Person (MFP) initiative and 20 are from the Rapid Reintegration Project (RRP).

Objective A1.12: By the end of FY 2011, through the provision of rental subsidies, implement a statewide permanent supportive housing initiative which targets an additional 300 consumers acquiring decent, safe, and affordable housing and support services in a manner consistent with the national standards for this evidence based practice.

Indicators:

- **Number of consumers who acquire appropriate permanent supportive housing in FY 2011. (National Outcome Measure)**
- **Number of DMH-funded providers participating in the program.**
- **Amount of money expended for the program in FY 2011.**

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 educational programs through local public school systems. DMH will continue to emphasize consumer and family education in FY2011 through a variety of educational activities. Recent legislation amended the School Code to provide statewide uniformity for students with disabilities who are now eligible to receive special education services up until the day of their 22nd birthday. This is particularly helpful to transitioning youth.

Substance Abuse Services

Services for individuals with substance use problems are provided by community-based substance abuse treatment programs 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 Mental Health Disorder and Substance Abuse

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, 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 has been previously described.

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 illnesses 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). For hospitalized patients, this process is begun as close to admission as possible.

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 provided 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 continues to explore options for collaboration with Health Resources and Services Administration (HRSA) funded Federally Qualified Health Centers (FQHCs) in Illinois. Several CMHC'S have participated in this collaboration in the past three years. In FY2008, DMH partnered with staff of the Illinois Department of Healthcare and Family Services (DHFS) in applying for and obtaining a federal Medical Emergency Room Diversion (ERD) Grant from CMS. The grant provided \$2 million over a two-year period to improve access to, and quality of, primary health care services through peer-delivered crisis response services. Through the grant, two new Community Health Center (CHC) sites will be located on or near hospital campuses which will partner with behavioral health providers so consumers seeking non-emergent care may be seen in a non-emergent primary care and behavioral health setting. DHFS will seek proposals from CHC/hospital and behavioral health collaborators and will fund two collaborations, one in Chicago and one in an area serving rural citizens.

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.

The Home-Based Support Services Program, which is legislatively mandated, provides reimbursement for support services to adults with serious mental illnesses (SMI). Requests for services 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 these program resources are not intended for any services that are available through other programs or entitlements. The program currently serves 192 adults.

GAPS Work Incentive and Planning Assistance Project. To assist mental health consumers and other individuals with disabilities, DMH applied for and received the Work Incentives Planning and Assistance grant funded by the Social Security Administration, which began in October 2006 and has now been extended for another

three years. This cooperative 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 Work Incentive Planning Assistance (WIPA) 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 (IDEA)

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 1,517 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. 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 after 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 CST and ACT programs through Medicaid Reimbursements have been priorities in recent years.

Community Support Teams: A Recovery Approach

The Community Support Team (CST) model was established by DMH in FY2008 as a core service to support recovery/resilience. Community Support Team services consist of therapeutic interventions delivered by a team that facilitates illness self-management, skill building, identification and use of natural supports, and use of community resources aimed at decreasing hospitalization and crisis episodes and increasing community functioning in order for the consumer to achieve rehabilitative, resiliency and recovery goals. CST services can be provided face-to-face and by telephone or videoconference, to an individual or family member. Providers are required to deliver 60% of all CST services in natural settings, during times and at locations that reasonably accommodate the consumer's needs, and at hours that do not interfere with the consumer's work, educational and other community activities. Community Support is seen as an active intervention that builds capacity by assisting the individual to do for self. Reimbursement is based on medical necessity requiring documentation of psychiatric disability (diagnosis), currently assessed need, an existing service plan with allowed interventions, and a continuing assessment of progress toward achieving recovery/resilience goals.

Assertive Community Treatment

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

During FY 2007, the Illinois ACT model was modified as part of the State Medicaid Plan amendment to bring it into line with the National ACT Model and a plan was developed to monitor the fidelity of ACT services. Subsequently, several agencies determined that they did not have the capacity to deliver the evidence-based ACT model, and chose to adopt the step-down model of the Community Support Team (CST) instead. During FY 2010, DMH continued to provide additional technical assistance to agencies that elected to provide ACT services to help them in meeting the National ACT fidelity requirements. There are ten ACT teams in Illinois and nine of the ten have had fidelity visits this year, with the last one scheduled to occur in the next few weeks. The tool used is based on the Dartmouth tool, with the only modifications being where the state Medicaid rule is more stringent than the Dartmouth standard. This year, the teams were required to submit plans of improvement for any individual items on the fidelity tool for which they scored less than 5/5. On average, providers are being asked to do plans of improvement for 3 items on the fidelity scales, with considerable variety as to which items were missed.

Also, in FY2010, the EBP conference held 4 sessions aimed specifically at ACT and addressed issues of integrating recovery concepts and other EBPs into ACT teams, as well as a focus on the specific items on the fidelity score which teams were being asked to address in plans of improvement. Technical assistance, including statewide calls, will continue in FY 2011.

Objective A1.14. Continue provision of Assertive Community Treatment that meets national fidelity model requirements.

Indicators:

- **Number of persons with SMI receiving Assertive Community Treatment in FY 2011 (National Outcome Measure)**
- **Number of ACT teams meeting National fidelity standards by the end of FY 2011.**

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 June 30, 2010 was ____ (1,319 on 6/30/09) 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 FY1987 to _____ in FY2010 (10,045 in FY2009). 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 FY1993 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 and has consistently resulted in over 90% compliance over the past several years.

- **Community Based Programs for High Users:** High users (3+ admissions in a year) of psychiatric hospitalization have been targeted since FY1994 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. Each Comprehensive Community Region (CCSR) 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 FY2004 was 8,844 and increased slightly each year to 10,770 in FY2006 which was a number not seen since the mid-1990s. Civil adult (non-forensic) admissions for FY2010 were _____. The median length of stay for this same population has steadily decreased from 19 days in FY2000 to 11 days in FY2006 and remains steady there. At the present time, all civil state hospitals are quite small, with some having a census of 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.

Decreased Rate of Civil Readmissions

DMH will continue to monitor the number of adults readmitted to state hospitals within 30 days of discharge and the number of adults readmitted to state hospitals within 180 days of discharge with a FY2011 goal of maintaining or decreasing the level of re-hospitalization through the use of community based services that provide alternatives to hospitalization. However, it is to be expected that individuals with serious mental illnesses, may, at times of crisis and relapse, require access to inpatient services for evaluation and stabilization in a safe, structured, and supportive environment. See the Adult-Goals, Targets, and Action Plans section for data and information about these indicators that are National Outcome Measures (NOM)

Objective A1.14 (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.**

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 seen 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. The DMH currently operates programs for forensic patients at five state hospitals and contracts with community agencies to provide services to those placed in the community. In an effort to ensure continuity of care when these individuals are discharged from state services, the DMH Forensic office offers 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.

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, including evidence-based practices (EBPs) and best practices.

and strives to make EBPs available throughout the state by providing training and technical assistance to mental health agencies, and by involving mental health consumers and families in the expansion of such practices in Illinois. In April 2010, the DMH convened a third annual statewide conference on EBPs, entitled From Vision To Action: Evidence-Based Practice in Illinois. Presentations focused on the practical and philosophical aspects of organization, financing, and implementation issues to be considered in planning for implementation of EBPs. More than 200 individuals

(consumers, family members, advocate, providers and state agency staff) attended the two-day conference.

In addition to ACT, EBSE, and the evidence-based PSH model described above, DMH is active in developing and expanding Medication Algorithms and Family Psychoeducation.

Medication Algorithms

The Center for the Implementation of Medication Algorithms (CIMA) is an initiative designed to disseminate empirically informed medication algorithms, patient and family education, and outcomes assessment systems that support the psycho-pharmacotherapeutic treatment of schizophrenia, major depression, and bipolar disorder, consistent with recommendations of the 2003 report of the President's New Freedom Commission on Mental Health. Since its inception in July 2004, CIMA has provided education, implementation planning, and clinical training to personnel in mental health treatment agencies across the state of Illinois.

- The program uses a three-stage training model:
 - Level 1-Education: Introduces and informs potentially interested service providers about the role of CIMA and how agencies can participate in the project.
 - Level 2-Planning: This second stage of engagement involves meetings with specific, interested agencies. An assessment is made to determine what changes are required to convert the agency's existing service delivery system to one that supports algorithm use.
 - Level 3-Training: The third step in training involves clinical training of agency personnel in the use of the algorithms, outcomes, educational materials, and documentation practices that support algorithm use.

Delivery of Level 1-Education takes multiple forms, including, for example, the dissemination of educational materials, meetings with leadership, or presentations to individuals, an agency or agencies, or several constituencies representing multiple agencies. Levels 2 and 3 are interventions aimed specifically to interested agencies.

As shown in Table 1 and excepting the first year of the program in which there was a high level of participation in the program, the number of new trainings per level has historically averaged 6 at Level 1 and approximately 3 each at Levels 2 and 3.

<u>FY</u>	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>
2005	18	12	7
2006	26 (8)	13 (1)	11 (4)
2007	31 (5)	15 (2)	14 (3)
2008	37 (6)	21 (6)	18 (4)
2009	43 (6)	24 (3)	20 (2)

To facilitate its dissemination efforts, CIMA has developed a Web site that offers materials and other resources related to the algorithms trained. Professional personnel at CIMA also provide consultation to agencies and agency providers ranging from systemic issues related to implementation to individual patient consultations. CIMA personnel also stay current with research in clinical psychopharmacology and outcomes assessment and update the algorithms as needed. CIMA was approached by general practitioners who treat persons with mental illnesses with a request for education in evidence-based approaches. A Level 3 training session with a group of family medicine providers, educators, and residents in training was held in May 2010. Lastly, CIMA personnel provided several individual consultations to physicians employed at agencies that have completed previous Level 3 training.

This past year has been a particularly challenging one for engaging State-Operated Hospitals (SOH) and community mental health centers (CMHC) in new programs or practices, including those trained through CIMA. We have had difficulty engaging agencies in any training beyond the level of education (Level 1). Nearly all agencies contacted have requested to put any planning (Level 2) or training/implementation (Level 3) on hold until they have gained some certainty about their financial futures. Consequently, while we have made several efforts to engage various constituencies, only one mental health agency has expressed interest in Level 3 training to date. When compared to the data in Table 1, this represents a reduction in participation at these levels from previous years. Although the year is not yet complete and efforts will continue to engage agencies, participation is likely to depend on the outcome of budgetary decisions made by the State for FY2011.

CIMA staff conducted clinical reviews of the algorithms during the past year. It was determined that the depression and schizophrenia algorithms were eligible for updates. These updates were completed and the training material revised to reflect them.

The CIMA Web site provides information to the public and profession consistent with the project including training opportunities, evidence-based psycho-pharmacotherapy practices, outcomes assessment and instruments, patient education materials, and links to other information resources. This year the site was updated and moved to a new address. The new address is as follows:

http://peoria.medicine.uic.edu/departments_programs/psychiatry_behavioral_medicine/PSY_Professional_Community_Education/PSY_CIMA/

CIMA is currently exploring attaining a new and simpler domain name.

Participants in CIMA's Level 3 training learn how to use evidence-based algorithms to guide clinical decision-making in the management of psychopharmacotherapy. After training participants are tested in their use of the algorithm by completing a series of increasingly difficult test cases. The new testing procedure was developed this year. Its implementation is planned at the next Level 3 training. Reporting its results will be done in terms of CME credits granted. CME is required for physicians to maintain their licenses and may serve as an incentive for participation. This year, CIMA applied and

was recently approved permission to grant continuing medical education (CME) credit through the University of Illinois College of Medicine for physicians who successfully complete CIMA training. When CME is granted to a physician it reflects their successful completion of the training program.

Objective A1.15: *Contingent upon available funding, (a) Continue and increase training and implementation of medication algorithms as an evidence-based practice. (b): Continue and increase the training of State Operated Hospitals and Community Mental Health Centers. (c) Determine if current algorithms require updating based on recent advances in psychopharmacological research and complete appropriate updates. (d) Update the CIMA Website in a manner that fosters greater public awareness and understanding of medication algorithms and their usage. (e) Report on the competency of participants trained through CIMA.*

Indicators:

- **Number of training sessions at each level.**
- **Number of State Operated Hospitals, affiliated Community Mental Health Centers, and other Community Mental Health Centers who complete training at each level.**
- **Number of algorithms updated.**
- **Evidence of updates on the website.**
- **Number of CME credits granted.**

Family Psychoeducation

Family Psychoeducation implementation efforts have continued in DMH Region I. This committee has evolved into a public/private Family Psychoeducation (FP) implementation group. The activities of this group have resulted in the formation of a number of family psychoeducation programs. Currently, three agencies in the region are implementing varying models of family psychoeducation. Several other agencies have developed programs in conjunction with these implementation teams. All of them have reported it as a positive experience and have cited the benefits to consumers as a result of family involvement. Staff members from community agencies, along with DMH Region I and central office staff members, continue to meet and provide mutual consultation on clinical, financial, and implementation issues, and to report on progress in individual program growth.

Other Evidence-Based Practices

DMH staff have discussed implementation of Illness Management and Recovery (IMR) within the state. However, no active planning has as yet occurred. Illinois cannot report data for Medication Management. Although plans were made to collect data on the number of consumers enrolled in algorithm treatment, data collection has not been undertaken because funding is not available to establish a database. The primary focus has been on education and training in the implementation of medication algorithms. (See Objective A1.16 above.) For Integrated Treatment of Co-occurring Disorders, the primary focus has been on developing provider interest and capacity to meet the service challenges posed by this model. In FY2007, the Division of Mental Health completed its

work on a three-year Training and Evaluation grant funded by SAMHSA/CMHS. Training and evaluation in the IDDT model were provided to nineteen agencies (17 community-based agencies and 2 state hospitals) located in Chicago. Participating agencies were provided with tailored technical assistance and consultation geared toward strengthening each agency's ability to move toward providing IDDT. The IDDT project emphasized statewide education and leadership to promote IDDT and established that consultation and technical assistance were the key means of strengthening the ability of agencies to move toward providing Integrated Dual Diagnosis Treatment services. The feasibility of realigning these activities with new funding is continuously being assessed.

Objective A1.16 (NOM): Continue efforts to increase the implementation of Family Psychoeducation and continue to study the feasibility of establishing the following Evidence Based Practices: Integrated Treatment of Co-Occurring Disorders, Illness Self-Management, and Medication Management.

Indicators:

- **Number of adults with SMI receiving Family Psychoeducation.**
- **Number of adults with SMI receiving Integrated Treatment of Co-occurring Disorders.**
- **Number of adults with SMI receiving Illness Self-Management.**
- **Number of adults with SMI receiving Medication Management.**

Criterion 2: Mental Health System Data Epidemiology
--

ESTIMATE OF PREVALENCE

The CMHS definition and methodology for prevalence estimation for adults is published in final notice form in the Federal Register Volume 64, Number 121, June 24, 1999. The methodology provides a calibrated point estimate of the 12-month number of persons who have Serious Mental Illness, age 18 and older in Illinois. This does not include persons who are homeless and institutionalized. The prevalence estimate provided by CMHS is 5.4%. Based on the adult population for Illinois, it is estimated that in FY2009 there were 523,155 adults with serious mental illnesses residing in Illinois.

QUANTITATIVE TARGETS

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. Two groups of consumers are the focus for service provision: a larger "eligible" group and a smaller "target" group. Persons who fall in the eligible group meet minimum criteria of mental illness or emotional disorder as well as significant impairment in life functioning and may be served in the Illinois system. Individuals who are considered part of the "target" population meet much stricter criteria, have a more debilitating level of impairment due

to their mental illness and must be served. The CMHS prevalence estimation methodology overlaps 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. This data is currently not 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”.

Individuals Receiving Services In FY 2010

Information on the number of persons served in FY2010 is derived from the Uniform Reporting System (URS) Tables 2A and 2B, which is currently being prepared. National Outcome Measures (NOMs)/Performance Indicators with quantitative targets related to increased access to services are described in the Goals, Targets and Action Plans Section.

The number of individuals with Serious Mental Illnesses (DMH eligible population) reported as receiving services from DMH-funded agencies in FY 2009 was 123,175,

approximately 95.2% of the total number of adults receiving services (129,419). FY2010 data is currently being gathered.

The definition of the DMH eligible population is somewhat broader than the definition for the target population. In FY 2005, 56.5% of adults receiving services met DMH criteria for the target population. In FY 2006 and FY2007, the percent remained steady at 56.5%, but in FY2008 it increased to 58.8%. It increased further in FY2009 to 61.3%. (Note: Data for FY2010 will be provided in the implementation report.)

Quantitative Targets For FY 2011.

The DMH continues efforts to increase access to services by adults with serious mental illnesses (the target population). All DMH objectives described in this Plan are designed to increase access to available services either directly or indirectly. Although DMH aspires to increase access yearly, an increase appears unlikely this fiscal year due to the current economic distress. Therefore the goal of maintaining a percentage of at least 60% will be pursued by DMH in FY 2011.

