



State of Illinois



**Illinois**  
WE HONOR  
**Mental Health**  
THE DIGNITY  
**2013-2018**  
AND WORTH OF  
**Strategic Plan**  
EVERY INDIVIDUAL

# Overview

One in five Americans experiences a mental illness every year, including Illinois residents of all ages, races, and economic backgrounds.<sup>1</sup> Among all Medicaid beneficiaries with disabilities, almost half have a mental illness diagnosis. The economic impact of mental illness is estimated to be about 15 percent of the total economic burden of all diseases. Yet, it is estimated that about two-thirds of individuals with mental illnesses go without treatment, due in large part to their inability to access care or to the stigma about mental illness that may keep them from seeking services. This is despite the fact that success rates for mental health treatment are comparable to those for physical health disorders, such as heart disease and diabetes.

During 2013-2018, Illinois will be challenged to develop and implement more effective and cost-efficient strategies to meet the needs of individuals with mental illnesses. This challenge emerges from three significant environmental changes affecting the delivery of mental health services in our state. First, funding for mental health services has notably decreased in recent years. The total mental health funding for community services, hospital operations, and administrative costs for FY 2012 has dropped approximately 18 percent from FY 2009 levels. To stretch available resources, the Illinois Department of Human Services (IDHS) Division of Mental Health (DMH) began restricting eligibility and the array of services provided to non-Medicaid eligible people with mental illnesses beginning in FY 2011.

Second, Illinois is actively engaged in implementing key strategies to promote community integration for people with mental illnesses, consistent with the U.S. Supreme Court's decision in *Olmstead v. L.C.* Illinois' actions are in response to consent decrees resulting from two class action lawsuits. In

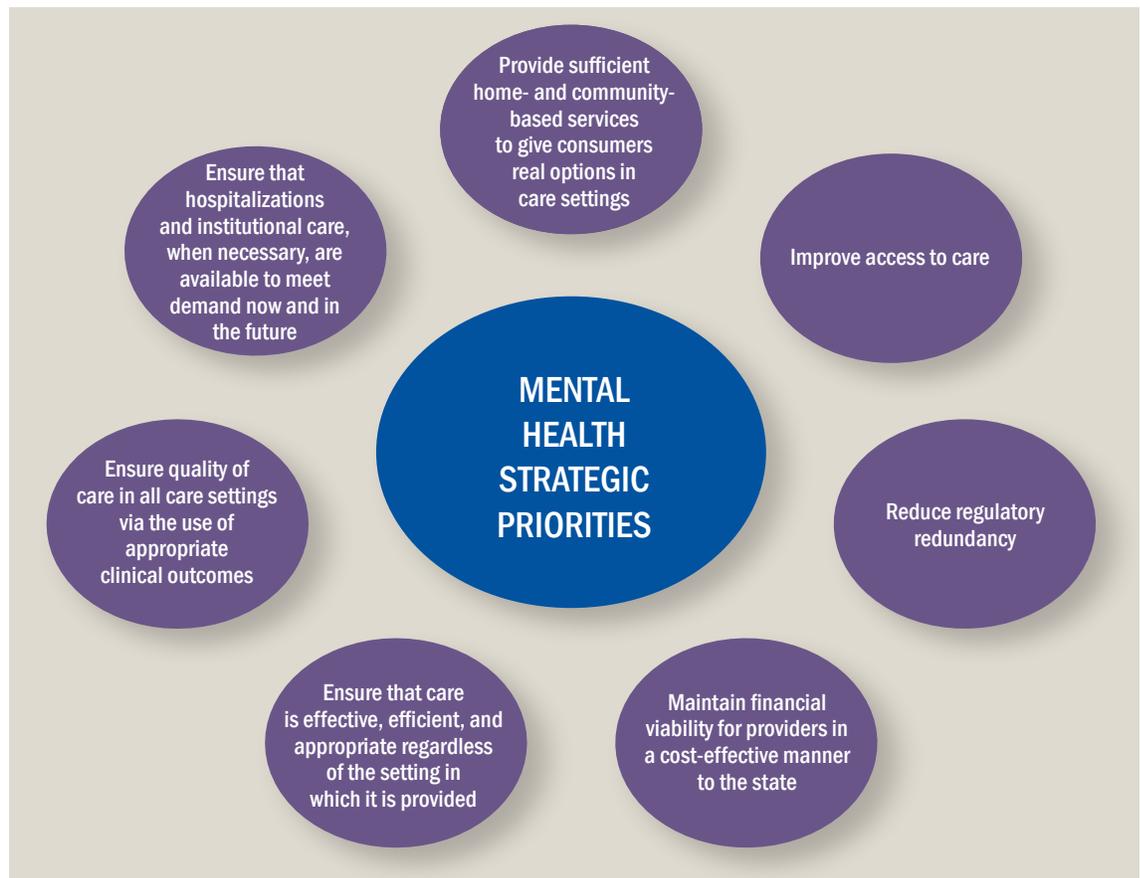
<sup>1</sup> Data in this paragraph were compiled by the National Council for Behavioral Health and are available at [http://www.thenationalcouncil.org/galleries/default-file/may\\_infographic\\_print.pdf](http://www.thenationalcouncil.org/galleries/default-file/may_infographic_print.pdf)

*Williams v. Quinn*, more than 4,500 residents of Institutes for Mental Disease (IMDs) in Illinois—nursing facilities where more than 50 percent of the residents are diagnosed with a serious mental illness—alleged that they were denied due process to move out of these facilities when they no longer required or desired that level of care. In the settlement agreement approved in 2010, the state agreed that all class members will be assessed and given the choice to transition to the most appropriate integrated community-based options with support services by 2015. A second lawsuit, *Colbert v. Quinn*, includes a class of 17,000 people with disabilities—including up to 6,800 people with mental illnesses, who are residents of non-IMD nursing facilities within Cook County.

Finally, consistent with its commitment to the principles of *Olmstead*, Illinois is engaged in a process of “long-term care rebalancing” — a systematic effort to remove barriers to community living for people of all ages with disabilities, including mental illnesses, by offering a reasonable array of options that include adequate choices of community and institutional options. The goal is to achieve an appropriate balance between the proportion of total Medicaid long-term support expenditures used for institutional services and those used for community-based services in order to honor individuals' choices. These efforts include a successful Medicaid “Money Follows the Person” demonstration, through which Illinois is receiving \$14.9 million dollars in federal Medicaid reimbursement to assist individuals who have serious mental illnesses and who are living in non-IMD nursing facilities with seamless transition to community residential alternatives (non-group home settings) and necessary support services.

***One in five Illinois residents experiences a diagnosable mental disorder every year.***

In light of the challenges and opportunities presented by this changing environmental context, the Illinois legislature has identified seven key priorities for improving and maintaining the public mental health system in our state. These priorities, which form the basis for the strategic plan described in this report, are the following:



## Introduction

**This report provides a strategic plan for the delivery of mental health services in Illinois during 2013-2018.** The plan was developed by the Mental Health Services Strategic Planning Task Force, as established by the Illinois State Legislature in August 2011 (Pub. Act 097-0438). As directed by the legislature, the Task Force included a broad range of stakeholders, with the shared mission of producing a five-year comprehensive strategic plan. Task Force members included mental health consumers and family members, mental health providers/vendors, academia, representatives from trade associations and labor unions, state agencies, members of the judiciary, law enforcement, courts, the legislature, and representatives from the Governor's office. A complete list of Task Force members is included in Appendix A.

To complete the strategic plan, the Task Force established five standing committees. Four of these committees were charged with focusing on one of the following specific population groups: adults, veterans, individuals with forensic involvement, and children and adolescents. The fifth committee studied and developed a plan regarding administrative issues facing DMH. Each committee met multiple times to review data, study information provided by DMH and other stakeholders, and develop a series of goals and objectives based on the seven strategic priorities identified by the Legislature (see graphic above).

**The sections that follow encompass the key components of the strategic plan, including 1) vision, values, and principles; 2) the current system structure and populations served; 3) system strengths and gaps; and 4) key goals and objectives to guide DMH and other state agencies serving adults with mental illnesses and children and adolescents with emotional disorders. A detailed list of goals and objectives agreed to by each Task Force committee rounds out the report. Appendix B includes the text of the Task Force subcommittee reports.**

# Vision, Values, and Principles

## VISION

An efficient, effective, high-quality mental health service delivery system must be grounded in a clear vision that supports the recovery of adults with mental illnesses and promotes the resilience of children and adolescents with emotional disorders. In Illinois, we envision:

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All children with a diagnosis of, or at risk for developing, an emotional disorder will have access to a family-driven, youth-guided, trauma-informed, culturally and linguistically competent, strengths-based system of care that supports optimal physical and mental health and social and emotional wellbeing.

All adults with a diagnosis of, or at risk for developing, a mental illness will have access to a coordinated, integrated, well-funded mental health system that promotes recovery and social inclusion through timely access to prevention, treatment, and recovery support services.

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## VALUES

The values that underlie development of community-based services for adults with mental illnesses and children and adolescents with emotional disorders are as important as the individual service components themselves. They represent our goals for the people we are privileged to serve.

- In Illinois, we honor the dignity and worth of every individual. Accordingly, we believe:
- Adults with mental illnesses and children and adolescents with emotional disorders are *people first*. Their choices, aspirations, and beliefs drive the treatment system.
- Individuals with mental illnesses are expected to recover.
- Mental, emotional, and behavioral problems in children and adolescents *can be prevented*.
- Fostering social and emotional wellbeing is the goal for services to children and adolescents.
- Promoting social inclusion is the goal for services to adults.
- Discrimination and stigma against individuals with mental health conditions is unacceptable and counterproductive.

*“Mental health is essential to health. With this Strategic Plan, we have set the stage for all residents of Illinois to be healthy, productive members of their families, schools, workplaces, and communities. They deserve nothing less.”*

– Pat Quinn, Governor of Illinois

## PRINCIPLES

Principles operationalize our values and help us realize our goal of providing quality, accessible, community-based care that provides a full range of options to individuals who seek our services. In Illinois, the following principles guide the design, delivery, and evaluation of all mental illness prevention, treatment, and recovery support services:

- Services for individuals of all ages with mental health conditions are person centered, strengths based, trauma informed, and culturally competent. Services are founded on evidence-based, evidence-informed, best, and emerging promising practices.
- Services are flexible, tailored, and provided in the least restrictive setting appropriate to the individual’s needs.
- Adults with mental illnesses are provided with the support they need to live in mainstream housing and have real jobs that pay a living wage.
- Children with emotional disorders have access to a broad, flexible array of effective community-based services and supports that are integrated at the system level and individualized to each child’s and family’s needs.
- The direct involvement of individuals with lived experience of mental illnesses, and of family members of children and adolescents with emotional disorders, guides the planning, provision, and monitoring of mental health services.
- Individuals with mental health conditions are served wherever and whenever they present for care (“no wrong door”). Family members of children and adolescents with behavioral health conditions and of active duty service members and veterans receive the help they request (“no wrong person”).
- Services are integrated, to the greatest extent possible, across mental health and primary care settings. Coordination extends to adult- and child-serving systems, and to all systems that serve veterans and individuals currently or previously involved in the criminal or juvenile justice systems. Service members, veterans, and their families receive the help they need from practitioners working in organizations that are competent in military culture, and these individuals are served in the setting where they want to be served.
- Individuals involved with the criminal justice system are diverted to mental health treatment and services as appropriate to their situation and with regard for public safety.
- Outcomes are standardized and measured at the individual, provider, and service system level. Outcome data drive quality improvement efforts.
- The mental health workforce is sufficiently sized, appropriately trained, and properly credentialed.
- Funding for mental health services is appropriate to meet identified needs and priorities within state budgetary constraints. All additional sources of funding (federal, private, insurance, etc.) are maximized.

# System Structure

IDHS manages human service systems in the state, including management of the public mental health system through DMH. DMH has the statutory mandate to plan, fund, and monitor community-based mental health services and inpatient psychiatric services provided in state hospitals. As such, DMH is the federally recognized State Mental Health Authority for Illinois.