DMH tracks access through three key performance indicators. These are:

Increased Access to Services (NOM)

Indicator:

- **Number of persons served.**

Increased Access to Services by the DMH Target Population

Indicator:

- **Percentage of the DMH adult target population receiving services**

Increased Access to Services by the DMH Eligible Population.

Indicator:

- **Percentage of the DMH adult Eligible Population receiving 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 Decision Support, Evaluation and Research 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.

Progress In Performance Measurement

The DMH has established reporting requirements and standards for data submission and has incorporated them in all DMH-funded agency contracts. DMH has worked with the Illinois Mental Health Collaborative for Access and Choice (Collaborative) to redesign

and implement a new management information system (MIS). This work included the development of a data warehouse that houses eligibility, registration, billing/services information, a provider database, and service authorization in one place. DMH now has unprecedented access to this data. One of the updates to the MIS is the requirement to update key clinical and demographic fields that will be used to track consumer outcomes over time.

Data is submitted to the information system developed jointly with the Collaborative. DMH has made several modifications to enhance data collection requirements and to permit collection of data that is compatible with Uniform Reporting System requirements as developed under the State Infrastructure Grants (DIGs). DMH 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). Data reported to the community reporting system 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.

Unduplication of Consumers for Reporting

Since FY2006 all individuals seeking mental health services have been assigned unique ID numbers referred to as RINS. RINS are also being assigned to consumers who access services under other Divisions within DHS, as well as to individuals receiving services through the Child Welfare System and Corrections. The use of RINS will improve tracking of services received by consumers across state systems, as well as increase accuracy in the unduplication of consumers receiving services in the mental health system.

Criterion 4: Targeted Services to Homeless Populations, Targeted Services to Rural Populations, and Services to Older Adults.
--

OUTREACH TO HOMELESS

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 to 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 FY2008 totaled approximately \$8.7 million. Between July 1, 2008 and June 30, 2009 there were 41,517 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 2,012,866 nights of shelter, served 2,334,706 meals and delivered 1,825,084 units of supportive services.

The IDHS Emergency Food and Shelter (EF&S) program issues an annual report that reviews trends in services provided to homeless persons in Illinois. *The data should not be construed to represent the total homeless population in Illinois, because the EFS program does not serve all 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 FY 2009 Report

The most recent report by EF&S (FY2009) provides an interesting profile of the homeless population receiving services.* The number of participants in the program decreased from 45,418 in FY2008 to 41,517 in FY2009. Males made up the majority of the adult homeless population statewide at 60.1%. There were 28,067 total households (the measurable unit of family composition) and, of these, single males comprised 16,182 households and single females, 5,685. The other households were: couples with no children (246), couples with children (681), single males with children (170) and single females with children (5,103).

In FY2008, the racial composition of the homeless population served by EF&S consisted of 59.4 percent African American and 31.3 percent European-American. The other categories tracked: American Indian/ Alaskan Native/Pacific Islander/Asian (597), Mixed ((1227) and Other Race (2,042) accounted for the remaining 9.3%. Persons of Hispanic or Latino origin (3,232) constituted 7.8% of those served

The 5,954 households with children noted above accounted for 12,191 participants under the age of 18 (29.4% of the total served) of which 52.9% (6,453) ranged from newborn

* For services in Chicago, the IDHS contracts with the Chicago Department of Human Services (CDHS). The CDHS uses non-profit organizations to provide food, shelter, and supportive services to homeless individuals and families within the city. The CDHS has oversight for organizations, monitors services, vouchers funds, reports to the Department and operates an emergency call system. The appropriation for EF&S is divided between Chicago (54%) and the remainder of the state (46%). CDHS combines EF&S funds with federal and municipal money. The EF&S program funded 37 projects in Chicago through 23 providers in FY2008. Data submitted by CDHS is included in the annual report. However, CDHS does not report on length of stay in shelters for all entrants and shelters' refusal and referral data.

infants through five years of age. In comparison, only 1.8% of those served (793) were over the age of 62 and the majority were those ages 18-50 (55%)..

Over 17% of participants served by the EF&S program declared a disability in FY2009 (7,103) of 41,517). Substance abuse and alcohol abuse continued as the most common reported disabilities. Mental illness comprised 15% of the disabilities reported in FY2009 and was reported by 10.5% (4,385) of the total number of persons served. In FY2009, it was the third most prevalent special need/condition reported by adults after 23% (6,989) reported substance abuse, and nearly that many reported alcohol abuse (6793).

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)

The State of Illinois has an extensive history of working with individuals and families who are experiencing homelessness. Since 1988, Illinois has been a recipient of federal funds provided by the Stewart B. McKinney Act, which was enacted into legislation to address the crisis of homelessness among the nation's population of individuals who are homeless or at imminent risk of homelessness with a serious mental illness who may have a co-occurring substance abuse disorder. In 1991, this block grant evolved into a federal formula funding award titled Projects for Assistance in Transition from Homelessness (PATH). The funds are governed by the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), and the Center for Mental Health Services (CMHS). Illinois providers have developed an array of services that include in vivo case management, crisis intervention services, a day center/drop-in-program, and two (2) mobile assessment units in the City of Chicago.

Allocations for the PATH program have fluctuated in recent years, and providers have diligently continued to use funds to expand and enhance services to homeless persons with mental illness. In FY 2006, the funding increased from \$2,192,000 to \$2,441,000. In FY 2007, funds decreased from \$2,441,000 to \$2,414,000, and in FY 2008, funds decreased from \$2,414,000 to \$2,366,000-a loss of \$49,000- which was reconciled by a pro-rated percentage per provider. However, in FY2009, the PATH allocation increased to \$2,686,000.

Currently, all PATH funding is used for the provision of case management services with the exception of \$53,000 for a drop-in center (Rockford) and \$653,000 in two Mobile Assessment Units (Chicago) operated by Thresholds - which do in vivo outreach and engagement. In the past three years the number of individuals served has steadily increased from 2,763 in FY2007, 2,830 in FY2008, and as of the end of April, 2009, 3,077 individuals have been served.

The State of Illinois' Federal PATH allocation was increased from \$2,366,000 to \$2,686,000. The additional funds are being utilized in FY2010 to increase the allocations and numbers of people served by two (2) programs: Beacon Therapeutic Diagnostic and Treatment Center (Chicago) - which serves homeless families, and Shelter Care Ministries (Rockford) - which provides a drop-in center for individuals who are homeless, and to collaborate with IDOC/OMH to develop two (2) FTE positions to work in conjunction with existing PATH programs in Rockford and Chicago; targeting ex-offenders returning to the communities who are homeless with serious mental illness and increasing the availability of much-needed services.

In FY 2009, the Illinois PATH Program received a \$320,000.00 increase in allocation, which enabled an increase in allocations for program enhancements. In FY 2010, due to these enhancements, providers are projected to serve an increase of 106+ more individuals than reported in the Annual Report Data for FY 2009 (3571 served, 1754 enrolled).

In FY 2009 (SFY 2010), IDHS/DMH allocated \$44,000.00 to support the SSI/SSDI, Outreach, Access and Recovery (SOAR) Trainings (SOAR is a nationwide initiative that teaches front-line/outreach workers how to successfully navigate the SSI application process, assemble comprehensive applications for individuals who are homeless with serious mental illness, and receive approvals in an expedited manner. The State PATH Coordinator is a member of the SOAR Training Team and advisory committee – and to date, five (5) trainings have taken place in the cities of Rockford (1) Chicago (2), Hines (1), and Springfield (1). Approximately 144 individuals state-wide have received the training to date – and 13/20 PATH programs have 1-4 staff members who have become SOAR-certified.

Contingent on funds and personnel in FY2011, The “Creating a Clear PATH – with Unlimited Connections”: 2010 Illinois PATH Conference is scheduled to take place September 09-10, 2010, in Springfield, Illinois, and the following presentations are planned: (a) Housing Resources for Individuals who are Homeless, (b) From Outreach to Data: PATH Eligibility and Enrollment Criteria – Process, (c) Working with Families with Serious Mental Illness (SMI), (d) Learning to Listen: Practical Take-aways for Case Managers, (e) Trauma-Informed Services, (f) From Data to Outcomes: Tracking Data/Using Data to Support Programs (g) An Introduction to Cognitive and Behavioral Treatment, (h) Consumer Involvement: Normalizing Disclosure in the Workplace, (i) Harm-Reduction Strategies, and (j) An Overview of the Mental Health Court System. The 2010 list of speakers includes Laura Gillis, Director, and Gloria Dickerson, Recovery Specialist of the PATH TA Center.

Objective A4.1: Utilizing an anticipated increase of \$264,000 in the Illinois Federal PATH allocation, continue to enhance existing PATH programs and increase the number of PATH eligible consumers served in FY2011.

Indicators:

- **Number of persons receiving case management services under the PATH initiative by the end of FY2011.**

- **Number of ex-offenders who are homeless with serious mental illness served by the end of FY2011.**

DMH and Continuums of Care

The U.S. Department of Housing and Urban Development (HUD) initiated the Continuum of Care process in 1994 to encourage a coordinated, strategic approach to planning for programs that assist homeless individuals and families. To apply for federal funding, jurisdictions must submit a continuum of care plan that demonstrates the broad participation of community stakeholders and that identifies the resources and gaps in the community's approach to providing a range of homeless services. Community stakeholders determine local priorities for funding. The fundamental components of a comprehensive Continuum of Care system are:

- Outreach, intake, and assessment to identify the individual's or family's service and housing needs and link them to appropriate housing /service resources.
- Emergency shelters and safe, decent alternatives to living on the streets.
- Transitional housing with supportive services to help people develop the skills necessary to permanent housing.
- Permanent housing and permanent supportive housing.

Significant progress has been reported in the collaboration between homeless service providers and mental health service providers through Continuums of Care. The Division of Mental Health (DMH) is represented on Continuums of Care statewide throughout its Comprehensive Community Service Regions (CCSRs), and its funded Community Mental Health Centers (CMHC's) who are members. In this capacity, DMH and PATH-funded programs are members of the Chicago Alliance to End Homelessness, the Homeless Action Committee – Chicago, and the Alliance to End Homelessness in Suburban Cook County. As a large percentage of persons who are homeless in the Chicago area have diagnosable mental illnesses, HUD funding is vital to support the provision of mental health services and the development of permanent supportive housing. In suburban Cook County, HUD funds support Project WIN (Wellness Initiative Network), which is a multi-agency, multi-service collaboration to provide coordinated care in the areas of mental health, medical health, and substance abuse treatment. To engage persons who are homeless in these critical services, a team of clinicians provides on-site assessments and linkage to mental health services at the emergency shelters.

In Greater Illinois, PATH funded mental health providers are actively involved in Continuums of Care located across the State. Mental Health Centers of Central Illinois (MHCCI) - Springfield, is a member of the Heartland Continuum of Care, Delta Center, Inc. – Cairo (the southern-most tip of the state) and Southern Illinois Regional Social Services (SIRSS) – Carbondale, are members of the Southern Illinois Continuum of Care Network, CBHC of St. Clair County - East St. Louis, is a member of the Homeless Action Council, the Supportive Housing Providers' Association, and the Homeless Action Coalition in St. Clair County. Janet Wattles Center and Shelter Care Ministries - Rockford (northwestern Illinois) are both founding, active members of the Rockford Area

(HUD) Continuum of Care under the auspices of the Winnebago/Boone Counties Mayors' Task Force on Homelessness; (established in Rockford, 1988).

Number of Homeless Persons Receiving Services

A System Performance Indicator was created in FY1999 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. This indicator can be found in the Goals, Targets, and Action Plans section and is now named **Increased Stability in Housing (a National Outcome Measure)**. The indicator provides the number of individuals being served by DMH-funded community-based providers who are reported as homeless or living in shelters at the time of entry into service. In FY2008, 7,121 homeless adults received DMH funded services.

RURAL AREA SERVICES

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.

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 and an array of outpatient services including psychiatric services, community

support, psychosocial rehabilitation, and residential services in rural areas across the state.

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. CCSR staff work closely with mental health providers serving the more sparsely populated rural areas to design a range of services that are as accessible as possible to meet the treatment and support needs of rural residents.

The Stark County Rural Mental Health Initiative

The Stark County Rural Mental Health Initiative is a unique development in rural mental health for Illinois. It demonstrates the resolve of persons residing in sparsely populated rural areas to access the mental health services they require. The grass roots beginning of this initiative, the enthusiasm it engendered, and the regional and state support it has received reflect the nature of rural settings and are evidence of the significant system change that can occur when stakeholders with a common interest work together.

Stark County is a rural county located in north central Illinois, not far from Peoria. The total population of the county is 6,300. A series of mental health related deaths prompted several citizens to become concerned and, in 2004 the Stark County Citizens Mental Health Task Force was formed with a collaboration of citizens, ministers, law enforcement, and a mental health provider. A survey of the county revealed that less than ten individuals in the county were receiving mental health and substance abuse services and that distances to providers in other counties were prohibitive. The Task Force subsequently developed a rural mental health initiative based on the collaboration between the Stark County Citizens' Mental Health Task Force, DMH, and participating regional and local service providers including the Henry-Stark County Health Department, the school district, and the local office of the Illinois Violence Prevention Authority. A CMHC has assigned a full time mental health clinician to the Stark county initiative who now oversees a caseload of sixty persons receiving needed mental health services in the county. The Stark County Rural Mental Health Initiative provides access, education, and advocacy services to the citizens of Stark County. The mission of the initiative is community-based, family-focused and recovery-oriented for persons with mental health and substance abuse problems. Access services provided by the initiative include: mental health and substance abuse screening and treatment; counseling services at school, in the home, or at the DHS Office in the county seat; an on-line community resource directory; and a crisis hotline available 24 hours a day. Educational activities include: training in suicide prevention skills; promoting awareness and understanding of mental health and mental illnesses; and family support. Advocacy occurs at several levels including support to individuals and families as they attempt to access services, collaborative work to improve communication and cut out "red tape", and local and regional interagency collaboration and planning. Sustainability of the initiative is planned through local fundraising efforts and a variety of modest grants.

Use of Communication Technology as a Basis for Service Delivery

In FY2011, as resources allow, 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 for better integration of mental health and primary healthcare programming in rural areas and assist in addressing the shortage of psychiatrists working in rural communities. Public Act 95-16 signed by the Governor in July, 2007 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 tele-psychiatry approaches, such as videoconferencing.

Tracking 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. 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 FY1999, when this system indicator was first established, 25,127 individuals who lived in the 76 rural counties were reported as receiving services. In FY2009, a total of 28,166 adults were served.

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. In Mental Health: A Report of the Surgeon General, (U.S. Department of Health and Human Services. Rockville, MD, 1999), an entire chapter is devoted to mental health issues faced by older adults. The Report states that: “a substantial proportion of the population 55 and older –almost 20 percent of this age group–experience specific mental disorders that are not part of “normal” aging.” (Page335) Estimated prevalence rates for this population were cited: Anxiety Disorder-11.4%; Mood Disorder-4.4%; Schizophrenia-0.6%; Somatization-0.3%; Severe Cognitive Impairment-6.6% and, Any Disorder-19.8%. While older adults may be more vulnerable to experiencing mental health problems, they often do not seek, or are not successful, at linking with needed mental health services. In FY2006, a total of 6,712 individuals over the age of 65 were served, accounting for only 4.6% of the total number of adults served. 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 that represent a variety of mental health older adult provider services and advises the Department on delivery of services to older adults.

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 Geropsychiatric Initiative focuses on three key areas: systems integration, mental health services/consultation and training/education. In FY 2010 there were five funded positions for Geriatric Specialists that cover 27 counties throughout the southern part of the state. However, Geriatric Specialists provided treatment and education resources for mental health services to the aging throughout the state. The Geropsychiatry Initiative received national recognition in 2005, 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 has been proposed by the Illinois Department on Aging, but acquisition of sufficient funding continues to be an obstacle to further development of this valuable resource.

Geropsychiatry for Persons Residing in Rural Areas

In rural areas, the older population often experiences the most difficulty in obtaining services that are geared to their needs. The Geropsychiatric Initiative described above 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.

The Geriatric Advisory Council

The Division of Mental Health convenes an Advisory Committee on Geriatric Services jointly with the Illinois Department on Aging (DOA). This Advisory Committee has focused its efforts on the assessment of the mental health needs of the elderly, identification of model programs, best practices and staff competencies, and increased awareness of geriatric mental health concerns. Training, consultation, and technical assistance in the area of mental health and aging continue to be provided through the efforts of the Advisory Committee. The Council promotes increased awareness of geriatric mental health concerns and has developed a position paper on issues of Self-Neglect that was used widely throughout the state 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 “Grandparents raising Grandchildren Task Force” 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 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 held in April 2009 was attended by well over 300 people –setting a record for the highest attendance for this yearly conference. The keynote theme of the conference was suicide prevention for older persons. A Statewide Conference was not held in FY2010 due to funding reductions. However, two regional conferences were held. One in the central part of the State (DMH Regions 3 and 4) with an attendance of 72 persons and one in the Southern Region (5) which was attended by 180 people.

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 FY2011.**

Criterion 5: Management Systems
--

RESOURCES FOR PROVIDERS

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.

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 FY1973, more than 70% of the mental health budget in FY2008 was allotted to fund community programs.

Since FY1999 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 FY2007 \$12,071,107 was allocated in transition funding to the Regions increasing to \$20,180,848 in FY2009.

Service Enhancement Using Block Grant Funds

Despite the fact that the allocation of Mental Health Block grant funds to Illinois by SAMHSA has decreased over the past four 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 provision of wellness, recovery and action planning (WRAP), community consumer support, crisis care 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. In FY2008, DMH partnered with staff of the Illinois Department of Healthcare and Family Services (DHFS) in applying for and obtaining a federal Medical Emergency Room Diversion (ERD) Grant from CMS. The grant provides \$2 million over a two year period to improve access to, and quality of, primary health care services. DMH was also awarded a SAMHSA Transformation Transfer Initiative grant for \$105,000 that funded a statewide needs assessment of mental health/criminal justice and system mapping initiative.

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 FY2008, careful planning and funding for previously established initiatives proved to be beneficial to mental health consumers both in quality of care and increased financial resources.

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). Since FY 2005, the DMH has received allocations for housing to support persons with mental illnesses. Starting with \$4.7 million in FY2005 additional supportive housing funding has been appropriated by the Legislature annually bringing the total for this initiative to \$14.5 million in FY2008. These dollars led to the addition of 36 new supportive housing projects statewide, and in the last two years, 397 new consumers were served through these appropriations.

SUBSEQUENT TO THE FINAL CLARIFICATION OF THE FY2011 MENTAL HEALTH BUDGET, INSERT PARAGRAPH HERE DOCUMENTING BUDGET REDUCTIONS AND THE IMPACT OF THE ECONOMIC RECESSION

Increasing Federal Financial Participation (FFP)

The content of this section is the same for both the Adult and the Child Plan.

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 adult and child and adolescent mental health services in Illinois. In contrast to FY1991, when Medicaid community billing for adult services was \$130,000, Medicaid billing rose to \$129,028,640 in FY2005.

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 FY2003, 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 (and establishing and implementing the structure for utilization of the Medicaid Trust Fund. 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 FY2003 Medicaid reimbursement through the Trust Fund was \$59 million; in FY2006 it had risen to \$79,689,964. In FY2007, \$84.4 million was deposited in the Trust Fund, and \$85.4 million in deposits was anticipated for FY 2008. The FY2010 amount is not yet available. The focus on increasing Medicaid capture will continue in FY2011.

Medicaid Billing For The Adult Population

Medicaid billing has risen substantially over the years. In FY2005 Medicaid billing for adults had risen to \$129,028,640 and in the following year it was \$149,599,641. By FY2007 it rose to \$164,742,868 and was maintained in FY2008 at \$164,407,968.

Through the Medicaid Rule revision, DMH has improved and clarified the documentation requirements to enhance providers' and states compliance with federal and state Medicaid regulations and expectations. Revisions to the state's Mental Health Medicaid Rule (Rule 132) were implemented in FY2009.

ENHANCING HUMAN RESOURCES

Staff Recruitment and Retention

Human resource development is a critical aspect of community-based services for both adults with serious mental illnesses and children with serious emotional disturbances 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. The continued support of public/academic linkages is one such effort of focus by DMH. 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.

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.

Human Resource Development Relevant To Adult Services

DMH continues to support human resource development through the following activities:

- Providing training events that assist in the implementation of the Recovery Vision in Illinois continues to be a priority. This training is offered statewide through DMH Regions and other venues to providers, consumers, family members and other interested stakeholders.
- 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).
- Tele-psychiatry 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.
- Training in team managed intensive case management has been ongoing in FY2008 with the introduction of the Community Support Teams (CST) and fidelity-related training in ACT.

EMERGENCY SERVICE PROVIDER TRAINING

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. An annual forensic conference that attracts a large audience of law enforcement, mental health, and other first responder personnel was extensively planned in FY2008 and occurred on July 15-17, 2008 (in FY2009).

Emergency and crisis service providers have also participated in a DMH training event focused on legal changes in the Illinois Mental Health Code which impact service provision. Clinical and legal experiences and insights are provided on how to implement changes in civil commitment standards and procedures while safeguarding the rights of recipients and families. Emergency service providers attending have received up-to date information on statutes regarding court-ordered medication, outpatient involuntary treatment, requirements and the clinical justification required for involuntary civil commitment to state hospitals, and guidelines for mental health providers and the rights of recipients under the Illinois Firearms Act. In 2008, the one-day training event successfully attracted nearly a thousand participants in the Northern Illinois in May and 175 participants in the Southern Illinois in November.

CIT Training

. As of February 2009, when it ended, the Cook County Reintegration Initiative had provided training and certification to 242 new CIT officers. By the end of FY2009, the Chicago Police Department trained over 1100 officers in Cook County and extended training to some police departments in Suburban Cook County as well as in other counties such as Rock Island (a CIT project addressing veterans) in Northwest Illinois and McClean County in Central Illinois.

Training and Coordination of Providers of Emergency and Disaster Services

The Governor has designated 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 NIMS, and assisting State funded agencies in the development of local response capability for issues of Mental Health.

In recognition of the potential for natural or terrorist caused disasters in the State, emphasis in disaster planning has been on developing and/or maintaining a local response capacity. This includes educational offerings and the availability of trained mental health professional and paraprofessional volunteers to respond to the needs of their community in time of crisis. A central list of Illinois mental health professionals who are willing to be deployed on an urgent (surge) basis is continually updated as a resource in the event of future terrorist aggression or disaster requiring a mental health response. As necessary, the Red Cross may draw down these volunteers in groups. DMH continues to provide training on disaster response in conjunction with other state agencies and entities.

ADULT- GRANT EXPENDITURE MANNER

Allocation Of Block Grant Dollars In FY2011

Allocations to specific agencies for service provision are displayed in Table 10 which is appended. The Illinois plan for the expenditure of the FY 2011 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. Administrative expenses are capped at 5%.. In FY2010, block grant dollars were allocated (for adults and children combined) as follows:

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

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

Block Grant Allocation - Adult Population

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

DESCRIPTION OF TRANSFORMATION

Background: Illinois Transformation Agenda

Since the President's New Freedom Commission on Mental Health released its final report, the Division of Mental Health 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.**
- 2) Mental health care is consumer and family driven.**
- 3) Disparities in mental health services are eliminated.**
- 4) Early mental health screening, assessment, and referral to services are common practice.**
- 5) Excellent mental health care is delivered and research is accelerated.**
- 6) Technology is used to access mental health care and information.**

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”

The Division of Mental Health (DMH), has continued to emphasize effective coordination of services, cohesiveness, cross-system planning, and the principles of the Recovery Model for the provision of clinical and supportive mental health services. Since 2005, the ideal system of care in Illinois has been characterized as:

- 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.
- 5) For consumers and their families, mental health services need to be integrated with other health and human services so as to appear seamless in access when needed.

In FY2007, extensive discussion in two comprehensive state planning meetings resulted in the current mission and vision statements.

Mission Statement:

“Illinois envisions a well resourced and transformed mental health system that is consumer directed and community driven with a continuum of integrated and effective culturally inclusive programs, 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"

Transformation Activities in FY 2011: 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 that 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. The Adult and Child Plans address the following 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 now making the coordination of primary care with mental health care an area of focus and practice shaping among the CMHCs it funds and has also partnered with staff of the Illinois Department of Healthcare and Family Services (DHFS) in implementing a federal Medical Emergency Room Diversion (ERD) Grant from CMS. NEED UPDATE!
- ❖ DMH has maintained a public awareness campaign aimed at reducing the negative portrayal of mental illness .

Mental health care is consumer and family driven.

- ❖ 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)
- ❖ DMH C&A Services has established a Family Driven Care initiative in Illinois that includes a Family Driven Care Commission and the establishment of "Family Advisory Councils" in each DMH Region to facilitate family friendly services and provide input toward improving the quality of care. DMH continues 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 their statewide deployment 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 Objectives C1.1 and C1.2)

Disparities in mental health services are eliminated.

- ❖ Consistent with this important NFC goal, the DMH continues to track data on gender, race/ethnicity, and age as a means discovering, analyzing, and solving disparity issues.

- ❖ The DMH continues to pursue maintaining access to services by adults with serious mental illnesses in this period of economic crisis.
- ❖ The DMH continues efforts to maintain access to services by children and adolescents with serious emotional disturbance.
- ❖ 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. (See Objective C3.1) 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 access by homeless adults to DMH-funded services has been a priority. This information is being gathered for FY2010 and will be tracked in FY2011. (See System Performance Indicator A-15)
- ❖ DMH continues to track the number of homeless youth entering community-based services. In FY 2009, youth were reported as undomiciled. (See the NOM Performance Indicator for Increased Stability in Housing.)
- ❖ The number of adults and children 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. Tracking and efforts to increase the number of adults in rural areas receiving services will continue to be a priority. (See System Performance Indicator A-25)
- ❖ There also appears to be a trend toward increased access of services by rural youth.
- ❖ The DMH collaborates closely with the Illinois Department On Aging (IDOA) to improve access to mental health services by older adults. In FY2010, the DMH and the IDOA continue to 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.

- ❖ 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 timely 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 Illinois Department of Corrections.
- ❖ Federal Project for Assistance in the Transition from Homelessness (PATH) funding is being directed to expand case management services to more adults who

- are homeless and who are PATH eligible. DMH, in collaboration with ICMHP, has maintained an initiative in each of the five DHS regions to develop and provide Mental Health Early Intervention Services for Children and Adolescents. A major goal of this initiative is to identify and engage children and adolescents with mental illness or social/emotional problems who are untreated, and those at risk of serious emotional disturbance or social/emotional problems. The overall objectives of this initiative are to implement a statewide system of early intervention services and to develop a network of providers who will be able to identify best practice models through their experience. (See Objective C3.3)
- ❖ DMH, in collaboration with ICMHP, has maintained a pilot project in each of the five DHS regions designed to develop and provide mental health services that address the unique and special needs of older adolescents (16-17 years old) with SED who are transitioning from C&A services to adult services and for any youth with SED who is transitioning from correctional services to the community. In addition to providing an array of mental health services these projects are expected to assist in building community infrastructure that will facilitate transition services for youth, improve the effectiveness of services, and support the further development of a system of care for youth in transition. (See Objective C3.2).
 - ❖ The DMH continues 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.

- ❖ The DMH is continuing its work on advancing evidence-based practice in Illinois:
 - DMH is implementing a statewide permanent supportive housing initiative that targets 600 consumers over three years to acquire decent, safe, and affordable housing and support services in a manner consistent with the national standards for this evidence based practice.
 - 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 is continuing. 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.
- ❖ DMH is committed to advancing the implementation of evidence-informed practices in the child and adolescent service system through training events and a

clearly laid out curriculum based upon research and practice experience. (See Objective C1.3).

- ❖ Training in trauma-informed service provision is being provided to child mental health providers, child welfare, and juvenile justice staff through a collaborative effort with DCFS and ICMHP.
- ❖ Early Childhood Mental Health assessment and treatment services for children ages 0-5 and their families was prioritized in FY2010 with the establishment and continuing support of five pilot sites across the State and collaboration with the ICMHP to provide early childhood consultation statewide. (See Objective C3.4)

Technology is used to access mental health care and information.

- ❖ A state-of-the-art management information system (MIS) currently 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 MHCAC will also provide for access to this data by developing a data warehouse that is accessible to DMH staff.
- ❖ 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. DMH C&A Services is implementing a telepsychiatry pilot project in seven rural sites in Illinois and assessing service utilization and the need for further enhancement and expansion in FY2010. (See Objective C4.1)
- ❖ The Child and Adolescent Outcomes Analysis system, a Web-based system that features the ability to generate immediate feedback at the individual, agency, and statewide levels was enhanced in FY2010 and is continuing. (See Objective C2.1)

ADULT- GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: #A-1 (NOM) Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
	Actual	Actual	Projected	Target	Target
Performance Indicator	144,845	129,419	144,845	?	N/A
Numerator	N/A				
Denominator	N/A				

Table Descriptors:

Goal:	To monitor access to services.
Target:	Maintain access to services for adults with mental illnesses at the FY2008 level.
Population:	Adults with mental illnesses.
Criterion:	2:Mental Health System Data Epidemiology
Indicator:	Number of adults served.
Measure:	Number of adults receiving services from DMH-funded community-based providers.
Sources of Information:	DMH ASO Community Reporting System. This indicator is generated from URS Tables 2A and 2B
Special Issues:	The DMH Fiscal Year 2010 community mental health services budget has been cut by 8% or approximately 42 million dollars. The impact on programs/services was described in the mental health block grant plan narrative. Because of the draconian nature of these cuts, DMH is not projecting an increase in access to programs.
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 FY2010 using the methodology described below. The data will be submitted via the URS and will continue to be partitioned by gender, age and race/ethnicity. DMH community funded providers by contract must submit registration and claims data for all individuals receiving services funded using DMH dollars. Data is submitted daily or weekly to the community reporting system maintained by the DMH's Administrative Services Organization (ASO), the Illinois Mental Health Collaborative For Access and Choice. Once this data is processed, it is then transferred to the DMH Data Warehouse for storage. This information is then used to develop reports. FY2009 data will be reported in the FY2009 Implementation Report.

Name of Performance Indicator: #A-2 (NOM) Reduced Utilization of Psychiatric Inpatient Beds -30 days (Percentage)

(1)	(2)	(3)	(5)	(6)	(7)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	13.39	13	12.39	12.39	
Numerator	1,366	1,353			
Denominator	10,205	10,256			

Table Descriptors:

Goal:	To decrease readmissions of individuals to state hospitals within 30 days by providing treatment that results in sufficient clinical stabilization such that subsequent treatment is provided in the least restrictive setting.
Target	Decrease readmissions within 30 Days to state hospitals by 1% based on actual FY2008 value. (FY2009 data not currently available).
Population:	Adults with serious mental illness
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems
Indicator:	Decreased Rate of Civil Readmissions to State Psychiatric Hospitals within thirty days.
Measure:	Numerator: Number of civil readmissions to any state hospital within 30 days. Denominator: Total number of civil discharges in the year.
Sources of Information:	DMH Inpatient Clinical Information System (CIS) This indicator is generated from URS Table 20A.
Special Issues:	There are no special issues that impact this indicator.
Significance:	Individuals with mental illnesses should receive services in the least restrictive settings possible. However, there are times when access to inpatient services is required. Treatment provided in these settings however, should not result in an individual's return to the inpatient setting within a short period of time.
Action Plan:	This data is generated by DMH on an annual basis for evaluation and monitoring purposes. DMH will continue to monitor the number of adults readmitted to state hospitals within 30 days of discharge with a FY 2010 goal of decreasing the level of re-hospitalization through use of services in the community that provide alternatives to re-hospitalization.

Name of Performance Indicator: #A-3 (NOM): Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	23.37	22	21	21	N/A
Numerator	2,385	2,345			
Denominator	10,205	10,256			

Table Descriptors:

Goal:	To decrease readmissions of individuals to state hospitals within 30 days by providing treatment that results in sufficient clinical stabilization such that subsequent treatment is provided in the least restrictive setting.
Target:	Decrease the percentage of 180 day readmissions to DMH State Hospitals by 2% (based on FY2008 indicator value).
Population:	Adults with Serious mental illnesses.
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3. Children’s Services
Indicator:	Decreased Rate of Civil Readmissions to state psychiatric hospitals within 180 days.
Measure:	Numerator: Number of civil readmissions to any state hospital within 180 days. Denominator: Total number of civil discharges in the year.
Sources of Information:	Inpatient Clinical Information System. This indicator is generated from URS Table 20A.
Special Issues:	Note that an incorrect value of 11.43 was reported for FY2007. The FY2008 actual value of 23.37 is however correct and FY2009 and FY2010 projections are based on this value. Individuals with mental illnesses should receive services in the least restrictive settings possible. However, there are times when access to inpatient services is required. Treatment provided in these settings however, should not result in an individual’s return to the inpatient setting within a short period of time
Significance:	
Action Plan:	DMH will continue to monitor the number of adults readmitted to state hospitals within 180 days of discharge with a FY 2010 goal of decreasing the level of re-hospitalization through use of services in the community that provide alternatives to re-hospitalization.