DMH contracts with approximately 150 comprehensive community mental health centers and 30 specialty providers to provide community-based services. These contracted organizations provide mental health services funded principally under the Medicaid Rehabilitation Option, including psychiatry, psychotherapy, medications, psychosocial rehabilitation, and case management to individuals eligible for Medicaid. For individuals not eligible for Medicaid, DMH directly purchases crisis services and a limited package of services that includes assessment, psychiatry, and medication/case management services.

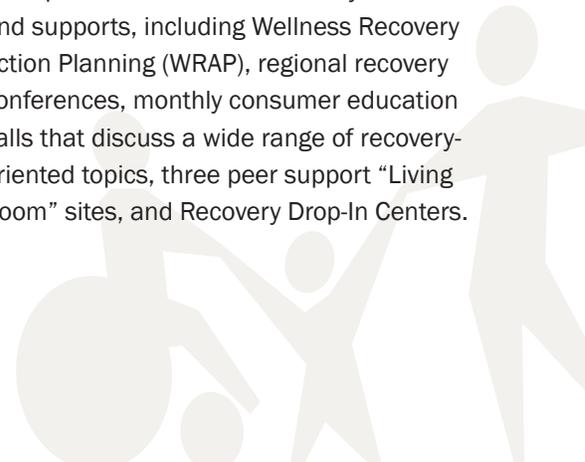
DMH also operates seven state mental health hospitals and one treatment detention facility. In addition, DMH supports services provided through nursing facilities (both regular nursing facilities and IMDs), residential treatment centers, and other congregate living settings. Planning and budgeting decisions throughout the system are guided by the basic principle that individuals will receive the most effective services in the least restrictive, clinically appropriate environment.

The state's geographic diversity, ranging from inner-city urban areas to sparsely populated rural areas, along with other factors, such as stigma, result in mental health service delivery in non-traditional settings. These include physician offices, primary care clinics, general hospitals, emergency rooms, child welfare centers, schools, juvenile detention centers, jails, and prisons. Although DMH provides some funding, the

services provided in these diverse treatment settings are also supported by a variety of other sources.

In addition to clinical services, DMH purchases non-clinical supports for adults, including the following:

- **Supportive housing.** Access to supportive housing has been a focus for several years and includes a service model, identified funding sources, and a referral network for those leaving long-term care settings. This investment in supportive housing demonstrates a commitment to helping individuals achieve their independent living goals, with community settings becoming the expected living situation for most adults who are diagnosed with serious mental illnesses.
- **Employment services.** To help individuals access and maintain employment, Illinois has adopted the Individual Placement and Support (IPS) model, an evidence-based practice for which there is robust data indicating success. With the support of both DMH and the IDHS Division of Rehabilitation Services, the IPS model has demonstrated a 63 percent successful Federal Vocational Rehabilitation Rate (the percentage of people stably employed in a job of their choosing after 90 days), which is above the national average.
- **Recovery supports.** With input from individuals with lived experience in recovery, DMH provides innovative recovery services and supports, including Wellness Recovery Action Planning (WRAP), regional recovery conferences, monthly consumer education calls that discuss a wide range of recovery-oriented topics, three peer support "Living Room" sites, and Recovery Drop-In Centers.



DMH's Child and Adolescent Services (C&A) serves children and adolescents with social, emotional, and behavioral disorders who depend on public funding, through a network of community-based mental health providers. C&A collaborates with the Illinois State Board of Education, the Department of Child and Family Services, the Illinois Department of Juvenile Justice, IDHS/Division of Alcoholism and Substance Abuse, the Illinois Department of Healthcare and Family Services, and the Illinois Children's Mental Health Partnership to implement Systems of Care statewide. The Illinois Departments of Children and Family Services (IDCFS) and Juvenile Justice (IDJJ) also have statutory responsibility to provide mental health services in some instances. No one agency is responsible for ensuring the integration of behavioral health care services across all child-serving systems.

DMH's Forensic Services collaborates with a range of agencies in the criminal justice system to oversee and coordinate the inpatient and outpatient placements of adults remanded to DMH by Illinois county courts because they are considered to be unfit to stand trial (UST) or not guilty by reason of insanity (NGRI). Inpatient services are provided at five state hospitals with secure forensic units. DMH also helps lead several programs to address other individuals with behavioral health needs in jails and prisons, including the Jail Data Link Program and other initiatives focused on recovery, diversion, reintegration, best practices, and the appropriate use of inpatient and community resources. Because of budgetary constraints, many community-based mental health services are available only if the individual has health benefits through private insurance, Medicaid, or Supplemental Security Income. These constraints also apply to individuals involved with the criminal justice and juvenile justice systems.

Mental health services are purchased or delivered by many other state agencies and local mental health authorities in some areas of the state (including county 708 boards, the City of Chicago and other municipalities, and Cook County). Over the years, DMH has worked actively to develop and establish relationships across these systems with the goal of integrating mental health services under its purview with the services provided or purchased by other agencies.

The Illinois Department of Healthcare and Family Services (IDHFS), the state's Medicaid authority, is the largest purchaser of mental health services in the state. It purchases services provided by individual practitioners, hospitals, and nursing facilities, including medication, psychiatry, inpatient services, and long-term care. IDHFS implemented a pilot Integrated Care Program (ICP) on May 1, 2011. The ICP is a program for older adults, and adults with disabilities, who are eligible for Medicaid but not Medicare.

IDHFS is also in the midst of implementing a Care Coordination Project known as Innovations. Illinois Public Act 096-1501 (Medicaid Reform) requires that a minimum of 50 percent of Medicaid clients be enrolled in coordinated care by 2015. Innovations is the vehicle by which this will be achieved, through contracts with Coordinated Care Entities, Managed Care Community Networks, and Managed Care Organizations. IDHFS has also released its Solicitation for Care Coordination Entities for Children with Complex Medical Needs, which is a component of the Innovations project. In addition, IDHFS is taking the lead on coordinating work on the *Olmstead*-related consent decree for *Colbert v. Quinn*, which focuses on individuals residing in nursing homes in Cook County. DMH also collaborates with the following state agencies:

- IDHS Division of Alcoholism and Substance Abuse to address services for individuals with co-occurring mental and substance use disorders.

**“People with mental illnesses can and do recover. In Illinois, we envision that every citizen has access to the prevention, treatment, and recovery support services they need to achieve optimal physical and mental health and social and emotional wellbeing.”**

– Lorrie Rickman-Jones, Ph.D., Director, Division of Mental Health, Illinois Department of Human Services

- IDHS Division of Developmental Disabilities to address the needs of persons with autism spectrum disorders and individuals with co-occurring developmental disabilities.
- IDHS Division of Rehabilitative Services to increase the access of individuals with serious mental illnesses to vocational rehabilitation services and to improve the coordination of psychiatric and vocational services through initiatives such as the IPS model of supported employment.
- Illinois Housing Development Authority and IDHFS to implement the Williams v. Quinn Consent Decree and provide permanent supportive housing.
- Illinois Department on Aging to increase training opportunities in the geriatric field and to improve the quality and accessibility of services for elderly persons with mental illnesses.
- IDHFS and the Department of Public Health (IDPH) to support people with serious mental illnesses who require long-term care services. In FY 2011, IDPH reported 114,375 admissions to beds designated for individuals with acute mental illnesses. These admissions resulted in 887,220 inpatient days, with an average daily census of 2,431.
- Illinois Departments of Veterans Affairs and Military Affairs (National Guard and Air Guard) to coordinate and improve services for service members, veterans, and their families throughout the state. In FY 2010, 660,104 outpatient sessions were provided to veterans by the Veterans Health Administration (VHA). Eighteen percent of the individuals receiving these services were women. Only 50 percent of eligible veterans receive services from the VHA.
- Illinois Department of Corrections (IDOC) and IDJJ to address the needs of adults and juveniles involved with the justice system. It is estimated by IDOC health care staff that 16 percent of 48,000 individuals in the total DOC population have a mental health disorder. Fourteen percent of the detainees in reporting Illinois county jails have mental illnesses. IDJJ reports that for FY 2013, as of December 2012, 17 percent or 155 youth under their purview have been identified as having moderate mental health needs. Another 50 percent or 461 individuals have been identified as having mild mental health needs. All of these youth, which represent 67 percent of the population, are receiving mental health treatment (group or individual).
- Illinois Department of Children and Family Services (IDCFS) on a number of initiatives, including Screening, Assessment, and Support Services (SASS). Collaborative efforts include training for child welfare staff and service providers to examine and respond to the trauma children and families experience as a result of physical abuse, neglect, sexual abuse, and domestic violence. IDCFS has noted that 50 percent of children in the child welfare system have mental health problems, often related to early trauma.
- Illinois State Board of Education on the Interconnected Systems Model of School-Based Mental Health, and collaboration on the Illinois Positive Behavioral Interventions and Supports Initiative to facilitate the integration of community mental health providers into schools to address the social, emotional, and behavioral needs for students, teachers, and families.

# Description of the Population

Mental health programs and services provided by the state serve children and adults across the lifespan who have or are at risk for having a behavioral health disorder. With limited resources and a responsibility to provide a safety net for those most in need, DMH prioritizes services and supports for adults with serious mental illnesses and children with serious emotional disorders and their families, especially those without the resources to secure treatment and support independently.

The term “serious mental illness” is used to describe the unique needs of individuals who are age 18 and older who have been diagnosed with a mental illness resulting in impairment of emotional or behavioral functioning that interferes with their ability to live in the community without supportive treatment. Using the federal definition and methodology for determining the prevalence rate of serious mental illness, it is estimated that more than 526,000 adults in Illinois — 5.4 percent of the adult population — had a serious mental illness in 2012. Of the 100,377 adults who received DMH-funded community-based services, approximately 95 percent were diagnosed with a serious mental illness. Thus, it is estimated that DMH provided funding for services to approximately 20 percent of Illinois adults with a serious mental illness. As stated above, however, other agencies and private practitioners also provide funding for and services to individuals with serious mental illnesses.

The term “serious emotional disorder” is used to describe the unique needs of children and adolescents under age 18 who have, in the past year, been diagnosed with a mental, emotional, or behavioral disorder resulting in functional impairment that substantially interferes with or limits the child’s role or functioning in family, school, or community activities. Using the federal definition and methodology for determining the

prevalence rate of serious emotional disorder, it is estimated that nearly 175,000 children and adolescents in Illinois — 7 percent of the population under age 18 — had a serious emotional disorder in 2012. DMH supported community-based services for 35,670 children and their families, approximately 20 percent of those diagnosed with serious emotional disorder.



In addition to individuals served in the community, 8,393 adults were admitted to DMH state hospitals in FY 2012. Nearly all were diagnosed with serious mental illness, and many also received community mental health services purchased by DMH.

A growing number of inpatient admissions were referred for treatment by the criminal justice system. During the five-year period from FY 2007 to FY 2012, forensic admissions increased from 581 to 625, and the average daily census in DMH state-operated facilities increased from 621 to 649. In FY 2012, individuals with misdemeanors made up more than 36 percent of the forensic referrals statewide and more than 50 percent of the forensic referrals in the Chicago metro area (including Cook and Winnebago counties). Many of these individuals present with serious and persistent mental illnesses, are not always adherent to outpatient service plans, and are marginally adjusted in their communities. As a result, the average

length of stay for individuals in a forensic status in DMH hospitals is more than 1,400 days.

The growing number of long-term forensic patients, most of whom have been found NGRI, has reduced programming capacity to serve individuals who are determined to be UST and has contributed significantly to hospital forensic waiting lists. Because many NGRI patients have a history of sex offenses, arson, or past violence, judges are reluctant to approve the conditional release of NGRI patients, especially since there is a lack of specialized programming and supports in the community to serve these individuals. A limited number of individuals are on conditional release in the community and receiving services; additional people could be served if more specialized resources were available in the community.

In addition to people who are mandated for treatment under forensic statutes, many adults and children with mental disorders are involved in the criminal and juvenile justice systems. For example, 1,400 of the 9,600 inmates in Cook County Jail receive DMH-funded psychiatric services. Data from the DMH Jail Data Link Program suggest that, at any given time, 14

percent of individuals in county jails received outpatient or inpatient mental health services prior to detention.