Name of Performance Indicator:#A-4 (NOM):-Evidence Based-Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	2	3	3	3	N/A
Numerator	N/A	--	--	---	
Denominator	N/A	--	--	--	

Table Descriptors:

Goal:	To maintain the availability of EBPs within the state
Target:	Maintain the 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 and data generated From the DMH ASO Community Reporting System.
Special Issues:	EBPs are very difficult to implement requiring the dedication of many resources. As noted previously, the DMH community services budget has been cut by 8% this year. It is unlikely that there will be an increase in the number of EBPs implemented in FY2010. As a general note, many EBPs take multiple years to implement especially without additional or targeted funding to do so. DMH has a goal of increasing the number and type of EBPs provided within the state. During the past few years, DMH has focused on Supported Employment (SE), Assertive community Treatment (ACT) and Permanent Supported Housing. Grant funding from SAMHSA and other sources has been largely used for SE related implementation efforts. Although there is much discussion with regard to Integrated Dual Diagnosis Treatment, Illness Self-Management, and Medication Algorithms there is still much work to do in this arena. DMH has made a concerted effort to implement Supported Housing as noted in the Narrative. However, we will not be reporting on this effort for FY2010.
Significance:	Adults with serious mental illnesses should have access to evidence-based practices.
Action Plan:	As discussed in the narrative, DMH worked with its ASO to implement a new Community Services Reporting System in FY2009. DMH community funded providers by contract must submit registration and claims data for all individuals receiving services funded using DMH dollars. Data is submitted daily or weekly to the community reporting system maintained by the DMH’s Administrative Services Organization (ASO), the Illinois Mental Health Collaborative For Access and Choice. Once this data is processed, it is then transferred to the DMH Data Warehouse for storage. This information is then used to develop reports. The DMH has created special codes for the reporting of ACT and to some extent, SE. Once all data is received for FY2009, the indicator will be calculated and the values will be reported in the FY2009 Implementation Report.

Name of Performance Indicator: #A-5 (NOM)-Evidenced Based- Adults with SMI Receiving Supported Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	N/A	303	200	200	N/A
Numerator					
Denominator					

Table Descriptors:

Goal:	Provide Permanent Supported Housing (PSH) to adults needing these services.
Target:	Increase the number of individuals with SMI receiving permanent supportive housing by 150 in FY2009.
Population:	Adults with serious mental illnesses.
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems
Indicator:	Number of adults with SMI receiving Supported Housing.
Measure:	Number of adults with SMI receiving permanent supportive housing.
Sources of Information:	This data will be generated from a web-based database created especially for this initiative. This indicator will be generated from URS Table 16.
Special Issues:	Individuals receiving permanent supported housing are not required to be registered for mental health treatment services. Therefore, it was necessary to create a special database to track access to and receipt of permanent supportive housing for individuals with SMI.
Significance:	Adults with serious mental illnesses who are in need of supported permanent housing should have access to it.
Action Plan:	The DMH has implemented Permanent Supportive Housing. DMH staff work with The ASO to receive and evaluate applications for permanent supportive housing. A web-based data base is in the process of being created to accept this data. The expected completion date is January 2010. Once implemented, DMH community providers working with Individuals with an interest in residing in permanent supportive housing will submit electronic applications on behalf of consumers. The database that will retain the applications will also collect information with regard to the outcome of the submitted application. This information will then be aggregated and used to provide data on this indicator.

Name of Performance Indicator:#A-6 (NOM)-Evidence Based-Adults with SMI Receiving Supported Employment (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2011 Target
Performance Indicator	1,738	2,026	1,800	1,800	N/A
Numerator					
Denominator					

Table Descriptors:

Goal:	Provide Supported Employment to individuals with SMI who want to receive this service.
Target:	Maintain availability of SE to those individuals receiving it.
Population:	Adults with serious mental illnesses
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems
Indicator:	Number of persons with SMI receiving supported employment
Measure:	Number of adults with SMI receiving supported employment
Sources of Information:	Reports submitted to the DMH Central Office coordinator of supported employment by agencies providing this service. The indicator will be generated from URS Table 16.
Special Issues:	All SE data has not yet integrated into DMH ASO Community Reporting System; Data is being collected through a data base designed for this purpose.
Significance:	Adults with serious mental illnesses who want competitive employment should be able to attain this goal. Supported employment supports adults with SMI in their recovery
Action Plan:	DMH staff have been working with DMH funded community providers to streamline reporting Of data and to report in a more consistent manner. Data regarding some key services has been integrated into the DMH ASO Community Reporting System, however, data for key indicators related to fidelity and outcomes has not. This data is being reported through Excel spreadsheets developed for this purpose. DMH Decision Support staff are working to develop a web-based reporting system to collect this data. It is expected that the design will be complete and available for data submission by late FY2010.

Name of Performance Indicator:#A-7: Evidence Based –Adults with SMI Receiving Assertive Community Treatment (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	674	653	N/A	N/A	N/A
Numerator					
Denominator					

Table Descriptors:

Goal:	Provide access to assertive community treatment
Target:	No target was projected for FY 2009 due to the fact that ACT was revamped to ensure that the EBP is meeting fidelity to the national model. We will consider establishing a target for FY2010 once data is generated for FY2009.
Population:	Adults with serious mental illnesses with multiple psychiatric hospitalizations
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems
Indicator:	Number of adults with SMI receiving ACT
Measure:	Number of adults with SMI receiving ACT
Sources of Information:	DMH ASO Community Reporting System. This indicator will be generated from URS Table 16.
Special Issues:	During FY2009 DMH undertook an effort to ensure that evidence-based assertive community treatment is being provided. All teams underwent a fidelity assessment this year. Fidelity assessments will also be undertaken in FY2010.
Significance:	ACT should be available to individuals who will benefit from this service
Action Plan:	DMH community funded providers by contract must submit registration and claims data for all individuals receiving services funded using DMH dollars. Data is submitted daily or weekly to the community reporting system maintained by the DMH’s Administrative Services Organization (ASO), the Illinois Mental Health Collaborative For Access and Choice. Once this data is processed, it is then transferred to the DMH Data Warehouse for storage. This information is then used to develop reports. This system will be utilized to obtain data for FY2010. FY2009 data will be reported in the FY2009 Implementation Report.

Name of Performance Indicator:#A-8: Evidenced Based- Adults with SMI Receiving Family Psychoeducation (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator		--	---	---	--
Denominator		-	-		---

Table Descriptors:

Goal:	Indicator Not Applicable: The DMH is not currently implementing this EBP.
Target:	No target; planning underway to implement.
Population:	Adults with mental illnesses.
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems
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:	Although DMH continues to have a discussion with a small group of providers regarding implementation of this EBP, DMH is not currently implementing it.
Significance:	
Action Plan	No current plans to implement in FY2010.

Name of Performance Indicator:#A-9 Evidenced Based- Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders (MISA) (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator		--	---	---	--
Denominator		-	-		---

Table Descriptors:

Goal:	Not Currently Applicable. DMH is undertaking planning to continue implementation of IDDT..
Target:	Not Applicable-Zero; still in process of implementing.
Population:	Adults with co-occurring serious mental illnesses and substance abuse disorders.
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems
Indicator:	Number of individuals receiving IDDT services.
Measure:	Number of individuals receiving IDDT /MISA.
Sources of	Not available.

Information:

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

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

Action Plan The DMH will continue its efforts to implement IDDT/MISA during FY2010.

Name of Performance Indicator:#A-10: Evidenced Based- Adults with SMI Receiving Illness Self-Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Projected	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	---	---	--	
Denominator	N/A	-		---	

Table Descriptors:

Goal: Availability of Illness Self- Management-Not Applicable

Target: Not Applicable; Continuing efforts to implement this EBP.

Population: Adults with serious mental illnesses.

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

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

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

Sources of Information: Not implemented ; No data 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 service.

Name of Performance Indicator:#A-11: Evidenced Based- Adults with SMI Receiving Medication Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	--	---	---	--	
Denominator	-	-		---	

Table Descriptors:

Goal: NOT APPLICABLE: Availability of medication management.

Target: Not Applicable 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

Indicator: Number of individuals receiving Medication Management..

Measure: Numerator: Number of individuals receiving Medication Management..
Denominator: Total unduplicated number of adults with SMI served by DMH funded care.

Sources of Information: None currently –not applicable as EBP has not been implemented.

Special Issues:

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

Action Plan The DMH will continue its work with the University of Illinois to implement medication algorithms in state hospitals and community agencies during FY2010.by providing training and support. However, this EBP has not yet been implemented..

Name of Performance Indicator: #A-12 (NOM) Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	60.0	77	61.40	61.40	N/A
Numerator	258				
Denominator	427				

Table Descriptors:

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

Target: Increase perception of positive treatment outcomes by 1% (over that reported in FY2008).

Population: Adults with mental illnesses receiving mental health treatment

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

Indicator: Percentage of adult consumers reporting positively about outcomes.

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

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

Special Issues:

Significance: Mental health services should result in positive outcomes
As in previous fiscal years, DMH will select a random stratified sample of individuals Receiving treatment in June 2009. This sample will be the basis for the survey which will Be disseminated in October 2009 with a goal of all data collected by early November. DMH staff will strive to complete the analysis by the implementation report due date, however data may not be readily available until January 2010.

Action Plan:

Name of Performance Indicator:#A-13 (NOM): Increase/Retained Employment

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	23.49	23.81	24	24	N/A
Numerator	28,199	26,172			
Denominator	120,058	109,924			

Table Descriptors:

Goal:	Increase in competitive employment status by adults with mental illnesses receiving treatment
Target:	Maintain or increase competitive employment rate. (Currently this data is only collected at intake prior to treatment, therefore there is no expectation that there will be an increase. Such a target will be set when we begin collecting data at T1 and T2.)
Population:	Adults with mental illnesses receiving treatment.
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems
Indicator:	Percent of adult clients who are competitively employed.
Measure:	Numerator: Number of adult consumers competitively employed full or part time (includes supported employment). Denominator: Number of adult consumers competitively employed full or part time (includes supported employment)plus number of persons unemployed plus number of persons not in the labor force (includes retired, sheltered employment, sheltered workshops, and other). This does not include persons whose employment status is “not available”
Sources of Information:	DMH ASO Community Reporting System. Employment status is currently reported at case opening or admission.
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:	Although the states, CMHS and the DIG State Data Infrastructure Coordinating Center are still working to define measures for change in Employment status for individuals receiving treatment, the Illinois DMH has developed a policy to require 6 month updates of employment status for consumers. This new requirement will be instrumental in helping to track this important variable across time. Once the quality of data is ascertained through a data integrity plan which is in process of being implemented, DMH will be able to report change in employment status. Employment status will continue to be reported on URS Table 4.

Name of Performance Indicator: #A-14 (NOM) -Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	80.77	N/A	N/A	N/A	N/A
Numerator	21				
Denominator	26				

Table Descriptors:

Goal:	Decreased involvement with the justice system by adults with serious mental illnesses
Target:	No target established as this measure is a developmental measure
Population:	Adults with serious mental illnesses who have had involvement with the justice system
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems
Indicator:	Percent of adult consumers arrested in Year 1 who were not rearrested in Year 2.
Measure:	Numerator: Number of adult consumers arrested in T1 who were not rearrested in T2 (new and continuing clients combined) Denominator: Number of adult consumers arrested in T1 (new and continuing clients combined)
Sources of Information:	This indicator was collected using the MHSIP Survey in FY2008 and will be collected again by this method for FY2009.
Special Issues:	The states, CMHS and the DIG State Data Infrastructure Coordinating Center (NRI) are still working to define a measure for decreased criminal justice involvement.
Significance:	There is an expectation that adults receiving mental health services who have been involved with the justice system will decrease this involvement, however questions remain regarding the appropriate measure.
Action Plan:	Illinois will collect this data using the MHSIP Consumer Survey in 2009. However, due to the small response rate and the developmental nature of the measure NO target has been established for FY2010.

Name of Performance Indicator: #A-15 (NOM) -Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	5.30	5	5	5	N/A
Numerator	7,121	--			
Denominator	134,288				

Table Descriptors:

Goal:	Improve stability of housing for adults with serious mental illnesses
Target:	Track number of individuals who are homeless. This data is collected at intake prior to treatment

so we do not expect change to occur. Once we begin to track data at T1 and T2 we will specify a target.

Population: Adults with serious mental illnesses
Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
Indicator: Percent of adult consumers who are homeless or living in shelters.
Measure: Numerator: Number of adult consumers who are homeless or living in shelters.
 Denominator: All adult consumers with living situation excluding persons with Living Situation Not Available.

Sources of Information: DMH ASO Community Reporting System. .

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

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

Name of Performance Indicator: #A-16 (NOM) Adult -Increased Social Supports/Social Connectedness

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	62.79	N/A	N/A	N/A	N/A
Numerator	275				
Denominator	438				

Table Descriptors:

Goal: Increased perception of social support/connectedness by individuals participating in treatment.
Target: None as we consider this to be a developmental indicator. There is no basis on which to set target. Note that we indicated that the target is not applicable for FY09 in our FY08 Application.
Population: Adults with serious mental illnesses
Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

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

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

Sources of Information: This information was collected as a component of the FY2009 Adult MHSIP Survey.

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

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

Action Plan: The DMH will continue to work with CMHS, NRI and the states to refine this indicator. As in previous fiscal years, DMH will select a random stratified sample of individuals receiving treatment in June 2009. This sample will be the basis for the survey which will be disseminated in October 2009 with a goal of all data collected by early November. DMH staff will strive to complete the analysis by the implementation report due date, however data may not be readily available until January 2010.

Name of Performance Indicator: #A-17 (NOM) Adult -Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	61.98	N/A	63	63	N/A
Numerator	269				
Denominator	434				

Table Descriptors:

Goal: Improved functioning for adults with mental illnesses receiving services

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

Population: Adults with mental illnesses receiving treatment

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

Indicator: Percent of adult consumers reporting positively about functioning.

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

Source of Information: MHSIP Consumer Survey.

Special Issues: .

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. As in previous fiscal years, DMH will select a random stratified sample of individuals

receiving treatment in June 2009. This sample will be the basis for the survey which will be disseminated in October 2009 with a goal of all data collected by early November. DMH staff will strive to complete the analysis by the implementation report due date, however data may not be readily available until January 2010.

Name of Performance Indicator: #A-18 ACT SERVICE HOURS IN COMMUNITY

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	63	68	63	63	N/A
Numerator	38,034	42,651			
Denominator	60,714	62,302			

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:	Maintain delivery of services in community locations at the 63% level. (Note: target is based on FY08 actual data as FY09 data is not currently available.
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:	DMH ASO Community Reporting System.
Special Issues:	ACT services were being revamped in FY2008 in Illinois with an eye toward assuring that the services delivered have fidelity to the EBP model.
Significance:	The ACT model emphasizes provision of services outside of traditional service settings.
Action Plan:	As discussed in the narrative, DMH worked with its ASO to implement a new Community Services Reporting System in FY2009. DMH community funded providers by contract must submit registration and claims data for all individuals receiving services funded using DMH dollars. Data is submitted daily or weekly to the community reporting system maintained by the DMH’s Administrative Services Organization (ASO), the Illinois Mental Health Collaborative For Access and Choice. Once this data is processed, it is then transferred to the DMH Data Warehouse for storage. This information is then used to develop reports. The DMH has created special codes for reporting of ACT. Once all data is received for FY2009, the indicator will be calculated and the values will be reported in the FY2009 Implementation Report..

Name of Performance Indicator: #A-19: Co-Occurring Substance Abuse Disorders –Adults

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	13.6	9.5	13.60	13.60	N/A
Numerator	19,740	12,575			
Denominator	144,845	131,702			

Table Descriptors:

Goal:	To improve identification of individuals 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 DMH ASO Community Reporting System. Moderate change is expected as this is a point in time measure collected at intake.
Population:	Adults with mental illness.
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems
Indicator:	Percentage of adults served with a co-occurring disorders based on diagnostic category.
Measure:	Numerator: Number of adults served in the community with a co-occurring mental health and substance abuse diagnosis at intake. Denominator: Total number of adults served in the fiscal year.
Sources of Information:	DMH ASO Community Reporting System.
Special Issues:	DMH notes that the percentage reported is likely an underestimate.
Significance:	The data reporting system showed that 14% of DMH consumers were identified at intake as having a substance abuse and a mental health diagnosis in FY2008. 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 continues to encourage and support increased training for community mental health professionals in the identification, reporting and treatment of co-occurring disorders. DMH will continue to track the number of individuals reported with co-occurring disorders. time of intake. In FY2009, DMH included an additional variable geared toward determining the extent to which individuals with co-occurring disorders are being screened.

Name of Performance Indicator: #A-20: Eligible Population -Adults

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	90.20	95.20	90.20	90.20	N/A
Numerator	130,675	123,175			
Denominator	144,845	129,419			

Table Descriptors:

Goal:	To assure resources and services are provided to the DMH eligible population
Target:	Maintain performance level of 90%(based on FY08 data—FY09 is unavailable) of individuals

being served by DMH community-based providers meet the DMH eligibility criteria

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: Total number of individuals being served by DMH-funded community-based providers.
Sources of Information: DMH ASO Community Reporting System.
Special Issues: The DMH Fiscal Year 2010 community mental health services budget has been cut by 8% or approximately 42 million dollars. The impact on programs/services was described in the mental health block grant plan narrative. Because of the draconian nature of these cuts, DMH is not projecting an increase in access to programs.
Significance: State mental health resources and services should be provided to the priority populations of the Public mental health system.
Action Plan: In FY2010, DMH will continue to monitor access to services.

Name of Performance Indicator:#A-21: Employment

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	23.4	23	N/A	N/A	N/A
Numerator	28,199				
Denominator	120,058				

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: Percent of adults who are engaged in full or part-time employment that is unsubsidized at case opening.
Measure: Numerator: Number of adult consumers reported employed full or part time in unsubsidized employment at time of case opening...
Denominator: Total number of adults receiving services within the fiscal year
Sources of Information: DMH ASO Community Reporting System. The data from which this indicator is derived is used to complete URS Tables 4 and 5.

Information:

Special Issues:

Significance:

Action Plan:

Employment is a key issue relating to recovery and resilience. In FY2008, employment rates were slightly above 20% at point of intake. This descriptive data, collected 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 supportive employment services.

DMH community funded providers by contract must submit registration and claims data for all individuals receiving services funded using DMH dollars. Data is submitted daily or weekly to the community reporting system maintained by the DMH’s Administrative Services Organization (ASO), the Illinois Mental Health Collaborative For Access and Choice. Once this data is processed, it is then transferred to the DMH Data Warehouse for storage. This information is then used to develop reports. As discussed in the plan narrative, DMH has established a policy requiring providers to update this information on a bi-annual basis. Once it has been determined that the quality of the data is good, DMH will begin to report change data for this variable. Until then DMH plans to continue tracking this data while developing specialized employment services.

Name of Performance Indicator: #A-22: Forensic Outpatient

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	1.80	1.10	1.80	1.80	N/A
Numerator	2,665	1,442			
Denominator	144,845	129,419			

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 DMH ASO Community Reporting System 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 a finding of Not Guilty by Reason of insanity (NGRI), found unfit to stand trial (UST) by criminal court at the time of case opening.
Measure:	Numerator: Number of adults reported as unfit to stand trail, not guilty by reason of insanity or court ordered into treatment at the time of case opening. Denominator: Total number of adults served in the fiscal year.
Sources of Information:	DMH ASO Community Reporting System
Special Issues:	
Significance:	Community mental health staff track forensic outpatient status at the time of case opening.

Nearly 2% 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. (See Objectives A1.5 to A1.10.in Establishment of System of Care section)

Name of Performance Indicator: #A-23: History Of Involvement With The Criminal Justice System

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	2.20	1.93	2.20	2.20	N/A
Numerator	3,185	2,497			
Denominator	144,845	129,419			

Table Descriptors:

Goal: To track forensic status of adult clients served by the Illinois Mental Health system.

Target: Track 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 consumers reporting involvement with the Justice System at the time of case opening.

Measure: Numerator: Number of adults reported as involved with the justice system (e.g. probation, Parole) at the time of case opening.
Denominator: Total number of adults served in the fiscal year.

Sources of Information: DMH ASO Community Reporting System

Special Issues:

Significance: Identifying individuals experiencing involvement with the justice system at time of case opening can increase coordination of services between the mental health and justice systems.

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

Name of Performance Indicator: #A-24: Living Independently

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	79	78.20	79	79	N/A
Numerator	114,101	101,199			
Denominator	144,845	129,419			

Table Descriptors:

Goal:	To track demographic information on living arrangements of adult clients.
Target:	Track number of individuals living independently at case opening. No increase is projected as this data is collected at intake prior to treatment.
Population:	Adults with mental illness.
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems
Indicator:	Percentage of adults living in private residences, unsupervised, and considered to be living independently at the time of case opening.
Measure:	Numerator: Number of adults living in private residence, unsupervised, and considered to be living independently at the time of case opening. Denominator: Total number of adults served in the fiscal year.
Sources of Information:	DMH ASO Community Reporting System
Special Issues:	
Significance:	The proportion of individuals reported as living independently at intake has increased from about 63% to nearly 80% over the past several years. This demonstrates the need for ongoing attention to housing services for individuals with mental illnesses. The increase in consumers who indicate living arrangements of private residence and unsupervised means that targeting of resources to persons with serious mental illness who have the greatest need for housing supports can become more precise.
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.

Name of Performance Indicator: #A-25 RURAL RESIDENTS SERVED –ADULTS

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	35,146	28,166	35,000	35,000	N/A
Numerator	N/A				
Denominator	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 35,000 persons with mental illness in rural areas of the state.
Population:	Adults with mental illness.
Criterion:	4:Targeted Services to Rural and Homeless Populations
Indicator:	Number of individuals being served by DMH-funded community-based providers who are

residents of rural areas at the time of entry into services.

- Measure:** Number of individuals reported by DMH-funded community-based providers who are residents of rural areas at the time of entry into services.
- Sources of Information:** DMH ASO Community Reporting System
- 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.

Name of Performance Indicator#A-26 Target Population-Adults

1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	58.71	61.30	58.80	58.80	N/A
Numerator	85,047	79,321			
Denominator	144,845	129,419			

Table Descriptors:

- Goal:** To assure resources and services are provided to the priority population of the publicly funded mental health system.
- Target:** Increase service level for persons with severe mental illness receiving mental health services in the publicly funded mental health system. Please note that target is based on FY08 data as FY09 data is not yet available.
- Population:** Adults with serious mental illnesses.
- Criterion:** 2:Mental Health System Data Epidemiology
- Indicator:** Percentage of individuals being served by DMH-funded community-based providers who meet the established criteria for “target population” at the time of entry into services.
- Measure:** Numerator: Number of adults being served by DMH-funded community-based providers who meet the established criteria for “target population” at the time of entry into services.
Denominator: All adults being served by DMH-funded community-based providers.
- Sources of Information:** DMH ASO Community Reporting System
- Special Issues:**
- Significance:** The target group of adults with serious mental illnesses (SMI) is the priority population for the delivery of mental health services.

Action Plan: DMH will continue to monitor service provision to assure that individuals with severe mental illness receive priority services.

Name of Performance Indicator:#A-27 Vocational Placement (Percentage of adults engaged in full or part-time employment in subsidized, supported or sheltered employment)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	2.30	2	2.30	2.30	N/A
Numerator	3,287	2,675			
Denominator	144,845	129,419			

Table Descriptors:

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

Target: Maintain FY2008 target of 2.3%. (Please note that FY09 data is not yet available)

Population: Adults with mental illnesses.

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

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

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

Sources of Information: DMH ASO Community Reporting System

Special Issues:

Significance: Employment is a key issue relating to recovery and resilience. At intake in FY 2008, Vocational placement levels were at slightly less than 3%. This descriptive data collected at intake –before services are initiated – is not expected to change over time. 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.

SECTION III-B
CHILD AND ADOLESCENT (C&A) SERVICES PLAN

Criterion 1. Comprehensive Community-based Mental Health System
--

ESTABLISHMENT OF THE SYSTEM OF CARE

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 with activities directed toward increasing family voice and participation in the provision of C&A services statewide and in DMH Regions. DMH continues to:

- Support the establishment of Family Resource Developers within Screening Assessment and Support Services (SASS) programs by contracting for assistance and training for FRD's through the Illinois Federation of Families, and through the involvement in the monthly FRD meetings of the DMH Family Consumer Specialists.
- Employ Family Consumer Specialists (FCS) as C & A staff members of DMH in each region of the state. All five of the DMH regions now have a Family Consumer Specialist actively involved.
- Increase family participation in Regional Planning Councils, and the IMHPAC. The Child and Adolescent sub-committee of the Illinois Mental Health Planning and Advisory Council has been successfully co-chaired by a parent who exhibits strong leadership and advocacy skills and a community mental health agency director.. This committee has become increasingly influential within the IMHPAC. Regional family advisory committees are now operating under the leadership of the family consumer specialists in each region.
- 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. The ICG parent group continues to be a robust voice in the development of child services in Illinois. DMH staff continue to play a supportive role and provide logistical support to the ICG parent group. This includes family notifications, supporting costs for meeting space, and technical assistance and education.
- Require that Family Resource Developers are members of the Community Support Team when these teams are providing services to youth and their families.

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. A survey of agencies is currently underway to determine the number of FRD's being employed and the turnover rate for these positions.

Monthly meetings are held for the FRDs in order to provide education, resource development and support for the positions. It is noteworthy that their support role has expanded as some agencies are using FRDs to assist with Individual Care Grant application processes and service planning. Other agencies have hired more than one FRD into their agency as they continue to recognize the value of the position.

Objective C1.1. Continue to facilitate parent-to-parent support through the use of Family Resource Developers and continue work with parents and parent-led organizations 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 FY2011.**
- **Number of FRD's hired in C & A programs other than SASS.**
- **By the end of FY 2011, maintain five Family Consumer Specialists and convene the Family Advisory Councils, one in each DMH region, to provide family voice to the DMH system and to increase the extent to which the DMH service system is family driven.**

Family Advisory Councils

The state currently operates five (5) 'Family Advisory Councils', one in each DMH region. These Family Councils include both parents and youth and are convened by the DMH Family Consumer Specialist in each region. The Councils are also part of the effort to move the system towards Family Driven Care.

The Family Driven Care Initiative

In 2009 Illinois was one of six states that received a SAMHSA award that paid expenses to participate in a policy academy focused on Family Driven Care. This project has supported collaboration with other child serving systems and supporters (DCFS, ISBE, CHP, DJJ, DASA, IFF, ICMHP) to address the extent to which the system is Family Driven. The one-year project involves work towards goals of a qualitative and quantitative survey of families and providers, development of a multi-agency Family Driven Care Commission, and the beginning development of a state recognized certification for parent providers. The initiative will not be finalized at the end of the year, and the expectation is that moving the system to truly family driven care will be an on-going effort for several years.

Objective C1.2.: In FY2011 advance Family Driven Care in Illinois by (1) developing the competency requirements and curriculum for the certification of parent providers as Family Partner Professionals. (2) Continue to educate family members and caregivers through monthly parent empowerment teleconferencing.

Indicators:

- **A proposal of a protocol for certification and an established curriculum are completed by the end of the fiscal year.**
- **Number of statewide parent empowerment calls completed and the number of parents participating in the calls.**

Teen WRAP

The WRAP curriculum was modified to address the needs of youth. There are three agencies piloting WRAP in Chicago, one in LaSalle, the forensic adolescent inpatient unit in Springfield, and a sixth agency in southeastern Illinois. Representatives of the pilot sites for Teen WRAP meet monthly via teleconference to review the status of this new and innovative project throughout the past year. Agencies as a whole have had very good success in running Teen WRAP groups and have provided them in various locations and with various age groups. The Teen WRAP committee continues to operate and a ‘refresher’ training brought these agencies together again in 2009. Discussions are ongoing to consider how to bring this curriculum to a larger scale. This new adaptive program has been well received with satisfactory results and appears to have a promising future.

Evidence-Informed and Evidence-Based Practices

DMH has an evidence based practice subcommittee that is co-chaired by DMH staff and a leader of the Community Behavioral Healthcare Association, the trade organization of the mental health centers. This committee is comprised of a diverse membership; including parents, university professors, child advocacy organizations, community mental health agencies and DMH staff. Recognizing the extreme diversity of the population in Illinois and the narrow definition of specific EBP models, the EBP committee advised the DMH C&A Statewide Office to actively promote Evidence Informed Practice (EIP). Evidence Informed Practice is defined as “a collaborative effort by children, families and practitioners to identify and implement practices that are appropriate to the needs of the child and family, reflective of available research, and measured to ensure the selected practices lead to improved meaningful outcomes”. As a result, the three Evidence-Based Practices identified as National Outcome Measures (NOMs) are not being implemented in Illinois. These are:

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

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

1. Educate C & A agency leadership on an Evidence Based Practice Paradigm.
2. Train providers in specific evidence-based treatments.
3. Develop partnerships between universities that train the C & A workforce and the community provider, agencies. Develop the ability of training institutions to teach evidence-based practice during the early training of practitioners.
4. Review the extent to which Illinois Division of Mental Health policy supports or impedes evidence based practices.
5. Provide education to consumers on evidence-based practice.

During FY2010 a significant amount of progress has been achieved toward these strategies:

Training For Providers:

- As of the end of FY2009, 27 agency groups had participated in this series. Importantly, in the Spring of 2009 the evaluation of this project indicated that youth who were treated by clinicians who participated in these trainings improved at statistically superior rates versus those treated by comparison clinicians. The training model has been adapted, and outcomes for each cohort will continue to be evaluated to rate the impact of the model with youth outcomes.
- In FY2009 Illinois started a Learning Collaborative pilot with 12 community mental health agencies. The learning collaborative group meets monthly for 6 months. The topic being focused on is evidence based engagement strategies. Mary McKay PhD is the expert technical consultant. The initial response has been extremely positive from the participants and data from the evaluation should be forthcoming in Fall 2009.
- DMH required C & A providers to participate in a web-based outcome analysis system effective on 7/1/09. This system allows families, providers, supervisors, agency directors and the state mental health authority to access data which can be used to inform decisions regarding effectiveness of service, training needs of the system, and a description of the system as a whole. Clinicians use the OHIO Scale and families and youth complete the Columbia Impairment Scale on a quarterly basis. Training efforts have been underway to orient the child serving agencies to effectively utilize these instruments and technologies. **(See Objective C2.1 in the Quantitative Targets section)**
- Northern Illinois University is developing a virtual classroom that can be used by all the community mental health providers serving children, and another that will support information for families.

Partnerships with Universities

In FY2008, three Masters level training programs across the state began to graduate students with certifications in evidence based child and adolescent services. These three programs have continued and are graduating their second cohort. An effort is underway to add a fourth program in the southern part of the state during FY2011. This initiative

will increase the ability of the workforce to provide evidence-based intervention to youth in Illinois in the long term.

Education to Consumers

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

The following objective will continue to be a priority for FY 2011:

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

- **Implement video based training methodologies in an effort to further disseminate the current training resources to the more rural areas of the state.**
- **Broaden the impact of the EBP certification program by contracting with a fourth training University in the southern area of the state.**
- **Continue to offer training opportunities on evidence-based engagement strategies**

Indicators:

- **Number of training events provided in FY 2011 which advance evidence-informed practices.**
- **A virtual classroom system is operational by the end of the fiscal year.**
- **A contract and curriculum is established with a fourth university to provide certification at the graduate level.**

Individual Care Grants for Children with Mental Illness

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

Community-based ICG services are coordinated through agencies funded to provide SASS services. Agency staff work with families to identify appropriate support services. As of April 1, 2009 the Collaborative began administering the community-based ICG program. The SASS agency serves as a fiscal agent by purchasing the services specified in the approved plan and monitoring their effectiveness in meeting the youth's clinical needs. ICG services are available across the state.*

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

Progress in FY2010

In FY2010, the ICG Program received 657 requests for applications. Of the 263 applications returned to the ICG Program for eligibility determination, 47 grants were awarded this fiscal year. This is consistent with the number of awards over FY2009. In FY2010, 150 youth were served in Community-Based care out of the 374 youth in the ICG Program, which represented 40% of the total population and is consistent with the percent served in Community-Based care in FY2009.

The Illinois Mental Health Collaborative for Access and Choice (hereafter the Collaborative), has continued to oversee the administrative procedures of the ICG

* Four categories of services are available to ICG recipients under the community-based model. These include:

1. Therapeutic Stabilization is 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 B is 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 B are 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.

4. Young Adult Support Services B are 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.

Program. In FY2010, ICG Providers were expected to bill all treatment encounters as fee-for-service and the Collaborative conducted Post-Payment Reviews to monitor ICG Provider compliance with the Illinois Medicaid Rule.

In FY2010, the ICG Program continued the use of the Ohio Scales and the Columbia Impairment Scale as outcome measures for ICG recipients. Residential and Community-Based providers continue to report this data on a quarterly basis. This information is available for provider review and analysis of treatment progress of ICG youth. In FY2010, Residential ICG Providers entered 65 new youth into the Ohio Scales and Columbia Impairment Scale systems. From July 1, 2009 to July 1, 2010 outcome baselines utilizing the Ohio Scales and the Columbia Impairment Scale will be obtained.

The ICG program continues to strive for continuity of services. In FY2010 transition to the Illinois Medicaid Rule (Rule 132) continued and required a focus on treatment practices and claiming practices. The ICG program adapted a Child and Family Team (CFT) model in FY2010 as a means of improving communication between providers and families, improving the transitional process and continuity of services for youth transitioning from residential to community services, and reducing length of stay in residential facilities. Training in the model included parents/caregivers, community based ICG/SASS workers, residential providers, the children themselves, and any others who could participate as team members.

Objective C1.4. In FY2011, continue to strengthen community service options in the DMH ICG program through increasing the number of youth served, implementation of outcome measures, and the use of a Child Family Team (CFT) approach.