DMH also provides services to youth involved with or at risk of becoming involved with the justice system. As many as 70 percent of youth involved with IDJJ have a mental disorder, and many of these have issues so severe as to impair their ability to function or assume adult responsibilities. These include youth identified as sex offenders, those with substance abuse histories, and those who have serious emotional disorders who are transitioning out of services provided by IDCFS. These children and adolescents present with numerous challenges, including a need for more robust case management services prior to discharge, a limited number of residential placement options, and a general lack of mental health and substance abuse service availability throughout the state. During the 10-year period from 2002-2012, DMH handled more than 15,000 referrals from IDJJ, IDCFS, and county juvenile detention centers and provided services to more than 5,800 youth.

## FAST FACTS ABOUT ILLINOIS VETERANS OF WARS IN IRAQ AND AFGHANISTAN

- 78% are in their 30s or younger.
- 67% have a high school diploma, and 22% have a college or professional degree.
- 13% are unemployed. This is the 4th highest statewide unemployment rate in the country for new veterans.
- 46% earn less than \$30,000 annually.
- 17% are women. These veterans are more likely than their male counterparts to be unemployed (18%, as compared to 11% for men).
- Of veterans with children, nearly half of the female veterans (47%) and one-fourth of the male veterans (25%) are raising them alone.
- 26% of veterans who were deployed since 9/11 were deployed more than once, leaving them more vulnerable to invisible wounds such as traumatic brain injury (TBI) and/or posttraumatic stress disorder.
- 50% live in the Chicago area and 17% live in the St. Louis area.

IDHS also supports services for military service members, veterans, and their families, including 76,000 troops returning from recent conflicts in Iraq and Afghanistan. Compared to the majority of veterans in Illinois, returning veterans are more likely to be young, female, and unemployed. They experience unique physical and mental wounds. As even more veterans return home,

many are dealing with mental and physical injuries stemming from their military service, including high rates of post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI) resulting from the use of improvised explosive devices. The U.S. Department of Veterans Affairs estimates that, across the country, 18 veterans die each day from suicide.

## System Strengths & Gaps

Illinois has a strong foundation on which to create a behavioral health system grounded in recovery and built on the premise that *mental health is essential to health*. With support at the highest levels, DMH and its partners in state government, communities, and the private sector engage in collaborative problem solving to address identified gaps and emerging needs. Specific system strengths and gaps are noted below.

### SYSTEM STRENGTHS

#### **A favorable legislative environment.**

Efforts to rebalance the provision of care for people of all ages with disabilities, stipulated in the *Williams and Colbert* consent decrees, provide renewed incentives to remove barriers to community living for adults and children with mental health conditions. Illinois Public Act 096-1501 (Medicaid Reform) requires the provision of coordinated care for adults and children who receive Medicaid-funded services. This will spur the development of innovative service models to improve health care outcomes, use evidence-based practices, and encourage meaningful use of electronic health records (EHRs).

**A pledge to work together.** Illinois works best when there is collaboration across agencies and other partners. Collaborative efforts that support adults and children with mental health conditions abound. Examples include SASS, which is a collaborative effort between IDCFS, DMH, and IDHFS to provide crisis services to youth with serious emotional disturbances; the DMH Jail Data Link program, which was developed by DMH to identify and coordinate services between county jails and mental health agencies for individuals with mental health needs; and the Integrated Care Pilot and Care Coordination Effort projects that span multiple state agencies.

The behavioral health and law enforcement systems work together in problem-solving courts and on law enforcement Crisis Intervention Teams. Support for Illinois service members, veterans, and their families comes from a broad range of community, faith-based, and fraternal organizations, as well as elected officials and the general public.

#### **A person-centered, recovery focus.**

Individuals with mental illnesses in Illinois are expected to recover. The state has shown a commitment to a recovery-oriented system of care by developing and supporting positions within state leadership, in the regions, and at the direct service level for Certified Recovery Support Specialists (CRSS). CRSS staff have a voice in directing policy, monitoring quality, and providing services to their peers. Certified Family Partnership Professionals provide family peer-to-peer support for families whose children have emotional and/or behavioral challenges.

**A commitment to evidence-based and evidence-informed practices.** Evidence-based practices are interventions for which there is consistent scientific evidence showing that they improve individual outcomes when implemented with fidelity to the model. Evidence-informed

practices refer to those practices determined by children, their families, and practitioners to be appropriate to the needs of the child and family, reflective of available research, and measurable with respect to meaningful outcomes. Illinois has devoted resources to support the implementation and use of evidence-based practices for adults with mental illnesses in such areas as outreach and engagement (Assertive Community Treatment), housing (Permanent Supportive Housing), employment (IPS), and recovery (Wellness Recovery Action Planning). Dollars also have been allocated to support the implementation and measurement of evidence-informed practices with child-serving agencies. Illinois has received several federal System of Care grants. Based on recent collaborative efforts on behalf of children and adolescents, Illinois is poised to create state-of-the-art services for children and families based on System of Care values, principles, and practices.

**A focus on technology.** In Illinois, technology is increasingly being used to help drive both service provision and data collection and analysis. Telepsychiatry, e-prescribing, and other mobile and video tools are currently being used in limited capacities to make services accessible to Illinois residents with mental health needs who otherwise might not be served. With establishment of the statewide Office of Health Information Technology (HIT), housed in the Governor's office, the state understands the need to embrace the potential for HIT to improve health care quality and reduce costs. Although Illinois behavioral health providers have exceeded the national average of 10 percent for implementation of EHRs, there is still much work to be done. (See the discussion of "gaps" below.) However, under a grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA), the state has begun developing needed infrastructure to promote the exchange of health information among behavioral health and medical care providers.

*Illinois has a strong foundation on which to create a behavioral health system grounded in recovery.*



## SYSTEM GAPS

**Fragmented services.** One of the significant strengths of the Illinois mental health system—the diversity of agencies and providers serving adults with mental illnesses and children with emotional disorders—is also a key weakness. Individuals and families must interact with a range of agencies to access services. This fragmentation results in frustration for consumers, potential duplication of services, increased costs, and interruptions in care. The situation is especially acute for certain groups, including youth transitioning to the adult system of care and individuals with mental health conditions who come into contact with the criminal justice system for lack of more appropriate alternatives.

**Insufficient resources.** Reduced funding for behavioral health services also creates significant gaps in service. Between 2009 and 2012, states cut more than \$1.6 billion for mental health services.<sup>2</sup> Illinois experienced one of the largest reductions in mental health funding. The reduction in funding is particularly pronounced for Illinois residents not eligible for Medicaid; cuts in state general revenue funds have resulted in the provision of little more than crisis services to many indigent individuals with mental health conditions. If Illinois decides to participate in the expansion of Medicaid under the Affordable Care Act, this may help strengthen the safety net. However, overall lack of funding

<sup>2</sup> Honberg, R., Kimball, A., Diehl, S., Usher, L., & Fitzpatrick, M. (2011). *State mental health cuts: The continuing crisis*. Arlington, VA: NAMI.

for mental health results in gaps of specific services, such as permanent supportive housing, and for particular groups, such as transition-age youth and individuals currently ineligible for Medicaid. Moreover, the evidence-based practices the state promotes require a significant amount of training, supervision, and monitoring to ensure fidelity to the model, costs that are not reimbursed by Medicaid.

**Lack of consistent data and support for its use.** The inability to collect consistent data and to share this information across agencies affects the state's ability to plan for and provide comprehensive services to adults and children with mental health conditions. Many agencies have neither the capacity nor the resources to implement EHRs. Also, though state mental health hospitals have worked with a national consulting firm to complete a requirements analysis, no resources have been allocated to begin the process of developing or adopting an EHR, an issue that will result in Illinois being out of compliance with federal regulations/requirements. Moreover, there is a lack of real-time access to statewide data to support strategic planning or system development efforts. Redundancy and duplication in data collection and lack of uniformity in data definitions across agencies inhibit collaboration. Finally, neither state nor federal funding has been allocated to support HIT at the state or local level.

**Workforce challenges.** Ultimately, behavioral health care is only as good as the workforce that provides it. Overall, the health care workforce in America is aging and insufficiently sized and trained to meet the growing demand for integrated physical and behavioral health care. Illinois has made strides in addressing

the education of future behavioral health care workers through collaboration with some key universities on graduate and training programs in psychology and social work. The state also has advocated and developed employment for peers, family members, and veterans as service providers. However, there is an overall lack in Illinois, as elsewhere, of such specialists as child and adolescent psychiatrists, advanced practice nurses, physician assistants, and other behavioral health care workers. Workforce members need to be trained to provide trauma-informed, culturally competent services, especially to youth involved in the justice system and returning veterans.

In the next five years, as noted in the Overview of the Strategic Plan that follows, Illinois proposes to build on its numerous strengths and address gaps in services to create an evidence-based, recovery-focused, consumer- and family-driven system of mental health for the 21st century.



*Collaborative efforts that support adults and children with mental health conditions in Illinois abound.*



# Overview of Strategic Plan

The State of Illinois is committed to strengthening and expanding the mental health services system of care throughout the state in multiple settings. Through the work of the Task Force and its subcommittees, Illinois has articulated a clear and direct approach to formalizing a system and creating a coordinated path toward improved mental health services for children, transition-age youth, and adults in the community, in institutional settings, within the criminal justice system, and elsewhere. They have taken into account the specialized needs of veterans and their families, emphasized the need for prevention and early intervention, and focused on increasing coordination and integration, not only across systems, but also between primary care and mental health.

Over the next five years, the state will invest in infrastructure and workforce development, which will create a strong platform on which to build a more intentional, recovery-focused, and effective overarching system of care. Additionally, Illinois will seek to reduce stigma, bias, and discrimination through education, outreach, and engagement. Below is a summary of the most salient points underpinning the Illinois Mental Health Strategic Plan, which will guide its future work.

***Illinois has articulated a clear and direct approach to formalizing a system and creating a coordinated path toward improved mental health services for all Illinoisans.***



## Provide Sufficient Home- and Community-Based Services to Give Consumers Real Options in Care Settings

Providing a range of services both within and outside of institutional settings is essential to ensuring consumers' right to receive treatment and recovery supports in the least restrictive setting possible, and in the setting of their choice. The state is committed to expanding the service array statewide to ensure that consumers are able to make meaningful choices not only about the nature of the care they receive, but also the location in which they receive it.

Accordingly, Illinois seeks to further develop a flexible, broad array of family- and person-centered, recovery-focused, and culturally and linguistically competent services across a continuum of interventions from promotion, prevention, early intervention, and treatment and recovery supports for individuals across the lifespan. These services will be available in communities and homes throughout the state to ensure and promote freedom of choice for consumers. Specifically, the state will:

- Conduct an exhaustive inventory of existing service options throughout the state, including home- and community-based services for individuals across the lifespan in all settings and circumstances.
- Provide training, technical assistance, and coaching for the workforce to better equip professionals, paraprofessionals, and peer providers to use evidence-based and evidence-informed practices effectively and with fidelity to proven models.
- Develop a systematic approach to identifying, defining, and promoting new evidence-based, evidence-informed, and emerging best practice service delivery models.

- Actively seek opportunities to blend traditional therapeutic interventions with alternative supports, and provide workforce development to help providers do the same.
- Adopt quality indicators and benchmarks that demonstrate the impact of home- and community-based options.
- Increase community residential resources for justice-involved youth and adults, including leveraging the Affordable Care Act to maximize community services for the justice-involved population.

### Improve Access to Care

Ensuring universal access to mental health services for all populations within Illinois is one of the state's core priorities. By formalizing and strengthening the mental health system of care, the state will create a solid structure by which to increase access, promote integration between behavioral health and primary care, and facilitate collaboration and information sharing across previously disparate systems. The goal is to ensure that there is no wrong door for an individual to receive needed mental health services and supports. Priorities for the mental health services delivery system include early identification and uniform assessment of mental health needs for individuals of all ages, prevention and early intervention services, and outreach and engagement services that seek to eliminate the stigma that deters many from seeking mental health services. Illinois also will embrace the following strategies around improved access:

- Establish a basic set of core, consistent mental health services available statewide in home, community, and facility/institutional settings.
- Develop a formal children's system of care within the larger mental health system that allows service delivery regardless of individual needs, strengths, and level of acuity, and pilot a model system of care for young adults with a diagnosis of serious mental illness or serious emotional disturbance.

- Minimize transportation barriers, particularly in rural areas. Further, use technology to improve access to mental health services and to support rural initiatives.
- Ensure access to appropriate, affordable housing and meaningful employment with appropriate supports for adults with mental health needs statewide. Additionally, identify resources and develop a formal plan to increase the availability of rental assistance/rental subsidy for individuals who are not members of the Williams Class.
- Enhance continuity of care across systems, particularly for individuals transitioning from one system to another, such as young adults aging out of the children's system, individuals returning to the community from a correctional setting, and veterans reentering civilian life, along with their families.
- Improve communication across mental health, correctional, and detention agencies to facilitate appropriate jail diversion, develop a secure system for transferring health information among and from correctional facilities, and identify and eliminate Medicaid and private insurance exclusions that are barriers to receiving mental health services.

### Reduce Regulatory Redundancy

In an effort to create a more coordinated system, the state also seeks to remove regulatory barriers that create redundancy and duplication of effort both within and across agencies. As well as actively cultivating partnership and collaboration with other state agencies, Illinois will:

- Align strategic behavioral health priorities and coordinate services across state agencies.
- Create and maintain a process for performing ongoing review of existing and proposed regulations to identify potential redundancy.
- Implement uniform mental health outcome measures evaluation and data collection processes, as well as a system of sharing data across agencies and systems.

- Ensure that managed care contracts and other regulatory documents are consistent with the System of Care approach and federal mental health mandates, such as those promulgated by SAMHSA, the Centers for Medicare and Medicaid Services, and the Office of the National Coordinator for Health Information Technology.

### Maintain Financial Viability for Providers in a Cost-Effective Manner to the State

To ensure the sustainability of the changes proposed for Illinois' mental health system, the state seeks to develop a financial framework that leverages federal, state, and private funding. In particular, the state envisions a transition from reliance on grants for significant funding to a market-driven, strategic approach that responds to consumer demands while increasing financial stability and predictability. Key elements of this approach include:

- Reinvest funds saved from system restructuring initiated by the state, while maintaining and building on current infrastructure elements that support the vision articulated in this strategic plan. Additionally, the state will maximize alternative funding sources while identifying cost-savings opportunities and opportunities for flexible financing.
- Explore strategies for leveraging managed care and health home models of service delivery to increase cost effectiveness, with a focus on positive clinical and quality-of-life outcomes.
- Explore the development/implementation of waivers and state Medicaid plan changes.
- Link state funding to key mental health outcomes by using pay-for-performance strategies.
- Maximize both use of Medicaid expansion dollars (beginning in 2014) and services to non-Medicaid populations.

- Create a targeted workforce development strategy that will build capacity for current and future needs for mental health services as well as ensuring adequate reimbursement for qualified staff.

### Ensure That Care Is Effective, Efficient, and Appropriate Regardless of the Setting in Which it Is Provided

To fully meet the needs of state residents, mental health services must be of consistently high quality across all agencies, systems, and service settings. The introduction of statewide universal and consistent screening for mental health needs and a uniform set of cross-system treatment planning requirements will inform admission, discharge, and utilization decisions, as well as guide planning around workforce and infrastructure development. In addition, Illinois will:

- Emphasize the need for cultural and linguistic competence, recovery orientation, trauma awareness, and active and direct consumer involvement in planning, provision, evaluation, and monitoring of services.
- Design programs that are person centered, not program centered, and emphasize outreach and engagement.
- Foster the implementation of evidence-based and evidence-informed practices across the service system array, with a strong focus on fidelity to proven models.
- Create a coordinated crisis intervention system for all populations, with a focus on suicide prevention and “no wrong door” to mental health services.
- Incorporate strong transition planning across the entire system of care, emphasizing care coordination, benefits, housing, and employment for adults and youth. Similarly, improve the referral process and provide guidance and navigation to support individuals transitioning between systems or receiving services and supports from multiple agencies.
- Expand the coordinated use of data generated from consumer and system

data to improve service effectiveness across all venues, enhance linkages, and strengthen coordination of services. Securely and confidentially share key information supporting treatment decisions across providers.

### Ensure Quality of Care in All Care Settings via the Use of Appropriate Clinical Outcomes

Meaningful data that speak to relevant clinical outcomes are essential to driving high quality, consistency, and continuous improvement in the mental health system. Illinois seeks to develop a set of system outcomes appropriate across all providers and service settings to track performance, consumer outcomes, identify opportunities for enhancement, and pinpoint challenges and pockets of excellence throughout the state. The state will:

- Establish key outcome measures that include not only clinical outcomes (e.g., reduction in diagnosis-related symptoms) but also quality-of life-indicators, consumer and family member evaluation of services, life activities such as employment and housing, changes in justice involvement, and workforce-related measures.
- Collect, analyze, and interpret data across the entire system of care, including adult and child services, home- and community-based services, the justice system, institutional settings, veterans services, and others.
- Develop overall and population-specific (e.g., children, transition-age youth, adult, elderly, veteran, justice involved) statewide quality improvement plans; conduct continuous needs assessment; and maintain ongoing quality improvement efforts at all system levels, including assessing the impact of regulations on quality.
- Leverage state and federal resources to support development of a strong health information exchange and HIT infrastructure, as well as to ensure the interoperability of state and regional information systems.

*“In Illinois, every adult and every child with a mental health condition and his or her family is treated with dignity and respect. We honor their strength, their resilience, and their hopes and dreams. **This is not merely our goal; this is our promise.**”*

– Michelle R. B. Saddler, Secretary,  
Illinois Department of Human Services

### Ensure That Hospitalizations and Institutional Care, When Necessary, Are Available to Meet Demand Now and in the Future

Although Illinois’ priority is providing services in the least-restrictive environment, in some circumstances a hospital or other institution may be the most appropriate service setting to meet individuals’ needs. To help ensure access to institutional services when they are warranted to provide the best response to an individual’s needs, the state will:

- Thoroughly evaluate the role and operation of existing institutions to identify and implement changes that will ensure their functioning in line with the standards of a good and modern mental health system.
- Deliver services provided in all hospital and institutional settings in a recovery-oriented manner with clear plans and pathways to discharge.
- Maintain a sufficient number of hospital and institutional beds to serve uninsured individuals whose needs aren’t met by community-based emergency psychiatric care to prevent unnecessary and inappropriate contact with the justice system. Similarly, repurpose hospital civil units to provide non-secure forensic treatment for individuals with misdemeanor charges and to provide alternatives for individuals at risk for justice involvement (i.e., jail diversion).
- Ensure availability of residential treatment services for all children and adolescents who require that level of care regardless of guardianship.

# Adult Services Committee Goals and Objectives

The goals and objectives below reflect the work of the continuum of care, adult clinical, and adult recovery supports workgroups, all part of the adult services committee. Objectives are both short term (0-18 months) and long term (19-60 months).

## **STRATEGIC PRIORITY 1: Provide sufficient home- and community-based services to give consumers real options in care settings**

**GOAL 1: Ensure that services provided within the state are available to and meet the needs of individuals with mental illnesses.**

### **OBJECTIVES**

#### **SHORT TERM**

- Analyze current service array and develop a method and tool(s) to collect volume service need data from individual consumers and treatment providers.
- Implement data collection and analyze results.
- Implement health home models of care (Section 2703 of the Affordable Care Act [ACA]).

#### **LONG TERM**

- Develop needed services identified through the assessment of service needs.

**GOAL 2: Ensure that the service needs of individuals not eligible for Medicaid are considered.**

### **OBJECTIVES**

#### **SHORT TERM**

- Explore opportunities to enhance mental health service access to DMH non-Medicaid population.

#### **LONG TERM**

- Explore feasibility to make recommendations to achieve rapid disposition of Social Security Disability applications.
- Explore mechanisms that would decrease amount of time in the processing of Medicaid applications.

**GOAL 3: Pilot one model for young adults experiencing serious emotional disorders and/or serious mental illnesses.**

### **OBJECTIVES**

#### **SHORT TERM**

- Develop intensive service model for young adults experiencing serious emotional disorders and/or serious mental illnesses to prevent symptoms from becoming disabling.

#### **LONG TERM**

- Implement intensive service model for young adults and evaluate its efficacy and feasibility for dissemination and replication.



**GOAL 4: Determine the capability for integrated delivery of behavioral health and physical health services.**

**OBJECTIVES**

**SHORT TERM**

- Align holistic care design and delivery between the Department of Healthcare and Family Services (HFS) and DMH.
- Implement health home models of care (Section 2703 of the ACA).
- Review health information technology (HIT) and electronic health record (HER) readiness data collected by the Behavioral Health Integration Project.
- Survey primary care providers to assess their current capacity to serve individuals with serious mental illness as well as their interest in deepening their capacity to do so.

**LONG TERM**

- Enhance the capacity of non-traditional providers to deliver some mental health services within their practices.

**GOAL 5: Determine the feasibility of a statewide universal and consistent approach for effective screening and assessment for determination of mental health service needs, and its potential applicability for informing admission, discharge, and utilization review decisions.**

**OBJECTIVES**

**SHORT TERM**

- Implement PA97-1061, the Consumer Alternatives Program Act amending the Alcoholism and Other Drug Abuse and Dependency Act, by calling for a uniform screening, assessment, and evaluation process for substance abuse and mental disorders, where “uniform” does not mean the use of a singular instrument, tool, or process that all must utilize.

**LONG TERM**

- Ensure that data collected from a universal assessment is funneled into a central database from which analysis can inform the refinement of the service delivery system.

**STRATEGIC PRIORITY 2: Improve access to care**

**GOAL 1: Increase early identification of mental illnesses, substance use disorders, or serious emotional disorders at primary care and other settings, for assessment of risk and need for treatment.**

**OBJECTIVES**

**SHORT TERM**

- Implement PA97-1061, the Consumer Alternatives Program Act amending the Alcoholism and Other Drug Abuse and Dependency Act, by calling for a uniform screening, assessment, and evaluation process for substance abuse and mental disorders, where “uniform” does not mean the use of a singular instrument, tool, or process that all must utilize. (See Goal 5, Short-term Objective 1)
- Develop a toolkit of existing screening evidence-based practices such as Screening, Brief Intervention, and Referral to Treatment (SBIRT).
- Provide training to non-traditional providers in how to utilize and incorporate screening and brief intervention tools into their practice.
- Ensure that non-traditional providers can facilitate referrals to mental health services in an effective and efficient manner.

**LONG TERM**

- Evaluate the effectiveness of screening tools, training, and referrals.

**GOAL 2: Reduce stigma through education and other evidence-based interventions (e.g., Mental Health First Aid).**

**OBJECTIVES**

**SHORT TERM**

- Determine how to raise mental health awareness and early identification and linkage to treatment into schools (colleges, high schools, etc.) and reduce the stigma of mental illness.

**LONG TERM**

- Look at blended funding to provide this education with Illinois State Board of Education and Illinois Higher Education.

**GOAL 3: Ensure a strong state-wide system for suicide prevention.**

**OBJECTIVES**

**SHORT TERM**

- Review current models.
- Recommend state model.

**LONG TERM**

- Implement statewide model.

**GOAL 4: Ensure access to appropriate and affordable housing for adults diagnosed with mental illnesses.**

**OBJECTIVES**

**SHORT TERM**

- Identify resources and plans to increase availability of rental assistance/subsidy for all individuals with serious mental illness in need, including Class Members in Consent Decrees, with a focus on identifying additional funding sources for bridge rent subsidy.
- Collaborate with Illinois Housing Development Authority to ensure state priority of housing for individuals with mental illnesses.
- Build on relationship with housing authorities to expedite applications and identify opportunities to increase utilization of housing resources.
- Ensure that individuals currently living in permanent supportive housing are able to stay in their living situations with Bridge Subsidy assistance until permanent rental assistance is obtained or the consumer becomes economically self-sufficient with the ability to pay for housing due to recovery.
- Create a culture of acceptance and civic engagement by developing educational materials for landlords for distribution by agencies serving individuals with mental illnesses.
- Increase awareness of fair housing laws in both providers and individuals served by identifying resources and supports available for assistance in the community.

**LONG TERM**

- Expand the array of housing types so that the housing is designed to meet the needs of the individual.