Indicators:

- **Number of children served through ICG community service options in FY 2011.**
- **Evaluation of first year results of the implementation of outcome measures.**
- **Number of functional Child and Family Teams by the end of FY2011.**

Public Awareness 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 families and children experience when afflicted with serious emotional disturbances and mental disorders. *The DMH "Say It Out Loud" Campaign is directed to adults, children and families. For a description of the campaign, see Adult-New Developments and Issues and the Adult Plan-Establishment of System of Care.*

Assessing Parent/Caregivers Perception of Care

The DMH uses the National Outcome Measures (NOMS) along with additional system indicators to track mental health system service delivery and outcomes to aid in service planning. The Division has adopted the MHSIP: Youth Services Survey for Families to collect feedback from caregivers of children ages 0 – 12 who are receiving community mental health services funded by the DMH. The survey has been successfully completed annually since FY2007. The measures reported through the survey are: Client Perception of Care, Increased Social Supports/Social Connectedness, and Improved Level of Functioning.

The Youth Services Survey for Families is part of the Mental Health Statistics Improvement Program (MHSIP) Quality Report performance measures. The annual surveys address two goals of the Division: data-based decision-making in a continuous quality improvement environment and to enhance and expand the involvement of families and caregivers in the review, planning, evaluation and delivery of mental health services. Variables included in the analysis are: residence in Chicago, severity of emotional disturbance, race/ethnicity, and length of time in treatment. The information compiled in this report can be used for management, planning, quality improvement and feedback to providers, consumers and family members regarding state and federally funded services. The survey will be conducted again in FY 2011.

Objective C1.5 (NOM): The percentage of parents/caregivers reporting positive outcomes through the Youth Services Survey for Families will increase in FY2011. (Please note that an increase in return to/stay in school and a decrease in criminal justice involvement is not projected due to the developmental nature of these indicators. These indicators are however listed below.)

Indicators:

Percentage of parents/caregivers reporting positively about outcomes with reference to the following national outcome measures:

- **Client Perception of Care (Outcomes Domain)**
- **Return To/Stay in School**
- **Decreased Criminal Justice Involvement**
- **Increased Social Supports/Social Connectedness**
- **Improved Level of Functioning**

Other C&A Performance Indicators

Performance indicators are described in the Child-Goals, Targets and Action Plans section.

The web based outcomes analysis system noted above allows families, providers, supervisors, agency directors and the state mental health authority to access data which can be used to inform decisions regarding effectiveness of service, training needs of the

system, and a description of the system as a whole. The aggregate data provided (See Objective C2.1 in the Quantitative Targets section) from this system also offers opportunity for additional performance measurements.

AVAILABLE SERVICES

Available Services and Resources in the Comprehensive System of Care

Health, Mental Health and Rehabilitation.

Health

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.

Illinois Health Care Programs: The State of Illinois provides access to health care for children and adolescents through All Kids which is administered by the Illinois Department of Health Care and Family Services (DHFS). Funded by the Legislature in FY2006, this state program offers comprehensive, affordable health insurance for children in Illinois. It was the first program in the nation to make sure that every uninsured child, regardless of income or medical condition has access to health care. 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. Children must have had no insurance coverage for a 12 month period to qualify for All Kids except for a newborn child, a parent who lost a job which had provided insurance benefits, and a child on COBRA insurance. 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 and ranges from no monthly costs to affordable and 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 income limits which go up as the family size goes up. For example, a family of four can make up to \$ 44,000 per year and be eligible for Family Care. Parents must be US citizens or meet immigration requirements.

AllKids has two programs for pregnant women: Medicaid Presumptive Eligibility (MPE) offers immediate, temporary coverage for outpatient healthcare for pregnant women

including pre-natal checkups, doctor visits, lab tests, prenatal vitamins, medicine, specialty medical care, eye care, dental care, emergency room care, mental health and substance abuse services, and transportation to get medical care and other services. Moms & Babies covers healthcare for women while they are pregnant and for 60 days after the baby is born. Moms & Babies covers all the outpatient health services listed above, hospital services including labor and delivery, and provides for services to the baby up to one year after birth. There are no co-payments or premiums.

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.allkids.com.

Mental Health Services

The array of core mental health services purchased on behalf of Illinois citizens with mental illnesses are based on the tenets of the Community Support Program (CSP) and Child and Adolescent Support Services (CASSP) models. 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 the 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. The core outpatient services include Assessment, Treatment Planning and Monitoring; Counseling and Therapy Services; Psychiatric Services; and Medication-related Services. Youth with serious emotional disturbances and their families may receive specialized services including Screening, Assessment and Support Services (SASS); Child and Adolescent Wraparound Services; and services through the Individual Care Grant Program for Children with Mental Illness (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 Department of Children & Family Services (DCFS) and the Department of Healthcare & Family Services (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.

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.

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 have 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 and to improve the coordination of psychiatric and vocational services. Locally, services for youth and adults are obtained through joint planning and service efforts by community mental health centers (CMHCs) and local offices of DRS.

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. DRS has 150 STEP contracts which serve approximately 600 high schools.

- DRS maintains Cooperative Agreements with Illinois State Board of Education and local school districts. DRS Transition Specialists participate in ongoing education/vocational rehabilitation planning 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. Each DHS/DRS office assigns Vocational Rehabilitation counselors to schools to assist students' transition from school to work.
- 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. 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.

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 if they are living with an adult consumer who is 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 residential treatment programs by DCFS.

Education Services

Special Education In Illinois

The Illinois State Board of Education (ISBE) reports that 14.7% of Illinois students of school age (ages 6-21) received special education services in the 2007-2008 school year. Of those receiving special education services, 9.4% were classified as Emotionally Disturbed (ED) (26,413 students), the special education category that most closely approximates the federal definition of Serious Emotional Disturbance. Another 10,610 students were classified under Autism. For pre-school children ages 3-5 years, the number receiving special education services has increased annually from 31,389 in 2002-2003 to 37,137 in 2007, but showed a very slight decline in 2008 (37,035). 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. A gradual increase in the number identified with Autism from 2.9% in 2003 to 4.2% in 2008 reflects greater accuracy in the early childhood diagnosis of this disorder. ISBE identified 158 children in this age group as being in the ED category bringing the total number of children ages 3-21 classified with an emotional disability in 2008 to 26,571. This total number reflects a decrease of almost 1% in the past two school years.

Transitional Education

Legislation established uniformity in the School Code so that students statewide are 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. 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.

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 to them can be facilitated by the mental health provider.

Support Services

IDHS

A variety 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 family entitlements and identifying those IDHS families who are in need of assistance in accessing mental health services for their children.

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 no more than \$50,000. The program currently serves 29 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. The treatment of disorders of youth in the juvenile justice system with psychopharmacological and behavioral interventions, which are usually more successful when they are coordinated with other major service systems impacting the child and family. DMH has funded the Mental Health Juvenile Justice Initiative since FY2000 to address this need. This successful initiative is now statewide and provides services to juveniles detained in all the detention centers in Illinois.

Post-Traumatic Services

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 this initiative. Since FY2008, when funding was provided through the Illinois Children's Mental Health Partnership to expand this education and training initiative to mental health providers, DMH C&A staff have worked closely with DCFS to adapt the components of the DCFS approach and develop an effective training model to support mental health trauma work with children. The Train-the Trainer phase was completed and certified trainers began delivering training to DCFS and DMH funded provider staff in FY2009.

Case Management for Children and Adolescents

Youth with serious emotional disturbances and their families, by the nature of their difficulties, cannot be served in isolation. Case Management, a required service for youth with serious emotional disturbances who receive substantial services through the public mental health system, 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 and sustain youth with serious emotional disturbance in the community. Community mental health agencies serving children participate in local networks of child-serving agencies, which facilitate supportive services to families. In an outpatient setting, case management 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. Intensive case management is provided to especially high risk groupings 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, 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.

Each region has conducted pilot projects for 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 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 members were 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. These programs have provided essential information on the service models that work best.

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 fifteen residents and the SIRSS program in Carbondale serves ten. An oversight committee composed of staff and providers from both departments meets monthly to review and develop a common agenda and work out problematic situations. DCFS funded providers and mental health providers have been successful in resolving conflicts stemming from 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 FY1989 to 58 in FY2009. 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 that 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.

Decreased Rate of Readmissions

DMH will continue to monitor the number of youth readmitted to state hospitals within 30 days of discharge and the number of youth readmitted to state hospitals within 180 days of discharge with a FY 2011 goal of maintaining or decreasing the level of re-hospitalization through the use of community based services that provide alternatives to hospitalization. See the Child-Goals, Targets, and Action Plans section for data and information about these indicators which are a National Outcome Measure (NOM)

Objective C1.6(NOM): Continue efforts to decrease 30 day and 180 day readmission rates to DMH state hospitals.

Indicators:

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

Criterion 2: Mental Health System Data Epidemiology
--

ESTIMATE OF PREVALENCE

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 midpoint of the number estimated at the lower limit of a level of functioning of 50 (LOF=50) and the number estimated at the upper limit of that level of functioning (LOF=50 to 60). The figure has been updated by CMHS using 2008 census information to 111,086 or 7% of the population of children and adolescents aged 9 to 17 based on a 13.4% (FY2007) poverty rate.

QUANTITATIVE TARGETS

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. Two groups of consumers are the focus for service provision: a larger “eligible” group and a smaller “target” group. Persons who fall in the eligible group meet minimum criteria of mental illness or

emotional disorder as well as significant impairment in life functioning and may be served in the Illinois mental health system. Persons who are considered part of the “target” population meet much stricter criteria, have a more debilitating level of impairment due to mental illness and 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 un-served portion of the total estimated prevalence is contingent upon the availability of utilization data for psychiatric services provided in the private sector. That data 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.

Children and Adolescents Receiving Services in FY2009

DMH Target Population

In FY2008, the percentage of children and adolescents meeting the DMH target population criteria was 40.1%. This percentage was maintained in FY2009. Data for FY2010 will be provided in the Implementation Report. Since FY2005, the data for this indicator has likely been an underestimate due to the fact that the DMH still has no access to SASS data.

DMH Eligible Population

The number of youth with Serious Emotional Disturbance (eligible population) reported served in FY 2009 was 34,959 approximately 94.5% of the total served- an increase from the percentage served in FY 2008 (88.4%). FY 2010 data 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.

DMH tracks access through three key performance indicators. These are:

Increased Access to Services (NOM)

Indicator:

- Number of persons served.

Increased Access to Services by the DMH Target Population

Indicator:

- Percentage of the DMH Child/Adolescent target population receiving services.

Increased Access to Services by the DMH Eligible Population

Indicator:

- Percentage of the DMH Child/Adolescent eligible population receiving services

Progress In Performance Measurement for Children and Adolescents with SED

See the **Adult Plan- Quantitative Targets** for a discussion of progress in performance measurement and Illinois experience of collaboration with federal initiatives. This background is applicable to children's services as well as adults.

Child and Adolescent Outcomes Analysis: . The web-base Outcomes Analysis System began operating in July of 2008 The system consists of four measures: (1) The OHIO Scale-Worker version; (2) The Columbia Impairment Scale for Parents; (3) The Columbia Impairment Scale for Youth; and (4) Goal Attainment Scaling methodology (optional). The instruments are used at case opening, quarterly thereafter, and at closing. Users of the web-based system will be able to generate immediate feedback reports at each level of service. Clinicians will be able to generate reports and graphic profiles on their individual clients across specified time periods that are shared with the client and family. Access to this data is a valuable benefit to the client and family as a means of being able to see, use, and share an objective assessment of progress and accomplishments as well as identification of issues to work on. A term coined to describe this aspect is "refrigerator art"- something posted in a common place for all the family to see. 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.. . Implementation has gone well and has included training in the instruments and monthly Technical Assistance calls and Net meetings for users of the system. As of October 15th, 2009, 145 agencies were participating with 1923 users in the system. A total of 24,033 youth had received assessments and 44,421 Ohio scales had been completed. The average initial score statewide on the Columbia Scale-Parent Version was 22.48 and 22.33 at the 90 day reassessment. On the Columbia Scale –Youth Version, the statewide initial score was 17.92 decreasing to 16.17 at 90 days. The Initial Ohio Problem Score was 23.48 decreasing to 19.96 at 90 days (a 17% reduction), and the Initial Ohio Functioning Score was 46.25 increasing to 48.94. These results indicate

improvement in the youth who have so far been assessed. As the data comes in it is clear that the youth in the system in Illinois are overall making progress in their care.

In FY2010 the Outcomes system was expanded to include the Devereux Early Childhood Assessment Scales (DECA), an instrument to be used with children age 0 – 5. The DECA assessments for infants, toddlers and clinicians were added to the web system and trainings were held for providers on both use of the instruments and mental health work with young children.

Objective C2.1: By the end of FY2011, fully integrate the Web-based system into treatment planning and agency decision-making. Implement the Devereux Early Childhood Assessment Scales(DECA) and provide training for all providers serving young children ages 0-5.

Indicators:

- The number of agencies utilizing the web-based outcomes analysis system and able to include functional assessments in the billing process.
- The number of training sessions devoted to integration of the web-based clinical outcomes system into clinical practice
- The number of early childhood providers reporting DECA assessments.
- The number of DECA assessments reported by the end of FY2011.

Criterion 3: Children’s Services

SYSTEM OF INTEGRATED SERVICES

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: 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.

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 DMH has actively pursued interagency collaboration with other departments invested in providing 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 facilitated 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 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).

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 local collaborations exist such as the collaboration of the McHenry County 708 Board and the University of Illinois - Rockford on a SAMHSA System of Care grant .

SOCIAL SERVICES

The DMH collaborates with other IDHS Divisions such as Human Capital Division and Community Health and Prevention as well as free-standing state agencies such as DCFS and DHFS to access many of the social services that are needed by children and adolescents and their families.

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 that focuses on strengths and needs across multiple settings.

Teen R.E.A.C.H

Teen Reach was developed by the DHS Division of Community Health and Prevention (DCHP) and has now been in existence for twelve years. By the end of FY 2009, this program had grown to an expenditure of \$ \$15.7 million encompassing 90 community-based agencies which served 25,944 youth between the ages of 6 and 17. 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.

EDUCATIONAL SERVICES Including Services Provided Under the Individuals with Disabilities Education Act (IDEA)

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. The DMH developed the Positive Behavioral Interventions and Supports (PBIS) 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.

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

McHenry County Family CARE (Child & Adolescent Recovery Experience) emphasizes the use of the System of Care values and principles to empower youth and families as well as to implement system-wide collaboration. The use of Child and Family Teams engages traditional and non-traditional supports in care planning while family members are taught how to manage their care, resources and desired outcomes. Parents of SED youth, are employed throughout the community as Family Resource Developers and Child and Family Team Facilitators, providing peer support and resources to family members in need and assisting them in navigating mental health and education systems. across the county. A variety of committees including an active Family Council and Youth Council have been formed and are meeting with the aim of involving stakeholders in designing effective mental health services which build on the strengths of consumers and address cultural and linguistic needs. A Governance Council includes professionals, family members and youth to 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.

The goals of the McHenry County Child and Adolescent Recovery Experience (Family CARE) have been to:

- Enhance the capacity, accessibility, availability, and quality of services and supports for youth with complex behavioral and emotional needs with a special emphasis on the following populations: early childhood (0-7), transition age youth (17-22), youth with a co-occurring mental health and substance use disorder, and Latino Youth.
- Develop a network of culturally and linguistically sensitive services and supports for youth with complex behavioral and emotional needs.

- Develop additional peer-to-peer support options available to youth with complex behavioral and emotional needs, and their parents, across the community.
- Fully implement national and local evaluations and track the system of care in order to evaluate system processes and track the improved functioning of youth with complex behavioral and emotional needs within the four populations of focus, and their families, within the community.

As Family CARE moves forward, significant effort is placed on promoting Evidence Informed Practices which includes enhancing school/mental health partnerships, developing a trauma-informed system of care, collaborative cross-system training and professional development, the development of a local family organization, and cultural competency organizational planning and implementation. School coordinators, who may also be parents of SED youth, are partnered within several local school districts to help facilitate program access and keep school personnel linked with vital community resources. The team obtained a suicide-prevention grant from another source to provide suicide-prevention training for system of care families, youth, and partners. Recent process evaluation has highlighted the need for the initiative to further expand the continuum of care, continue strengthening the Governance Council, engage more community partners in system of care development, adhere to a logic model/strategic plan and significantly increase the focus on evaluation and continuous quality improvement.

Social Emotional Learning in Illinois Schools

The DMH has continued its on-going collaborative efforts with the Children's Mental Health Partnership in FY2008. 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.

JUVENILE JUSTICE SERVICES

Youth in the juvenile justice system have disorders that can be effectively treated with psychopharmacological and behavioral interventions. These interventions are usually more successful when they are coordinated with other major service systems impacting the child and family. Research has demonstrated that the majority of juveniles in

detention centers meet the criteria for a psychiatric diagnosis and one in six has a serious mental illness. Many of those also have a co-morbid substance abuse disorder (Teplin, et al. 2005). The juvenile justice system frequently either fails to identify these youth or fails to provide the necessary mental health treatment. The Mental Health Juvenile Justice (MHJJ) program was conceived and implemented to address this critical need. MHJJ provides an alternative to incarceration for juvenile detainees with serious mental illnesses, by arranging for the necessary mental health services to address individual clinical needs.