**GOAL 5: Ensure access to opportunities for employment, with supports needed to maintain employment, for adults diagnosed with mental illnesses.**

**OBJECTIVES**

**SHORT TERM**

- Review IDHS Division of Rehabilitative Services funding for supported employment to maximize flexibility and to identify enhanced collaborative funding opportunities to ensure full utilization of resources to support appropriate EBPs, evidence-informed practices, and related support services. Target underserved subgroups such as youth, justice-involved persons, persons with co-occurring behavioral health conditions and physical disabilities, and immigrants.
- Educate individuals with mental illnesses about the relationships among employment, recovery, physical, and mental health.

- Promote the IPS model of supported employment as a core mental health service within managed care.

**LONG TERM**

- Implement an integrated and simplified funding strategy that fully integrates health care (Medicaid) with employment supports.
- Expand the array of EBPs and evidence-informed practices and supports that promote and sustain employment, career development, and recovery to all parts of the state by maximizing funding options and achieving expanded access to IPS at 75 percent of providers.

**GOAL 6: Provide outreach services to individuals in need of mental health services that are effective in achieving engagement in treatment and services and employ strategies that move towards eliminating stigma.**

**OBJECTIVES**

**SHORT TERM**

- Develop a state strategy and funding mechanism around outreach to the homeless mentally ill and emergency department diversion through practices such as living room models and drop-in centers.
- Develop a cadre of peer leaders who are armed with effective tools for engaging individuals with serious mental illness.

**LONG TERM**

- Evaluate engagement efforts, identify best practices, and disseminate findings.

**STRATEGIC PRIORITY 3: Reduce regulatory redundancy**

**GOAL 1: Establish and maintain a process for the ongoing review by competent staff of existing and proposed regulations, the identification of suspected redundant regulations, and the effectiveness of appeals processes.**

**OBJECTIVES**

**SHORT TERM**

- Establish a working group with the expressed deliverable of aligning mental health documentation across state agencies while reducing redundancy, streamlining the volume of paperwork while ensuring federal compliance, and ensuring all new Medicaid managed care organizations utilize the same paperwork.
- Complete implementation of PA 97-0558, which created the “Management Improvement Initiative Committee” for IDHS.
- Maintain compliance with PA 92-0755, providing deemed status for providers accredited by certain national accreditation organizations.

**STRATEGIC PRIORITY 4: Obtain and maintain financial viability for providers in a cost-effective manner to the state**

**GOAL 1: Continue the evolution of state funding for mental health services from a grants approach to market-driven funding approaches responsive to consumer desires, and needs that ensure cost-effectiveness for the state and that offer the greatest amount of financial predictability and stability for providers.**

**OBJECTIVES**

**SHORT TERM**

- Investigate the ability of multi-year (two to three years) contracts with provider organizations to allow for some predictability.
- Finance increased access to the core services of psychiatry, medication, and crisis services, including mobile crisis, which is needed in most areas of the state.
- Explore capitated rate structures that focus on outcomes rather than procedures so that organizations may allocate resources in flexible ways while being held accountable to outcomes.

- Explore aggregating appropriations from multiple agencies to create a shared savings pool, to be allocated based on performance.
- Ensure that capitated rate structures account for the actual cost of care.

**GOAL 2: While sustaining an effective service system, ensure that alternative sources of funding for mental health services (such as federal financial participation funds) are maximized and that system savings for the state are identified.**

**OBJECTIVES**

**SHORT TERM**

- Implement health home models of care (Section 2703 of the ACA).
- Ensure that regulations for mental health services support provider efforts to weave together resources from other systems such as primary care, oral health, workforce development, and housing.
- Support community mental health centers in their effort to develop the skills necessary to compete for funding from other systems – especially housing and workforce development.
- Explore Medicaid waiver and state plan changes (e.g. 1915 c, 1115) to expand resources for community mental health services.
- Engage in deliberate and ongoing consultation and planning with community mental health authorities (708 Boards) to determine where aligning priorities and blending local and state funding might strengthen and enhance community programs and services.

**STRATEGIC PRIORITY 5: Ensure care is effective, efficient, and appropriate regardless of the setting in which it is provided**

**GOAL 1: Ensure the direct and active involvement of individuals with lived experience in the planning for and provision, evaluation, and monitoring of services.**

**OBJECTIVES**

**SHORT TERM**

- Ensure involvement of individuals with lived experience in agency decision making in all mental health provider agencies.
- Double the number of people with the Certified Recovery Support Specialist (CRSS) credential.

**LONG TERM**

- Promote the expansion of CRSS into the area of corrections.
- Strengthen the Wellness Recovery Action Planning (WRAP) infrastructure; provide WRAP at 50 new agencies within two years.

**GOAL 2: Through the coordinated use of client- and system-level data, improve the effectiveness of services across all service venues, including linkages and coordination of services as appropriate.**

**OBJECTIVES**

**SHORT TERM**

- Define standard outcome measures (e.g. Discharge-Linkage-Aftercare for adults and children and adolescents), indicators of improvements in individuals' quality of life (such as receipt of services in the least restrictive setting possible, employment, reduction in justice involvement or homelessness), and consumer and family perception of services as major indicators of system and provider performance.

**LONG TERM**

- Implement financing mechanism to pay for outcomes.
- Continuously evaluate outcomes and improve relevant processes.

**STRATEGIC PRIORITY 6: Ensure quality of care in all care settings via the use of appropriate clinical outcomes**

**GOAL 1: Employing state government leadership, foster the implementation and statewide diffusion of evidence-based and emerging best practices for mental health services.**

**OBJECTIVES**

**SHORT TERM**

- Survey providers regarding what EBPs they currently employ, those that they would like to employ with additional resources, and those for which state regulations stand in the way.
- Identify resources to support organizations as they integrate EBPs; such integration has short-term impact on productivity and other costs.
- Encourage providers who explore innovative solutions to unique challenges to measure the effectiveness of the practice-based evidence.

**LONG TERM**

- Evaluate the integration of EBPs into practice.

**GOAL 2: Ensure the maintenance of ongoing quality-improvement efforts at all system levels, including assessment of the impact of regulations on quality.**

**OBJECTIVES**

**SHORT TERM**

- Review current legislation and support changes to allow reasonable sharing of information among service providers.
- Utilize health information exchange (HIE) in a bi-directional fashion whereby providers share information with the HIE and the HIE shares information with the provider so that the provider has real-time feedback on where their service outcomes fall compared with those of their peers and relative to historical performance and regulatory standards.

**STRATEGIC PRIORITY 7: Ensure that hospitalizations and institutional care, when necessary, is available to meet demand now and in the future**

**GOAL 1: Ensure that hospitals, residential and other treatment facilities serving individuals with mental illness deliver services in a recovery-oriented manner with clear plans and “pathways” to discharge.**

**OBJECTIVES**

**SHORT TERM**

- Reduce the rate of psychiatric hospitalizations and rehospitalizations through greater use of community crisis intervention teams and the development of short-term subacute units in non-hospital residential treatment settings.
- Establish and strengthen ties between universities and state mental health centers to ensure access to and better training of mental health professionals and to foster the development of state mental health centers as centers of excellence in psychiatric treatment to serve as a model and support for system-wide improvements.
- Provide more effective transition from residential settings to the community with more deliberate and planned community living skills training before transition (such as promote “doing with” interventions rather than “doing for” interventions, such as training a person with diabetes in illness self-management rather than managing it for that person) and with better linkages between community agencies and residential treatment settings.
- Ensure greater integration of recovery-oriented approaches into residential treatment settings.
- Review treatment requirements and regulations imposed to determine whether there are barriers to providing good clinical practices and effective discharge planning.
- Move forward with the revamp of Sub Part S rules and SMHRF Act rules placed on hold.
- Strengthen community mental health agencies by allowing access to state mental health center expertise and training.

- With judicial concurrence, ensure greater transition to the community for clinically appropriate forensic clients served in state hospitals through effective partnerships with community agencies and structured programming in residential treatment settings.
- Preserve access to regional psychiatric hospital care for all individuals in need.

**GOAL 2: Assess the current role of existing residential and other treatment facilities and enhance the effectiveness, efficiency, and coordination of the service system by encouraging and facilitating new roles and responsibilities for key components of the system.**

**OBJECTIVES**

**SHORT TERM**

- Develop a plan to build on the relationships that exist between facilities and other community providers to create joint treatment approaches, discharge planning.
- Explore and plan for the transition and reclassification of some IMD nursing facilities to Subpart S Facilities or Specialized Mental Health Rehabilitation Facilities with a clear focus on rehabilitation and living skills development for adults with mental illnesses and development and dissemination of clear admission criteria (and differences from admission criteria for general nursing facilities).
- Explore clarification of one or more specific roles specialized mental health rehabilitation facilities could have in the service system, such as: (1) provide short-term services with a clear focus on rehabilitation and living skills development and transition to permanent housing; (2) serve as a site for sub-acute crisis stabilization; (3) serve as a longer-term treatment sites for specialized populations, such as individuals with significant behavioral problems or forensic issues, with a recovery-oriented approach focused on return to community living.
- Explore and plan for development or conversion of supervised residential sites to serve the needs of the forensic population and increase the focus of these programs as being transitional to permanent housing.
- Explore expansion of focus of transitional housing sites beyond just homeless individuals to include individuals with mental illness needing housing until a more permanent housing situation can be secured.
- Explore and plan for incorporation of 72-hour clinic observation beds for stabilization and expedient referral to the most appropriate treatment site from hospital emergency departments.
- Explore feasibility of an enhanced role of county/municipal jail psychiatric units in earlier initiation of fitness restoration efforts, as appropriate.
- Explore feasibility of an enhanced role of county/municipal jails in earlier initiation of fitness restoration efforts, as appropriate.
- Explore development and implementation of supported education models within university/college counseling center service settings.



# Veterans' Services Committee Goals and Objectives

The veterans' services committee identified goals and objectives to improve the availability and delivery of mental health services not only for individuals who served in the Armed Forces, but also for their family members. The table below addresses both short-term (0-18 months) and long-term (19-60 months) activities.

## **STRATEGIC PRIORITY 1: Provide sufficient home- and community-based services to give consumers real options in care settings**

**GOAL 1: Ensure that service members of the United States Armed Forces, veterans, and their families (SMVF) are included in the plans for real options in care settings.**

### **OBJECTIVES**

#### **SHORT TERM**

- Establish objectives in all planning committees for service care that enhance real options relevant to SMFV.

#### **LONG TERM**

- Adopt quality indicators and benchmarks that demonstrate sufficient home- and community-based care options.

## **STRATEGIC PRIORITY 2: Improve access to care**

**GOAL 1: Close the service gap between community behavioral health providers and the Veterans Health Administration (VHA) System of Care.**

### **OBJECTIVES**

#### **SHORT TERM**

- Develop an inventory of the existing behavioral health system for SMFV, including VHA, DMH-contracted community providers, and others.
- Create a coordinated crisis services intervention system between the VA and community providers, with special attention to suicide prevention.
- Enhance the referral handoff process.

#### **LONG TERM**

- Establish regular communication flow among VHA, IDHS, and community providers.
- Monitor effectiveness of intervention over time.

**GOAL 2: Improve and enhance suicide prevention systems across the state.**

### **OBJECTIVES**

#### **SHORT TERM**

- Begin to use SAMHSA SMFV TAC consultants to obtain national perspective on best practices.

#### **LONG TERM**

- Coordinate and complement activities of the Illinois Suicide Prevention Coalition with VHA suicide prevention efforts.

**GOAL 3: Minimize transportation barriers that negatively affect access to services.**

**OBJECTIVES**

**SHORT TERM**

- Assess regional problem spots for geographic barriers.

**LONG TERM**

- Identify solutions and resources.

**STRATEGIC PRIORITY 3: Reduce regulatory redundancy**

**GOAL 1: Organize all strategic SMVF behavioral health priorities across state agencies.**

**OBJECTIVES**

**SHORT TERM**

- IDHS Secretary will sign memorandum of agreement (MOU) with Illinois Joining Forces.
- Identify points of contact with all other IDHS divisions/governmental agencies and coordinate with Illinois Department of Veterans' Affairs on behavioral health service provision.
- Develop and evaluate a business case for the creation of full-time "Veterans" positions across state agencies to help ensure that SMVF issues are represented in policy decisions and operational implementation.
- Develop and evaluate a business case for the creation of full-time "Veterans Peer Support" positions through the requirement of a veteran-specific Certified Recovery Support Specialist (CRSS) credential. These positions will be designed for someone who has faced similar circumstances to provide help to SMVFs by drawing from the kind of understanding and encouragement toward growth that individuals who struggle with similar issues offer one another.