Mental Health and Juvenile Justice

Mental Health Juvenile Justice Program (MHJJ) is designed to divert youth, with serious mental illnesses, from the juvenile justice system and into community-based care. The Division of Mental Health initially funded MHJJ as a pilot project in 2000 in just seven counties and was subsequently expanded to each of the 17 Illinois counties with a detention center and one county without a detention center. The program was initially conceived as an alternative to secure detention, though eligibility criteria have been expanded to intercept youth at the earliest stages of justice involvement. In FY'08 two additional community agencies in Cook County offered MHJJ services with the goal increasing outreach and linkage to the Latino community. The MHJJ program now covers 34 Illinois counties, involves 21 community agencies and has approximately 60 staff.

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

The data for the FY 2009 indicators and the Year-to-date data for FY 2010 are detailed below:

FY'09	= 1319referred	FY '09 = 82.54 % linked to services
	= 644 screened	FY '09 = 31.3% re-arrest rate
	= 596 eligible	

	= 565 enrolled	
FY '10	= 1052 referred	FY '10 = 71.9% linked to services
(thru May 19, '10)	= 453 screened	FY '10 = 17.8% re-arrest rate
	= 411 eligible	
	= 374 enrolled	

In FY'10, minority enrollment continued to increase. This trend is consistent with past findings. It is also reflective of the MHJJ program's targeted outreach to, and education of, referral sources regarding minority youth with serious mental illnesses. Continuously increasing the percentage of minority youth referred and percentage of minority youth enrolled will continue to be a priority objective for the program particularly in light of the overrepresentation of minority youth in the juvenile justice system.

In FY'11, the overall mission of MHJJ will remain unchanged and liaisons will continue their efforts to intercept youth at the earliest stages of their justice involvement. Since the number of service sessions is associated with positive outcomes maintaining and increasing the number of service sessions offered will continue to be a priority. MHJJ has continuously increased clinical services most strongly associated with positive outcomes. Ongoing evaluation of such correlations will facilitate efforts to provide services proven most effective in improving overall functioning of these youth. The annual evaluation and outcome analysis consistently demonstrates that completion of the MHJJ program is associated with overall clinical improvement, decreased functional impairment, and reduced rates of recidivism for youth.

Finally, ongoing MHJJ evaluation findings indicate that parent engagement is associated with the most positive outcomes. As part of program enhancement, increased focus of parent engagement was initiated last fiscal year, resulting in increased hiring of parent liaisons. Working with agencies to increase the number of parent liaisons available to promote family engagement will continue to be a central program objective to MHJJ.

The following initiatives will be undertaken by the program in FY2011:

1. Collection of accurate information regarding race and ethnicity during the referral process will facilitate a more detailed analysis of any differences that exist with respect to referrals, enrollment, service linkages and outcomes. Adopting the national standard for recording this type of data would improve its accuracy and analysis.
2. Successful completion of the MHJJ program is correlated to decreased recidivism and improved overall functioning. An examination of attrition rates with focus on similarities amongst these youth will prove helpful in determining how to best meet the clinical needs of youth entering the MHJJ program.

Objective C3.1. In FY 2011, 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**

Substance Abuse Services for Dually Diagnosed (MISA) Youth

DMH 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.

As part of assessment at intake, the proportion of children and adolescents who are dually diagnosed with mental health problems and substance abuse has been tracked (*see Performance Indicator*). As reported above, relatively few children are identified (a little over 1%).

HEALTH AND MENTAL HEALTH SERVICES

Access to Health Care:

Collaboration with the Department of Healthcare and Family Services supports access to health care for children and adolescents through the ALLKIDS program which was described in the Child-Available Services section.

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 obtained a \$6.5 million budget that included funding for the expansion of key projects in services to transitioning youth, early childhood consultation, early intervention and the introduction of early childhood treatment programs.

Mental Health Transitional Services

DMH, in collaboration with ICMHP, awarded a total of ten (10) pilot sites for \$1,000,000 in statewide funding to provide mental health services that address the unique and special needs of older adolescents (16-17 years old) with SED who are transitioning from C&A services to adult services and for any youth with mental health needs and/or social/emotional impairment who is transitioning from correctional services to the community. In addition to providing an array of mental health services, the projects were expected to build community infrastructure to facilitate expansion of transition services for youth, support the effectiveness of services, work toward developing a system of care for transitioning youth. . By the end of FY2009, the transitional pilot programs served a total of 435 youth. Of these, 320 were youth ages 16-18, with Serious Emotional Disturbance who required transitional services and 115 were transitioning from juvenile justice settings. Transition age and newly paroled youth and their families received 5,060 hours of direct clinical, case management and support services and a total of \$175,000 was billed to Medicaid. Some reported challenges were: engaging families or other supports in the treatment process, maintaining youth in treatment, and obtaining financial resources to assist youth with daily expenses like transportation and housing. Some reported successes were: establishment of working relationship with local providers of adult mental health services, implementation of groups designed to assist youth develop adult life skills, and engaged youth demonstrate significant improvement in functioning. These pilot programs provide vital information as to the service models and intervention strategies that work best for the target population groups addressed.

In FY2010, due to fiscal constraint and the lack of continuation funds, the five pilot programs originally funded for a three-year period in FY2007 were discontinued. The five programs funded in FY2008 continued, one in each DMH region. The ICMHP and DMH are evaluating the data and information gained from the pilots so far with the aim of developing plans for statewide services to transitional youth for implementation as funding becomes available.

Early Intervention

The Mental Health Early Intervention Initiative is a granting opportunity to agencies with the aim of identifying children and adolescents at risk, especially those at risk of mental health or social/emotional impairment, and to intervene early. Flexibility was emphasized allowing each agency to develop its own plan and approach to early intervention based on the unique geographic, cultural, and interagency service environments in each region. A major goal of this initiative is to identify and engage children and adolescents with mental illness or social/emotional problems who are untreated, and those at risk of serious emotional disturbance or social/emotional problems. Case finding needs to go on in venues outside the normal service paths for children with serious disturbances. During FY 2009, agencies funded to provide early intervention services served 609 registered consumers and 891 unregistered consumers. They provided an array of clinical, case management, and support services. Direct service hours provided to consumers who were registered totaled 6,500 and 1,200 hours were provided to unregistered consumers. A total of \$84,530 was billed to Medicaid. Successful engagement strategies identified in the quarterly reports included: (1) Services provided at daycares and pre-schools yield the best engagement outcomes for the 0 to 5 year old group. (2) For older children providing services within the school setting is the most successful approach but parent participation is frequently lacking, and (3) Addressing the parent-child relationship is the most successful strategy in treating the behavior issues of young children.

The overall objectives of this initiative are to implement a statewide system of early intervention services and to develop a network of providers.

In FY2010, due to fiscal constraint and the lack of continuation funds, the five pilot programs originally funded for a three-year period in FY2007 were discontinued. The five programs funded in FY2008 continued, one in each DMH region. The ICMHP and DMH are evaluating the data and information gained from the pilots so far with the aim of developing a plan for statewide early intervention services for implementation as funding becomes available.

Early Childhood Mental Health

The Early Childhood Mental Health Program was established during FY2008. DMH Child and Adolescent Services and the Illinois Children's Mental Health Partnership (ICMHP) identified early childhood mental health as a priority in Illinois and collaborated in funding appropriate mental health services to children ages 0-5 who experience mental health and/or social/emotional development problems. Five (5) child-serving mental health providers, one in each of the five regions, were funded to: a) provide mental health assessment and treatment services to children age 0 – 5 years with psychological or social/emotional development needs; b) provide parent support services to families of eligible children; c) provide services that are child focused and family driven; and d) develop connections to referral systems/networks for early childhood. During FY2009 a total of 232 registered and 60 unregistered infants and young children and their families received clinical, case management and support services from

providers funded by the initiative. More than 4,000 direct service hours were delivered and over \$60,000 was billed to Medicaid. The five most reported services delivered in the order of prevalence were: therapy or counseling with families, community support to an individual, case management/collaboration, mental health assessment, and therapy or counseling to an individual.. This initiative continued in FY2010.

Objective C3.2: During FY 2011, through monitoring and program evaluation determine whether each Early Childhood Mental Health program is continuing to achieve the service and system development requirements of their grant. Implement a uniform web-based assessment/screening tool such as the Devereux Early Childhood Assessment (DECA); and collaborate with providers to identify strategies to address needs and gaps in each service region, and to develop recommendations for the enhancement of Early Childhood Services.

Indicators:

- The number of children ages 0-5 served in FY 2011.
- A description of services provided to children and their families/caretakers and the number of service hours provided for each service in FY2011
- Number of meetings convened with participating providers to share information on best practices, program outcomes, unmet needs, and strategies to address service gaps and needs.
- The number of web-based assessments/screenings completed by Early Childhood programs during the fiscal year.

GEOGRAPHIC AREA DEFINITION

Establishment of a defined geographic area for the provision of the services of such system: At the State Level, defined geographic areas (Comprehensive Community Service Regions (CCSRs)) have been established for the provision of services. At the local level, each funded provider has a defined geographic catchment area within the region and provides services to clients residing in that particular area.

CRITERION 4: Targeted Services To Homeless And Rural Populations.

OUTREACH TO HOMELESS

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 the Adult-Outreach to Homeless Section* . The Annual Emergency Food & Shelter Report noted that in FY2009, 5,954 households with children accounted for 12,191 participants in the program under the age of 18 (29.4% of the total served) of which 52.9% (6,453) ranged from newborn infants through five years of age.

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 34 Illinois counties and the Chicago Metropolitan Area. The IDHS-funded programs provide these important services for homeless youth:

- **Emergency/Interim Housing:** Either through placement in a shelter, group home or by purchasing lodging, youth are given a safe, clean, dry place to sleep.
- **Transitional Living:** Focus on skills necessary to support oneself, including education, employment services, and subsidized housing.
- **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.

In FY 2009, 21 Homeless Youth providers enrolled 1,127 youth, ages 14-20 in their emergency shelters and transition living programs. The program was funded at \$ 4.5 million in FY2009. Each youth is assessed for needs and strengths and a case plan is developed for service provision that 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:

Beacon Therapeutic Center's Shelter Outreach Services (S.O.S.) program utilizes a wraparound service delivery model which focuses on trauma informed, strengths based intervention with children and parents in the shelter setting and provides targeted case management and mental health services to women and children in 22 shelters on the south, north, and west sides of Chicago. Services focus on the identification of untreated mental illness, developmental delays, substance abuse, needs assessment, advocacy, coordination services and follow-up supportive services. 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 intervention team consists of qualified mental health professionals and case managers. Ancillary staff includes a child psychiatrist, psychologists, health educator, child development specialists 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. 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. Beacon Therapeutic School’s Shelter Outreach Service reports that it served 1900 (rounded figure) homeless children and 850 homeless families residing in Chicago shelters during FY2008. The program found and secured appropriate permanent housing for 268 families through its case management services.

Tracking Mental Health Services to Homeless Youth

A System Performance Indicator was created in FY1999 to track the number of homeless youth entering community-based services in the public mental health service system. This performance indicator is now a national outcome measure and is titled: **Increased Stability in Housing-Percent of Child/Adolescent Clients who are Homeless or Living in Shelters** This measure 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 FY2009 240 youth were reported as homeless at point of entry to community-based services.

RURAL AREA SERVICES

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.

Available Services 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 FY1997, 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.

Mental Health Services to Youth Residing in Rural Areas

DMH continues to focus on increasing access to child psychiatry for children/adolescents residing in rural areas. We continue to track the number of rural youth served (see System Performance Indicator titled: **Rural Residents Served: C&A** which provides the number of children being served by DMH-funded community-based providers who are residents of rural areas at the time of entry into services. (Goals, Targets, Action Plans section)

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 FY2009 10,354 youth were served in rural counties in Illinois.

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, matched 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 several years, child psychiatrists at the University of Illinois have performed many psychiatric consultations. This program has been highly valued by participating community mental health centers.

In FY2008, DMH budgeted approximately \$300,000 for a pilot project which allows six agencies to each purchase \$50,000 of qualified psychiatric consultation time to be provided through a Tele-Psychiatry approach ranging from informal case discussions to formal case reviews, and a telemedicine approach in which the child is present for assessment. The Tele-psychiatry initiative was established in Regions 4 and 5. Six agencies are now involved in the two regions. The project was awarded in February 2008 to Aunt Martha's Youth Services as the vender. Services include assessment, treatment

and ongoing monitoring of youth. By the end of FY2009, 168 children/adolescents and their families had benefited from Tele-psychiatry services and 939 psychiatry hours had been provided. Further enhancement and expansion is not realistic due to current fiscal constraints. The needs assessment for these services is continuing with a vision for possible implementation in the next fiscal year.

Objective C4.1: Continue to implement telepsychiatry services in six rural sites in Illinois. Explore possibilities for expansion through the support of recently approved Medicaid reimbursement for telemedicine services.

Indicator:

- **Number of youth served FY 2011**
- **Number of psychiatry hours provided in FY2011.**
- **A plan for expansion of telepsychiatry services for rural youth is completed and proposed.**

Criterion 5. Management Systems
--

RESOURCES FOR PROVIDERS

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. There are 124 child-serving agencies in Illinois. In this section, initiatives to enhance financial resources and human resources for children and adolescents including significant achievements are described. There is also a brief analysis of the systems strengths, needs and priorities.

Enhancing Financial Resources

See the ADULT- RESOURCES FOR PROVIDERS Section for a discussion of this topic and a discussion of Federal Financial Participation (FFP) which are applicable to both adults and children.

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. The system of care grant awarded by SAMHSA CMHS to McHenry County in FY 2005 was also funded at \$9 million dollars over a six-year period. The McHenry SOC will continue through FY2011. In FY2008, \$6.5 million dollars was allocated for mental health services for children and adolescents through a partnership with the Illinois Children's Mental Health Partnership.

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 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 were presented at seven locations in the State with over 2000 attendees. Two significant outcomes resulted: (1) telepsychiatry consultation was 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. The curriculum was promoted and marketed to both the academic and provider communities.

Another initiative to help enhance the competencies of C&A service providers is the provision of education and training in Evidenced Informed Practices and consultation to child and adolescent providers. These efforts are expected to continue. (See Child-Establishment of a System of Care-Objective C1.3 for detailed information). 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. Training on WRAP for providers who work with teens is ongoing. There are three agencies piloting WRAP in Chicago, one in LaSalle, the forensic adolescent inpatient unit in Springfield, and a sixth agency in southeastern Illinois..

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.

EMERGENCY SERVICE PROVIDER TRAINING

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. This training is applicable to both adults and children and a description can be found in Adult-Emergency Service Provider Training section.

Disaster Response: Emergency Health Services

As reported in the Adult Section 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. Disaster response for families and mental health services for children and youth are the responsibility of DMH in collaboration with other child-serving state agencies.

GRANT EXPENDITURE MANNER

Allocation Of Block Grant Dollars In FY2009

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

The Illinois plan for the expenditure of the FY 2011 Community Mental Health Services Block Grant is directed at providing services in community settings for children and adolescents with serious emotional disturbances. Administrative expenses are capped at 5%.

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

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

Approximately 23% of block grant funds are allocated to C&A Services. For FY2011, block grant funds will be directed toward the following community-based services for youths with serious emotional disturbances: psychiatric services and crisis services. The child and adolescent funding allocation of mental health block grant dollars is consistent with the State Mental Health Plan for Children and Adolescents.

CHILD- GOALS TARGETS AND ACTION PLANS

SYSTEM PERFORMANCE INDICATORS CHILD & ADOLESCENT SERVICES

Name of Performance Indicator:#C-1 (NOM) Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	40,313	36,768	40,313	40,313	N/A
Numerator					
Denominator					

Table Descriptors:

Goal:	Increase access to services.
Target:	Maintain access to services for children/adolescents with mental illnesses at the FY2008 level. (Note: FY2009 data not available; targets are based on FY2008 data.)
Population:	Children and adolescents with emotional and serious emotional disturbances
Criterion:	2:Mental Health System Data Epidemiology 3:Children's Services
Indicator:	Number of child/adolescents receiving services from DMH-funded community-based providers.
Measure:	Number of child/adolescents receiving services from DMH-funded community-based providers.
Sources of Information:	DMH ASO Community Reporting System. This indicator is generated from URS Table 2A and Table 2B.
Special Issues:	The DMH Fiscal Year 2010 community mental health services budget has been cut by 8% or approximately 42 million dollars. The impact on programs/services was described in the mental health block grant plan narrative. Because of the draconian nature of these cuts, DMH is not projecting an increase in access to programs.
Significance:	Services should be accessible to children and adolescents with mental health needs. DMH community funded providers by contract must submit registration and claims data for all individuals receiving services funded using DMH dollars. Data is submitted daily or weekly to the community reporting system maintained by the DMH's Administrative Services Organization (ASO), the Illinois Mental Health Collaborative For Access and Choice. Once this data is processed, it is then transferred to the DMH Data Warehouse for storage. This information is then used to develop reports. FY2009 data will be reported in the FY2009 Implementation Report.
Action Plan:	Implementation Report.

Name of Performance Indicator: #C-2 (NOM) Reduced Utilization of Psychiatric Inpatient Beds-30 day Readmissions (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	5	4.23	5	5	N/A
Numerator	4	3			
Denominator	80	71			

Table Descriptors:

Goal:	To decrease readmissions of individuals to state hospitals within 30 days by providing treatment that results in sufficient clinical stabilization such that subsequent treatment is provided in the least restrictive setting.
Target:	Maintain or decrease 30 day readmission rates of children and adolescents to DMH state hospitals
Population:	Children and adolescents with serious emotional disturbances.
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
Indicator:	Decreased rate of civil readmissions to state psychiatric hospitals within 30 days.
Measure:	Numerator: Number of civil readmissions to any state hospital within thirty days of being discharged. Denominator: Total number of civil discharges in the year
Sources of Information:	DMH Inpatient Clinical Information System.(ICIS)
Special Issues:	The Illinois DMH contracts the majority of inpatient services for children and adolescents to community hospitals, therefore the number of admissions and readmissions reported are very small. Data for private hospitals is not collected for the Inpatient Clinical Information System. Individuals with mental illnesses should receive services in the least restrictive settings possible. However, there are times when access to inpatient services is required. Treatment provided in these settings should not result in an individuals return to the inpatient setting within a short period of time.
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 FY2010 goal of maintaining or decreasing the level of re-hospitalization by maintaining services in the community that provide alternatives to re-hospitalization. As noted above, this information is entered into the DMH ICIS.

Name of Performance Indicator: #C-3 (NOM): Reduced Utilization of Psychiatric Inpatient Beds -180 day Readmissions (Percentage).

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	10	5.63	10	10	N/A
Numerator	8	4			
Denominator	80	71			

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 level of readmission rate to state hospitals within 180 days. (Note: Targets are based on FY2008 indicator value as FY2009 data is not yet available.).
Population:	Children and adolescents with serious emotional disturbances.

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

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

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

Sources of Information: Inpatient Clinical Information System.

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

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

Action Plan: DMH will continue to monitor the number of Children and adolescents readmitted to state hospitals within 180 days of discharge with a FY 2010 goal of maintaining or decreasing the level of re-hospitalization by maintaining services in the community that provide alternatives to re-hospitalization. As noted above, this information is entered into the DMH ICIS.

Name of Performance Indicator: #C-4 (NOM) Evidence Based -Children with SED Receiving Therapeutic Foster Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator					
Denominator					

Table Descriptors:

Goal: NOT APPLICABLE. Illinois is not implementing this EBP.

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

Population: Children/adolescents with serious emotional disturbances

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

Indicator: Number of children and adolescents receiving therapeutic foster care.

Measure: Number of children and adolescents receiving therapeutic foster care.

Sources of Information:

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

Significance:

Action Plan: DMH has no current plans to implement therapeutic foster care as this service would be administered by the child welfare agency.

Name of Performance Indicator:#C-5- (NOM) Evidence Based -Children with SED Receiving Multi-Systemic Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Projected	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator					
Denominator					

Table Descriptors:

Goal: NOT APPLICABLE. DMH has no plans to implement Multi Systemic FamilyTherapy in Illinois.

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

Population: Children/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 multi-systemic therapy..

Measure: Number of children and adolescents receiving multi-systemic therapy..

Sources of Information:

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

Significance:

Action Plan: While multi-systemic therapy is practiced by a few child-serving agencies, the DMH is not currently implementing multi-systemic therapy with children. DMH is focusing on evidence – informed practices

Name of Performance Indicator:#C-6 (NOM) Evidence Based -Children with SED Receiving Family Functional Therapy. (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Projected	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator					
Denominator					

Table Descriptors:

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

Target: DMH is not currently providing this EBP.

Population: Children/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 family functional therapy..

Measure: Number of children and adolescents receiving family functional therapy..

Sources of Information:

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

Significance:

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

Name of Performance Indicator:#C-7 (NOM): Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	52.11	60	55	55	N/A
Numerator	222				
Denominator	426				

Table Descriptors:

Goal: To assess the percentage of caregivers of children served by the DMH-funded community-based mental health service system that report positively about outcomes for children and adolescents receiving services.

Target: Increase by 3% the percentage of caregivers reporting positive outcomes for their children/adolescents receiving DMH funded mental health services.
(Please note that targets are based on FY2008 actual data as FY2009 data is not available.)

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

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

Indicator: Percentage of Families Reporting Positively About Outcomes.

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

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

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

Significance: Individuals receiving treatment should report positive outcomes for treatment

Action Plan: As in previous fiscal years, DMH will select a random stratified sample of individuals receiving treatment in June 2009. This sample will be the basis for the survey which will be disseminated in October 2009 with a goal of all data collected by early November. DMH staff will strive to complete the analysis by the implementation report due date, however data may not be readily available until January 2010.

Name of Performance Indicator: #C-8 (NOM) -Return to/Stay in School (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	43.02	N/A	N/A	N/A	N/A
Numerator	77				
Denominator	179				

Table Descriptors:

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

Target: No target specified due to low response rate and developmental nature of the indicator. Please note that no target was projected for FY09 as well.

Population: Children and adolescents with emotional and serious emotional disturbances.

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

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

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

Sources of Information: Annual Youth Services Survey

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

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

Action Plan: As in previous fiscal years, DMH will select a random stratified sample of individuals receiving treatment in June 2009. This sample will be the basis for the survey which will be disseminated in October 2009 with a goal of all data collected by early November. DMH staff will strive to complete the analysis by the implementation report due date, however data may not be readily available until January 2010.

Name of Performance Indicator: #C-9(NOM) Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	55.45	N/A	N/A	N/A	N/A
Numerator	61				
Denominator	110				

Table Descriptors:

Goal:	Monitor Juvenile Justice Involvement for children/adolescent who have forensic issues and who are receiving mental health treatment
Target:	Data for this indicator was collected in FY2008. However, due to the developmental nature of the measure and the low response rate we have elected not to set a target for FY2010. Please note that no target was projected for FY2009.
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:	Percent of children/youth consumers arrested in Year 1 who were not rearrested in Year 2.
Measure:	Numerator:: Number of children/youth consumers arrested in T1 who were not rearrested in T2. (new and continuing clients) Denominator: Number of children/youth consumers arrested in T1 (new and continuing clients combined)
Sources of Information:	Youth Services Survey for Families (Caregivers)
Special Issues:	This indicator is still developmental; as such DMH is not projecting targets.
Significance:	The provision of mental health services should have an impact on the outcomes for children/adolescents involved in the justice system .
Action Plan:	As in previous fiscal years, DMH will select a random stratified sample of individuals receiving treatment in June 2009. This sample will be the basis for the survey which will be disseminated in October 2009 with a goal of all data collected by early November. DMH staffwill strive to complete the analysis by the implementation report due date. However data may not be readily available until January 2010.

Name of Performance Indicator: #C-10(NOM) -Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	0.77	0.71	0.77	0.77	N/A
Numerator	293	240			
Denominator	37,589	33,996			

Table Descriptors:

Goal:	Increase stability in housing by reducing the number of children who are homeless or living in shelters. Indicator specifies increase, however, it is currently only a snapshot of consumers' status at admission; thus we would not project an increase.
Target:	Track percentage of children who are homeless or living in shelters. This data is collected at one point in time- at intake prior to treatment. Note that the FY2010 target is based FY08 actual data as FY09 data is not available.
Population:	Children/Adolescents who are homeless or living in shelters.
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
Indicator:	Percent of Child/Adolescent clients who are homeless and living in shelters.
Measure:	Numerator: Number of Child/Adolescent clients who are homeless and living in shelters. Denominator: All child/adolescent clients with known living situation (excluding persons with Living Situation Not Available.
Sources of Information:	DMH ASO Community Reporting System
Special Issues:	The data currently reported is point in time and only reflects youth status at intake/admission. Currently there is not a mechanism to track change over time, thus at this point DMH can only report status at intake.
Significance:	Children/Adolescents with serious emotional disturbances should have access to stable living environments
Action Plan:	DMH community funded providers by contract must submit registration and claims data for all individuals receiving services funded using DMH dollars. Data is submitted daily or weekly to the community reporting system maintained by the DMH's Administrative Services Organization (ASO), the Illinois Mental Health Collaborative For Access and Choice. Once this data is processed, it is then transferred to the DMH Data Warehouse for storage. This information is then used to develop reports. As noted above , DMH has established a policy requiring providers to update this information on a bi-annual basis. Once it has been determined that the quality of the data is good, DMH will begin to report change data for this variable.

Name of Performance Indicator: #C-11 (NOM)Child -Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	74.58	N/A	N/A	N/A	N/A
Numerator	311				
Denominator	417				

Table Descriptors:

Goal:	Monitor caregivers' perception that their children's social connectedness has improved as a result of participating in treatment.
--------------	---

Target: Developmental Measure – No Target established.

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

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

Indicator: Percent of families responding positively about social connectedness.

Measure: Numerator: Number of families of child/adolescent consumers reporting positively about social connectedness.
Denominator: Total number of family responses regarding social connectedness.

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

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

Significance: Treatment should result in positive outcomes for children.

Action Plan: As in previous fiscal years, DMH will select a random stratified sample of individuals receiving treatment in June 2009. This sample will be the basis for the survey which will be disseminated in October 2009 with a goal of all data collected by early November. DMH staff will strive to complete the analysis by the implementation report due date. However data may not be readily available until January 2010.

Name of Performance Indicator: #C-12 (NOM)-Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	61.98	N/A	63	63	N/A
Numerator	269				
Denominator	434				

Table Descriptors:

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

Target: No target established for FY2009 as there was no basis for establishing one.
For FY2010: Maintain or increase caregivers' perception of functioning of children receiving treatment.

Population: Children and adolescents with emotional/serious emotional disturbances.

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

Indicator: Percent of families reporting positively about functioning.

Measure: Numerator: Number of families of child/adolescent consumers reporting positively about functioning.
Denominator: Total number of family responses regarding functioning.

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

Information:

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

Special Issues:**Significance:**

Treatment should result in positive outcomes for children.

Action Plan:

As in previous fiscal years, DMH will select a random stratified sample of individuals receiving treatment in June 2009. This sample will be the basis for the survey that will be disseminated in October 2009 with a goal of all data collected by early November. DMH staff will strive to complete the analysis by the implementation report due date. However data may not be readily available until January 2010.

Name of Performance Indicator:#C-13- Corrections History -C&A

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	1.10	1	1	1	N/A
Numerator	456	310			
Denominator	40,313	36,768			

Table Descriptors:

Goal:	To track forensic status of children and adolescents served by the Illinois mental health system
Target:	Forensic population is expected to remain relatively constant at approximately 1%.
Population:	Children and adolescents with serious emotional disturbances.
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems
Indicator:	Percentage of children and adolescent clients reporting involvement with the Department of Corrections /Juvenile Justice at the time of case opening.
Measure:	Numerator: Number of children and adolescent clients reported as Department of Corrections clients (e.g, probation, parole) at the time of case opening. Denominator: Total number of children and adolescents served in the fiscal year.
Sources of Information:	DMH ASO Community Reporting System
Special Issues:	
Significance:	Tracking this information helps to insure coordination of services between the mental health 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 (a little over 1%) at the time of case opening. This data is collected as part of clinical assessments. DMH will continue to track these percentages in FY 2009

Name of Performance Indicator:#C-14 Co-Occurring Disorders-C&A

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	1.10	1	1	1	N/A
Numerator	456	390			
Denominator	40,313	36,768			

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 at approximately 1%.
Population:	Children and adolescents with serious emotional disturbance and a co-occurring substance use disorder.
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:	DMH ASO Community Reporting System
Special Issues:	There is underreporting for this population because many mental health professionals prioritize mental health issues as the principle treatment concern in reporting to the state mental health authority.
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 FY2010 with a goal of increasing capacity for identification of dually diagnosed youth.

Name of Performance Indicator:#C-15: Eligible Population-C&A

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012
Performance Indicator	88.43	95	88	88	N/A
Numerator	35,648	34,959			
Denominator	40,313	36,768			

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:	Maintain the percentage of children and adolescents receiving mental health services who meet eligibility requirements. Please note the target is based on FY08 actual data as FY09 data is not yet available.
Population:	Children and adolescents with serious emotional disturbances
Criterion:	2:Mental Health System Data Epidemiology
Indicator:	Percent of children and adolescents being served by DMH-funded community-based providers who meet the established criteria for “eligible population” at the time of entry into services.
Measure:	Numerator: Number of children and adolescents being served by DMH-funded community-based providers who meet the established criteria for “eligible population” at the time of entry into services. Denominator: All children and adolescents being served by DMH-funded community-based providers.
Sources of Information:	DMH ASO Community Reporting System
Special Issues:	
Significance:	This indicator is part of the monitoring process to insure that mental health services are accessible and accessed by those who need them most.
Action Plan:	The DMH Fiscal Year 2010 community mental health services budget has been cut by 8% or approximately 42 million dollars. The impact on programs/services was described in the mental health block grant plan narrative. Because of the draconian nature of these cuts, DMH is not projecting an increase in access to programs. In FY2010, DMH will continue to monitor access to services.

Name of Performance Indicator: #C-16: Forensic Outpatient-C&A

(1)	(2)	(3)	(4)	(5)	(7)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	1.20	0.55	1.20	1.20	N/A
Numerator	483	204			
Denominator	40.313	36,768			

Table Descriptors:

Goal:	To track forensic status of children and adolescents served by the Illinois Mental Health System.
Target:	Maintain the percent 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 trial, not guilty by reason of insanity, criminal, or directed for court ordered treatment at the time of case opening.

Denominator: Total number of children and adolescents served in the fiscal year

Sources of Information: DMH ASO Community Reporting System

Special Issues:

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

Action Plan: DMH will continue to track these percentages in FY 2010.

Name of Performance Indicator: #C-17: Living Arrangements-C&A

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	89.2	96	89	89	N/A
Numerator	35,956	34,959			
Denominator	40,313	36,768			

Table Descriptors:

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

Target: Maintain percentage of children and adolescents with serious emotional disturbances who live in private residences. The target is based on FY2008 data as FY2009 data is not yet available.

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 with known living arrangements.

Sources of Information: DMH ASO Community Reporting System

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 2008, the vast majority of children and adolescents lived with parents or other relatives in a private residence (89%). Nevertheless, services are needed to help those children who do not reside with their families.

Action Plan: DMH will track these percentages in FY 2010.

Name of Performance Indicator: #C-18 RURAL RESIDENTS SERVED -C&A

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	12,430	10,354	12,000	12,000	N/A
Numerator					
Denominator					

Table Descriptors:

Goal:	To assure that children with emotional disturbances who reside in rural areas are accessing the DMH-funded community-based mental health service system.
Target:	Maintain the number of children/adolescents residing in rural areas who receive services by using Tele-psychiatry and other strategies.
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:	DMH ASO Community Reporting System
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:	The DMH Fiscal Year 2010 community mental health services budget has been cut by 8% or approximately 42 million dollars. The impact on programs/services was described in the mental health block grant plan narrative. Because of the draconian nature of these cuts, DMH is not projecting an increase in access to programs. In FY2010, DMH will continue to monitor access to services.

Name of Performance Indicator: #C-19: Sass Service Hours In Community

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator					
Denominator					

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: Number of hours of service provided by the DMH-funded SASS Programs which occur outside of the provider’s offices or clinics.

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

Sources of Information: DMH ASO Community Reporting System

Special Issues: This data is no longer reported directly to the DMH. Data was not available for FY 2005, FY 2006, FY2007, and FY2008. We will retain this indicator as a placeholder because of its importance. We hope to reacquire the information in FY 2010.

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

Action Plan: DMH is still working to retrieve this information and is retaining this indicator as a placeholder pending the reacquisition of this data as it is important to monitor delivery of these critical services.

Name of Performance Indicator: #C-20 Target Population -C & A

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2012 Target
Performance Indicator	40	40	40	40	N/A
Numerator	16,166	14,773			
Denominator	40,313	36,768			

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

Population: Children and adolescents with serious emotional disturbances.

Criterion: 2:Mental Health System Data Epidemiology

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

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

Sources of Information: DMH ASO Community Reporting System

Special Issues:

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

Action Plan: DMH aims to maintain or increase the proportion of children and adolescents served who meet the criteria for the target population. However, The DMH Fiscal Year 2010 community mental health services budget has been cut by 8% or approximately 42 million dollars. The impact on programs/services was described in the mental health block grant plan narrative. Because of the draconian nature of these cuts, DMH is not projecting an increase in access to programs. In FY2010, DMH will continue to monitor access to services.