**LONG TERM**

- Establish communication protocols within IDHS to share data and track services to SMVF.
- Organize all strategic priorities across state agencies and identify policy implications and needed changes.

**STRATEGIC PRIORITY 5: Ensure that care is effective, efficient, and appropriate regardless of the setting in which it is provided**

**GOAL 1: Ensure military cultural competence throughout the state.**

**OBJECTIVES**

**SHORT TERM**

- Determine numbers and locations of needed military culturally competent providers.
- Reach consensus regarding baseline and advanced-level curriculum.

**LONG TERM**

- Map SMVF education and training activities through the state.

**GOAL 2: Develop a sustainable education and training infrastructure that reaches all regions of the state.**

**OBJECTIVES**

**SHORT**

- Identify needed supports and resources.

**LONG TERM**

- Establish a qualified provider network.



**STRATEGIC PRIORITY 6: Ensure quality of care in all care settings via the use of appropriate clinical outcomes**

**GOAL 1: Enable a culture of continuous quality improvement in the delivery of behavioral health services.**

**OBJECTIVES**

**SHORT TERM**

- Provide ongoing identification of needs of SMVF across the state.
- Acquire and develop benchmarks and quality indicators for service provision.

**LONG TERM**

- Create a statewide quality improvement plan for SMVF services.

**STRATEGIC PRIORITY 8: Increase awareness and availability of complementary and alternative medicine (CAM) interventions (including non-medical) that serve SMVF.**

**GOAL 1: Catalogue all SMVF-related CAM supports (including non-treatment and non-medical) throughout the state.**

**OBJECTIVES**

**SHORT TERM**

- Determine areas of penetration and need across the state.
- Establish forum for the dissemination of best programs/practices.

**LONG TERM**

- Focus on integration of CAM supports with other therapeutic interventions.

# Forensic Services Committee Goals and Objectives

The key objectives growing from the committee's identified priorities are stated under each legislative topic below. Most objectives are short term (less than 18 months) unless they are dependent on Affordable Care Act (ACA) benefit expansion in 2014.

**STRATEGIC PRIORITY 1: Provide sufficient home- and community-based services to give consumers real options in care settings**

**GOAL 1: If and when there is a legislative approval to expand Medicaid under ACA, the benefits should be leveraged to maximize community services for justice-involved adults and juveniles with behavioral health needs.**

**OBJECTIVES**

**SHORT TERM**

- Ensure that benefits for the expanding population are sufficient to establish and maintain recovery.
- Develop a taxonomy of services amenable to forensic situations, including state and civil hospitals, and work with emerging plans to secure inclusion of necessary mental health and substance abuse services in their benefit plan.
- Work to remove any exclusions in Medicaid and private insurance that are barriers to coverage of treatment.

**LONG TERM**

- Assess the possible use of the health home model to provide services for the justice-involved population.

**GOAL 2: Maximize Medicaid enrollment of individuals in jails and prisons.**

**OBJECTIVES**

**SHORT TERM**

- Build application and benefit suspension infrastructures to maximize the enrollment of individuals in jails and prisons.

**GOAL 3 : Increase community residential resources for justice-involved adults and youth with behavioral health needs.**

**OBJECTIVES**

**SHORT TERM**

- Expand supportive housing resources.
- Expand the community conditional release program model currently operating in Regions 2 and 4 and apply it to other residential settings.
- Develop flexible support services funding for community residential services.

**GOAL 4: Ensure that managed care organizations (MCOs) maintain responsibility for the justice-involved population.**

**OBJECTIVES**

**SHORT TERM**

- Identify any MCO legal, regulatory, or rule barriers to providing care.
- Investigate the possibility and feasibility of having MCOs maintain responsibility for paying for the health services of their members when they are in jail.

**LONG TERM**

- Develop MCO contracting requirements to ensure that benefits address the behavioral health service needs of the justice-involved population.

**STRATEGIC PRIORITY 2: Improve access to care**

**GOAL 1: Divert individuals with behavioral health needs from jail and prison.**

**OBJECTIVES**

**SHORT TERM**

- Support and expand law enforcement Crisis Intervention Team (CIT) program models that include community drop-off stabilization sites.
- Expand community-based programming for individuals on probation with behavioral health needs (i.e., mental health courts, special mental health probation services).
- Identify 17- to 23-year-olds in jails and, where appropriate, link them to community services and expand the role of Mental Health Juvenile Justice Initiative programs to include this transitional youth population.

**GOAL 2: Improve continuity of care among local/state mental health, detention, and correctional agencies.**

**OBJECTIVES**

**SHORT TERM**

- Improve information flow and sharing among mental health agencies, detention facilities, and correctional agencies (i.e., expand Jail Data Link [JDL]).
- Form a committee of state and local corrections officials and mental health advocates to create a plan to transfer mental health records from county jails to Illinois Department of Corrections (IDOC).
- Expand the JDL program to IDOC and additional county jails. Add additional linkage staff to improve the effectiveness of JDL.
- Develop dedicated bridge subsidies for forensic consumers who need support for long-term community residential treatment.

**GOAL 3: Train staff working with the justice-involved population in different settings.**

**OBJECTIVES**

**SHORT TERM**

- As IDOC implements its Risk Assets Needs Assessments (RANA) tool, ensure that the tool addresses mental health needs and staff are properly trained to use it effectively.
- Ensure that probation and parole agents are adequately trained to meet the needs of probationers and parolees with behavioral health conditions.
- Train residential staff in the forensic legal process, risk assessment approaches, trauma-informed care, recovery principles, and cognitive-behavioral therapies.

**STRATEGIC PRIORITY 3: Reduce regulatory redundancy**

**GOAL 1: Utilize uniform evaluation and data collection processes across all systems treating mental health/justice-involved populations.**

**OBJECTIVES**

**SHORT TERM**

- Expand the use of the Department of Mental Health (DMH) integrated database for problem-solving courts.
- Develop and implement uniform screening tools for jails and correctional facilities.
- Develop and implement behavioral health screening and risk assessment tools for probation and parole discharge planning and monitoring.

**STRATEGIC PRIORITY 5: Ensure that care is effective, efficient, and appropriate regardless of the setting in which it is provided**

**GOAL 1: Build a recovery-oriented and trauma-informed system of care for agencies involved with justice involved individuals with mental illness.**

**OBJECTIVES**

**SHORT TERM**

- Train community residential providers in trauma-informed care and recovery principles.
- Train IDOC and Department of Juvenile Justice (DJJ) staff managing the care of inmates with behavioral health needs on trauma-informed care.
- Include a trauma-informed care component in jail corrections officer, juvenile detention staff, probation, and parole officer training.

- Ensure that all residential programs address the needs of persons who are justice involved to facilitate their productive engagement with employment, education, healthy lifestyle, and other meaningful life activities.
- Expand supported employment programs for justice-involved individuals.
- Ensure that all corrections and detention facilities, including police lock-ups, provide adequate behavioral health services for emergency assessment and care and/or extended treatment.

**GOAL 2: Develop appropriate alternatives to forensic hospital care to reduce the chronic waiting list for DMH forensic unit hospital admissions.**

**OBJECTIVES**

**SHORT TERM**

- Develop alternative residential sites (other than DMH hospital forensic units) to provide fitness restoration services for low-risk individuals with misdemeanor charges.
- Explore cost effectiveness and jail capacity for providing on-site fitness restoration for appropriate referrals.
- Expand community providers' capacity to support mental health courts and jail diversion initiatives.
- Expand community providers' capacity to provide outpatient forensic restoration services.

**GOAL 3: Develop specialized Forensic Assertive Community Treatment (FACT) Teams to support recovery.**

**OBJECTIVES**

- Include FACT Teams in the taxonomy of services amenable to forensic situations (i.e., FACT support of community residential and stabilization programs, parole and probation, and problem-solving court initiatives).
- Work with Department of Healthcare and Family Services (HFS) to determine how FACT could be supported with Medicaid expansion.

**GOAL 4: Create triage and linkage units to provide alternatives to arrest and criminalization.**

**OBJECTIVES**

**SHORT TERM**

- Create dedicated civil beds to serve the high volume of individuals affecting the Cook County court system as the community system reduces the need for DMH civil inpatient beds.

**STRATEGIC PRIORITY 6: Ensure quality of care in all care settings via the use of appropriate clinical outcomes**

**GOAL 1: Establish a system-wide set of clinical outcome measures for justice-involved individuals.**

**OBJECTIVES**

**SHORT TERM**

- Review the National Outcome Measures (NOMs) for the justice-involved population.
- Integrate justice-involved outcome measures into DMH management information system.

**GOAL 2: Provide information to community stakeholders that will increase their understanding of best practices, legal expectations, rights, and service needs of individuals with mental illness who are justice involved.**

**OBJECTIVES**

**SHORT TERM**

- Disseminate the DMH Forensic Manual statewide to service providers and court personnel.
- Expand the resources and capacity of the Illinois Center of Excellence for Behavioral Health and Justice to provide technical assistance, training, and dissemination of best practices and other relevant information throughout Illinois.

**GOAL 3: Improve assessment of and treatment for persons who are detainees and inmates with mental illness and comorbid conditions in jails and prisons.**

**OBJECTIVES**

**SHORT TERM**

- Form a committee of state and local correction officials and mental health advocates to assess training of jail and prison front-level staff to address the needs of detainees and inmates with behavioral health conditions.
- Increase resources for psychiatric and behavioral health care including appropriate use of telepsychiatry in DJJ, IDOC, jails and alternative settings (e.g., shelters).
- Explore risk and needs assessment tools to inform the courts and parole determiners on risk release issues.

**STRATEGIC PRIORITY 7: Ensure that hospitalizations and institutional care, when necessary, is available to meet demand now and in the future**

**GOAL 1: Maintain DMH civil beds necessary to meet the needs of uninsured individuals and individuals whose needs are not met by community-based emergency psychiatric care to prevent contact with the criminal justice system.**

**OBJECTIVES**

**SHORT TERM**

- Develop profiles of persons at risk for criminalization and recidivism.
- Develop inpatient DMH programs to serve persons with refractory conditions who may need longer-term care.
- Work closely with community inpatient and stabilization program providers to determine who is best treated in a state hospital.
- Train DMH staff to provide recovery-based care, behavior management, risk assessment and other modalities to address the needs of individuals with more challenging inpatient care and community placement needs.
- Work closely with the courts and law enforcement to establish the role of DMH civil hospitals as alternatives to incarceration for individuals with behavioral health needs.

**GOAL 2: With Medicaid expansion, repurpose DMH hospital civil beds.**

**OBJECTIVES**

**SHORT TERM**

- Assess the long-term impact of system rebalancing efforts on DMH inpatient bed utilization and private hospital and community-based program effectiveness in providing care for individuals who need acute psychiatric care, especially those who are justice involved or at risk of justice involvement.
- With Medicaid expansion, repurpose DMH hospital civil units to provide non-secure forensic treatment for individuals with misdemeanor charges and diversion of individuals at risk for justice involvement.
- Increase necessary staffing in DMH forensic inpatient units to reduce length of stay and increase the discharge rates of individuals in with “unfit to stand trial” (UST) legal status and conditional discharges of individuals in “not guilty by reason of insanity” (NGRI) status.



# Child and Adolescent Services Committee Goals and Objectives

The primary recommendation of the children and adolescents committee is the creation of a formal children's system of care, which is reflected in the goals and objectives below. Short-term goals refer to months 0-18, whereas long-term goals refer to months 19-60 of the state's five-year plan.

## **STRATEGIC PRIORITY 1: Provide sufficient home- and community-based services to give consumers real options in care settings**

**GOAL 1: Develop and implement a statewide, unified, state-of-the-art system of care to promote optimal social and emotional development for all children, adolescents, and young adults with behavioral health needs.**

### **OBJECTIVES**

#### **SHORT TERM**

- Review all current services for conformity to the Committee's vision, mission, and values.
- Revise policy and service delivery as necessary to support the vision, mission, and values.
- Review the Medicaid rule to ensure all necessary services are addressed and covered by the rule.

## **STRATEGIC PRIORITY 2: Improve access to care**

**GOAL 1: Develop and implement a workforce development strategy to ensure the expansion of core competencies within the behavioral health system that are grounded in the system of care values and principles.**

### **OBJECTIVES**

#### **SHORT TERM**

- Review current training, technical assistance, and coaching approaches to identify gaps or opportunities to improve so as to ensure that providers are prepared and skilled in the systems of care approach.

#### **LONG TERM**

- Develop new curriculum to fill any identified gaps or opportunities to improve workforce strategies.
- Create an ongoing training, technical assistance and coaching mechanism to ensure that providers are prepared and skilled to provide effective services and supports consistent with the systems of care approach.
- Conduct newly developed and improved training.

**GOAL 2: Develop and redesign the current mental health system to allow service delivery for all children, adolescents, and young adults regardless of individual needs, strengths, and level of acuity.**

### **OBJECTIVES**

#### **SHORT TERM**

- Adopt quality indicators and benchmarks that demonstrate sufficient home-, school-, and community-based care options.

- Create an efficient and effective transition planning process to support children, adolescents, and young adults as they move across levels of care and child-serving systems.

**LONG TERM**

- Create a uniform set of minimum requirements for use across all child-serving systems for assessment and treatment planning.

**GOAL 3: Redesign the current children’s mental health service delivery array ensuring that Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) as well as intensive community-based services are available to avert, when possible, the need for crisis services.**

**OBJECTIVES**

**SHORT TERM**

- Identify options for expanding the use of telepsychiatry, tele-health, and teleconferencing.
- Identify options for expanding the use of Illinois DocAssist (psychiatric consultation) to support primary care physicians, advance practice nurses, and physician assistants.

**LONG TERM**

- Develop and expand the concept of a “no wrong door” approach to accessing children’s mental health services.
- Identify options for expanding the current Screening, Assessment, and Support Services (SASS) program to provide stronger EPSDT and long-term supports.
- Identify options for expanding services in schools through the use of family resource developers, peer supports, family consumer specialists, and navigators.

**STRATEGIC PRIORITY 3: Reduce regulatory redundancy**

**GOAL 1: Develop an administrative structure that will support implementation of the system of care.**

**OBJECTIVES**

**SHORT TERM**

- Develop a Children’s Cabinet at the executive level to bring together all child-serving systems to make decisions and monitor care.
- After the Children’s Cabinet is authorized, establish a Cabinet for system of care implementation.

**LONG TERM**

- Ensure that managed care and other contracts and regulatory documents are consistent with the systems of care approach, EPSDT, and federal mental health mandates.

**STRATEGIC PRIORITY 4: Maintain financial viability for providers in a cost-effective manner to the state**

**GOAL 1: Develop a financial framework that leverages all sources of federal, state, and private funding to support the systems of care.**

**OBJECTIVES**

**SHORT TERM**

- Amend current Rule 132 or develop a specific Medicaid Rule for Children, Adolescents, and Young Adults that will allow for the delivery of a flexible, broad array of community-based behavioral health services.
- Ensure that experts in children’s mental health (e.g., the DMH Child and Adolescent Services Unit [DMH-C&A], DCFS, DASA, ISBE School-Wide Systems of Support, etc.) are involved in all cross-system planning and implementation of any care management approach that may involve health homes, care management entities, or other Medicaid/Affordable Care Act (ACA) reform activity used in Illinois for children.

**LONG TERM**

- Develop policy and regulations to ensure that dollars saved from the use of effective diversion strategies from high-end services are reinvested in the expansion of community-based system of care services.

**STRATEGIC PRIORITY 5: Ensure that care is effective, efficient, and appropriate regardless of the setting in which it is provided**

**GOAL 1: Develop a uniform statewide approach across systems for assessment, treatment planning, and adopting quality indicators and benchmarks supporting system of care values and principles and resulting in the development of a continuum of interventions from prevention and promotion to early intervention and treatment that covers the age spectrum from birth through transition-age young adults.**

**OBJECTIVES**

**SHORT TERM**

- Ensure that all aspects of the service array are family driven, youth guided, and cultural and linguistically competent.
- Develop assessment tools that are consistent with the system of care values and principles.
- Develop treatment planning tools consistent with the system of care values and principles.
- Develop quality outcome measures consistent with the system of care values and principles.

**GOAL 2: Develop and implement a cross-system program to effectively transition young adults from child and adolescent services to the adult system, with emphasis on care coordination, education, benefits, housing, employment, and other necessary supports and services to ensure successful transition to adulthood.**

**OBJECTIVES**

**SHORT TERM**

- Create a model of transition from child and adolescent systems to adult systems.

**STRATEGIC PRIORITY 7: Ensure that hospitalization and institutional care, when necessary, is available to meet demand now and in the future**

**GOAL 1: To prepare for the future, add services to improve our ability to identify treatment needs.**

**OBJECTIVES**

**SHORT TERM**

- Continue availability of DMH-C&A Individual Care Grant and other residential services for youth and adolescents who meet Rule 135 criteria.

**LONG TERM**

- Ensure availability of residential treatment services for all children and adolescents who require that level of care regardless of guardianship.



# Administrative Issues Committee Goals and Objectives

The administrative issues committee focused heavily on the structure and authority needed to accomplish the vision of a unified mental health service system in Illinois. The goals and objectives below address both the short term (months 0-18) and long term (months 19-60).

## **Strategic Priority 3: Reduce Regulatory Redundancy**

**Goal 1: Explore licensure of mental health providers and other opportunities to streamline and create uniformity in monitoring regulatory processes.**

### **OBJECTIVES**

#### **SHORT TERM**

- Identify and explore strategies for licensing mental health providers.

## **Strategic Priority 5: Ensure that care is effective, efficient, and appropriate regardless of the setting in which it is provided**

**Goal 1: Empower a recognized behavioral health authority to coordinate, plan and set behavioral health policy across all state departments/agencies.**

### **OBJECTIVES**

#### **SHORT TERM**

- Identify best practices for behavioral health authority models that exist in other states. Use this information to inform planning in Illinois.
- Review stated goal (above) for mental health services structure/infrastructure with the Governor's Office (Michael Gelder), Healthcare and Family Services (Director Hamos), the Department of Human Services (Secretary Saddler), the Director of DMH (Director Jones), the Director of DASA (Director Binion) and other departments/divisions.
- Draft legislation or an Executive Order to establish a behavioral health authority that is housed in the Governor's Office.
- Formally establish the behavioral health authority as described above.

#### **LONG TERM**

- As part of behavioral health care/physical health care direction within unified budgeting, consider pay-for-performance initiatives. One potential methodology for allocating dollars based on performance may be to create a shared savings pool that would provide for dollars to be allocated to providers (physical health care organizations and community behavioral health organizations [CBHOs]) based on process, outcome, and other performance measures that are established.

**Goal 2: Work with post-secondary education programs to establish/develop relevant pre-service/in-service training programs.**

### **OBJECTIVES**

#### **SHORT TERM**

- Conduct a study/census of behavioral health service delivery staff to project workforce needs over the next five years.
- Identify educational institutions with an interest in establishing and developing curricula and coursework for the behavioral health care workforce, and leverage current relationships with educational institutions.

- Based on the results of behavioral health workforce study referenced above, work with training/educational institutions to develop a plan to address behavioral health workforce needs.

**LONG TERM**

- Work with educational institutions to develop appropriate coursework, curricula, practica, and internships that address the needs of individuals who need treatment and to address behavioral health from a public health perspective. Use the “science to service” paradigm to inform/plan training and curricula development where possible.

**Goal 3: The delivery of evidence-based/evidence-informed treatments will be provided by programs/individuals certified in the treatment/practice to ensure fidelity to the treatment model.**

**OBJECTIVES**

**SHORT TERM**

- Establish fidelity to evidence-based practices (EBPs) and evidence-informed service models as a contractual requirement for all vendors/providers.
- Assess fidelity to treatment models whenever/wherever service is provided on an ongoing basis.

**LONG TERM**

- Assess and track outcomes based on EBP fidelity models.

**Goal 4: All contracted providers will develop plans to ensure that their staff are culturally and linguistically competent/culturally informed.**

**OBJECTIVES**

**SHORT TERM**

- Establish an interagency workgroup to determine and establish cultural and linguistic standards for the behavioral health vendor/provider workforce.
- Expand existing requirements for cultural/linguistically competent service delivery in vendor/provider contracts, which is currently included in some mental health contracts.
- Vendor/providers will assess cultural and linguistic competence of their workforce using state-established standards to identify gaps in expertise.
- Using the results of assessment performed, vendors/providers will develop action plans to address and ameliorate identified gaps.
- Repeat cultural competence and linguistic competence assessments periodically to monitor progress of vendors/providers movement toward attaining cultural competence.

**LONG TERM**

- State agencies and contracted vendors/providers will recruit diverse staff with appropriate linguistic and cultural competencies and skills.

**Goal 5: Contracts for all mental health service delivery will specify licensing/professional qualification/certification requirements.**

**OBJECTIVES**

**SHORT TERM**

- Review state Medicaid plan and waivers to ensure that certification/staff qualifications for delivery of services by vendors/providers are included and update as necessary.
- Include certification/staff qualification requirements in all state vendor/provider contracts.
- Ensure that a mechanism is in place to monitor vendor/provider compliance with certification/qualification requirements.

**Goal 6: The workforce is adequately compensated to provide effective and cost-effective services.**

**OBJECTIVES**

**SHORT TERM**

- Obtain information on professional shortage areas by mental health professional to determine areas of need within the state.
- Use results and information from the professional shortage areas study described above to project gaps/shortages associated with the behavioral health workforce.
- Develop and issue a report to legislature, state agencies, and others to address shortages before they occur. Develop a list of proposed action steps for executive branch and legislature to take to prevent shortages.
- Develop advocacy platform to address behavioral professional staff shortages.

**LONG TERM**

- Establish incentives for recruiting mental health professionals to work in professional shortage areas (e.g., loan forgiveness programs etc).
- Identify funding models that provide appropriate compensation for service delivery.

**Goal 7: Monitor and assess outcomes of treatment associated with workforce requirements.**

**OBJECTIVES**

**SHORT TERM**

- Review contracts with managed care organizations, care coordination entities, insurance organizations, and vendors/providers to ensure that they specify services and workforce requirements and appropriate mental health recovery-based outcomes.
- Include requirement in all vendor/provider contracts regarding qualifications/credentials to ensure that workforce has adequate competencies/skills to achieve fidelity to service models, and to provide appropriate services including EBPs, evidence-informed practices, and promising practices.
- Ensure that all vendor/provider contracts, regardless of payer, include outcomes related to workforce issues.
- Ensure that the financial model(s), incentives, and compensation support and align with contractual requirements.

**STRATEGY PRIORITY 6: Ensure quality of care in all care settings via the use of appropriate clinical outcomes.**

**Goal 1: Identify and collect key recovery-oriented mental health outcome measures across all systems and providers regardless of payer.**

**OBJECTIVES**

**SHORT TERM**

- Adopt key universal mental health-focused, recovery-based outcomes that have been identified and vetted through nationally funded mental health initiatives such as the Substance Abuse and Mental Health Services Administration (SAMHSA) National Outcome Measures (NOMs), the Mental Health Statistics Improvement Program Quality Report, and the National Association of State Mental Health Program Directors, among others.
- Incorporate outcomes referenced above in vendor/provider contracts across mental health service delivery systems regardless of payer.
- Establish an interagency committee under the behavioral health authority in the Governor's Office to monitor and evaluate outcomes attained.
- Use outcomes as a basis for decision making (service planning, contracts, etc).

**Goal 2: Advocate for funding to support health information exchange (HIE)/health information technology (HIT) behavioral health initiatives at the provider and state levels.**

**OBJECTIVES**

**SHORT TERM**

- Establish an advocacy platform to advocate to obtain funding to support HIT/HIE initiatives at the provider and state levels.
- Work with state/federal authorities to identify funding and resource needs to support HIT and HIE activities.
- Implement an electronic health record (EHR) in DMH state hospitals to meet Centers for Medicare & Medicaid Services regulations.

**LONG TERM**

- Work with state/federal authorities to identify funding and resource needs to support HIT and HIE activities (short- and long-term objective as noted above).

**Goal 3: Key information supporting treatment decision making is shared among treatment providers while maintaining the confidentiality and security of information.**

**OBJECTIVES**

**SHORT TERM**

- Work with the Illinois Office of Health Information Technology to identify and apply lessons learned from the Behavioral Health Integration grant regarding HIT and HIE needs.

**LONG TERM**

- Behavioral health and primary health providers/vendors use established Health Insurance Portability and Accountability Act (HIPAA)-compliant protocols to exchange health information that support treatment planning and decision making when consent is given to share information by individuals receiving services.

**Goal 4: HIE/HIT principles are understood and used at all levels of the mental health services delivery system.**

**OBJECTIVES**

**LONG TERM**

- Establish standards for interoperability across state agencies, regardless of payer, to facilitate the use and exchange of information for monitoring, evaluation, and planning purposes.



# APPENDIX A

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Illinois Mental Health Services Strategic Planning  
Task Force Members



**We Honor the Dignity and Worth of Every Individual**

## Full Task Force Members

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# APPENDIX B

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Illinois Mental Health Services Strategic Planning  
Task Force Committee Reports



**We Honor the Dignity and Worth of Every Individual**

# Mental Health Five-Year Strategic Plan Task Force Adult Committee Report

*Incorporates the work of the Continuum of Care, Adult Clinical, and Adult Recovery Supports Workgroups*

## **Section 1: Background**

### **1A. Population Description**

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Approximately one in every five Americans experiences a mental illness every year, crossing all age groups, races and genders. Among all Medicaid beneficiaries with disabilities, almost half have a mental illness diagnosis. Similarly, more than half of all prison and jail inmates have a mental illness diagnosis.

The economic impact of mental illness is large, estimated at costing the U.S. economy over \$80 billion each year, or roughly 15% of the total economic burden of all diseases. Yet, it is estimated that about two-thirds of individuals with mental illnesses go without treatment, due mostly to the inability to access care or stigma about the illness. Individuals go without treatment despite the fact that treatment for mental illness is at least and sometimes more effective than treatment for other illnesses, such as heart disease, cardiovascular disease or diabetes.

For these reasons, a strategic plan for the mental health service systems should consider a broad approach; one that includes efforts at prevention, early intervention and crisis services which can help avoid or minimize further exacerbation of mental illness symptoms and reduce the development of psychiatric disability.

With limited resources and its principle role as part of a societal safety net, the DHS Division of Mental Health has focused on individuals with serious mental illnesses especially those without the resources to secure treatment and support- and the providers, families, and communities with which they are involved.

The term Serious Mental Illness (SMI) is used to describe the unique needs of individuals who are age 18 and older and have been diagnosed with a mental illness resulting in impairment of emotional or behavioral functioning that interferes with their ability to live in the community without supportive treatment. Using the federal definition and methodology for serious mental illness prevalence rate for Illinois (5.4%), it is estimated that 526,080 adults met this criteria in Illinois in 2012. For that same year, the Department of Human Services/Division of Mental Health registration data showed that of the 100,377 adults who received services from DMH funded agencies, 95,358 (95%) met SMI criteria. Thus, DMH funded services accounted for approximately 24% of the adult SMI population. Other state agencies, including Healthcare and Family Services, the Department of Children and Family Services and the Department of Corrections also fund care for some individuals who meet the SMI criteria, and still others receive services from a variety of public and private providers. Because there is no uniform data collection across this myriad of provider types, it is not possible to determine the exact number of individuals with SMI who are receiving care in a given year within Illinois. It is however possible to determine that a large number of individuals (in excess of 100,000) who, according to DHFS Medicaid information) have a diagnosis of serious mental illness, did not receive mental health Medicaid Rehabilitation Option services. In reviewing the State's Medicaid data, these individuals with an SMI diagnosis were found to have received significant primary care services, as paid under the State Medicaid plan. Further, it is anticipated that approximately 500,000 persons who are currently uninsured may become eligible for services under Illinois implementation of the Patient Protection and Affordable Care Act. This translates to an additional 27,000 people with a serious mental illness (based upon prevalence of 5.4%).

### **1B. Current System Structure**

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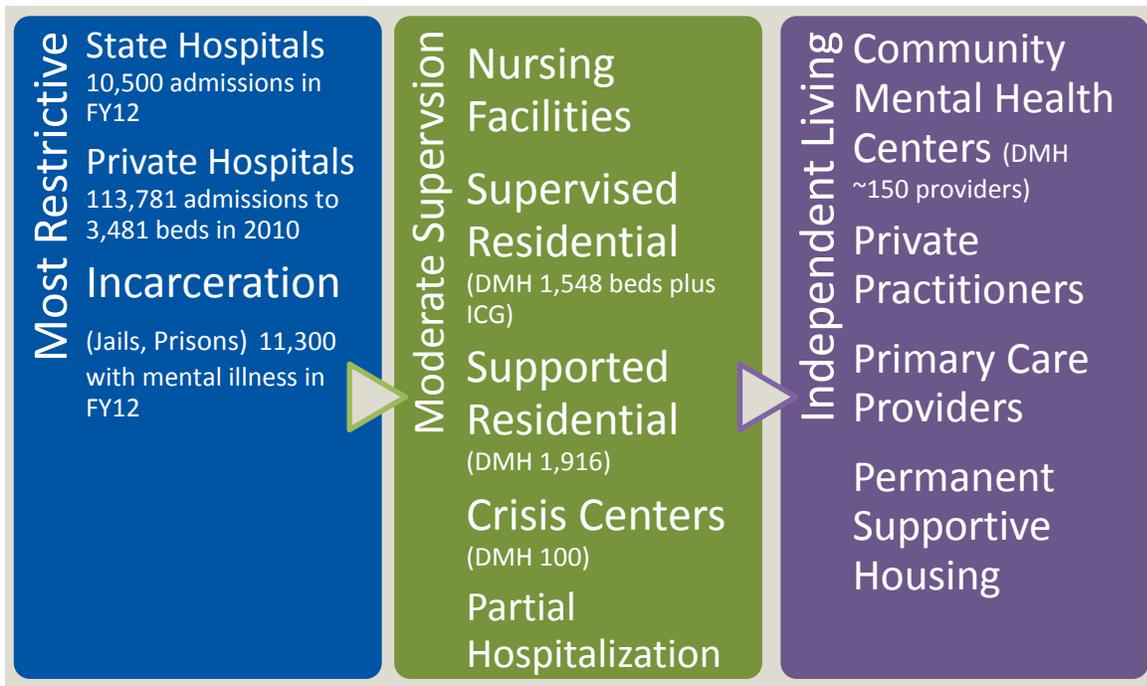
The current mental health system of care in Illinois contains many of the essential services and supports necessary for successful community reintegration and independence of adults diagnosed with serious mental illnesses. Ranging from the most restrictive settings of hospitals (there are 6 state hospitals operated by DHS/DMH) and corrections, through nursing facilities and residential treatment settings, to community-based outpatient services, the mental health system's diversity is made more complex by the range of geography of

the state, from the inner-city urban areas to sparsely populated rural areas. A strategic planning workgroup identified as many as 77 distinct settings in which individuals currently receive mental health care. Many of these were “traditional” behavioral health settings but a good number were settings not specifically developed for this purpose, such as physician offices, primary care clinics, general hospitals, emergency rooms, child welfare centers, jails and prisons. (See table below.)

	Venue Options for Individuals with Mental Health Service Needs ( <b>BOLD</b> for new role proposed; proposed expansion noted in future role)	Recommendations		
		New Role/ Services	Expansion of Existing Services	Improvement of Services
	<b>Venues Primarily Focused on Individuals with Mental Illness</b>			
1	State/Federal Prison Psychiatric Units			X
2	County/Municipal Jail Psychiatric Units ( <b>NEW ROLE</b> )	X		X
3	State Psychiatric Hospitals			X
4	Private Psychiatric Hospitals and Outpatient Clinics			X
5	Psychiatric Units of General Community Hospitals and Outpatient Clinics			X
6	IMD Nursing Facilities ( <b>NEW ROLE</b> )	X		
7	Specialized Mental Health Rehabilitation Facilities ( <b>NEW ROLE</b> )	X		
8	Facilities Providing Subpart S Services			X
9	Crisis Residential Facilities			
10	Mental Health Courts		X	
11	Comprehensive & Specialized Community Mental Health Centers (CMHCs)		X	X
	<b>Venues, Programs, and Services Often Provided by CMHCs:</b>			
12	CMHC Triage Centers		X	
13	CMHC Mobile Crisis Teams & Other Outreach		X	
14	CMHC Day Treatment ( <b>NEW ROLE</b> )	X		
15	CMHC Drop-In Centers		X	
16	Peer-Run Support Sites		X	
17	Behavioral Health Home/Health Home ( <b>NEW ROLE</b> )	X	X	
18	Wellness Centers ( <b>NEW ROLE</b> )	X	X	
19	Private/ Independent Mental Health Practitioner Offices			X
20	Supportive Housing		X	
21	Supervised Residential ( <b>NEW ROLE</b> )	X		X
22	Supported Residential			
23	Re-Entry Community-Based Housing		X	
24	Transitional Housing ( <b>NEW ROLE</b> )	X	X	
25	Certified Independent Living Centers			
	<b>Venue Options Available to But Not Focused Solely on Individuals with Mental Illnesses</b>			
26	VA Hospitals			
27	County Public Hospital			X
28	Hospital Emergency Departments ( <b>NEW ROLE</b> )	X		
29	Urgent Care Centers			
30	General Medical Units of Community Hospitals			X
31	County/Municipal Jails ( <b>NEW ROLE</b> )	X		X
32	State/Federal Prisons			X
33	Assisted Living Facilities			
34	Shared Housing Facilities			
35	Supportive Living Facilities			
36	Comprehensive Care in Residential Settings Demonstration Facilities			
37	Adult Day Care			
38	Shelter Care Facilities			
39	Hospice			
40	Faith-Based Organization Sites			X
41	County or Local Public Health Systems			
42	Homeless Shelters			
43	Domestic Violence/Women's Shelters			X
44	Child Welfare Centers			
45	Primary Care Physician Offices			X
46	Federally Qualified Health Centers (FQHCs)			X
47	Other Primary Care Clinics			X
48	Room and Board Settings			X
49	University/College Housing			
50	University/College Counseling Centers ( <b>NEW ROLE</b> )	X		X
51	Disaster Relief Sites			
52	DHS Family Community Resources Centers (Local Offices)			X
53	Employment/Job Sites			X
54	The Street			X
55	Internet			

The State Mental Health Authority (SMHA) in Illinois is the Department of Human Services' Division of Mental Health (DMH). DMH has contracts with approximately 150 comprehensive community mental health centers and about another 30 specialty providers. These centers primarily provide mental health services funded under the Medicaid Rehabilitation Option that include psychiatry, psychotherapy, medications, psychosocial rehabilitation and case management to individuals eligible for Medicaid. DMH also purchases crisis services for individuals not eligible for Medicaid and a limited package that includes assessment, psychiatry and medication/case management services.

In addition to clinical services, DMH purchases non-clinical supports. Access to supportive housing has been a focus for several years, and includes a service model, identified funding sources and a referral network for those leaving long term care settings. This is a demonstrated commitment to supporting individuals in achieving their independent living goals, with community settings becoming the expected living situation for most adults who are diagnosed with serious mental illnesses. To assist individuals in attaining and maintaining employment, Illinois has adopted the Individual Placement and Support (IPS) model, an Evidence Based Practice (EBP) for which there is robust data indicating successful outcomes when fidelity to the treatment model is attained. With the support of both DMH and the Illinois Department of Human Services/Division of Rehabilitation Services (DRS), the IPS model has demonstrated a 63% successful Federal Vocational Rehabilitation Rate, which is above the national average. With the opportunity for input from individuals with lived experience in recovery, a person-centered approach to treatment is being advanced which has resulted in the development of innovative services and supports, including Wellness Recovery Action Plan (WRAP) model, Regional Recovery Conferences, Consumer Education Calls, 3 peer support "Living Room" sites, and Recovery Drop In Centers.



The Medicaid Authority in Illinois is the Department of Healthcare and Family Services which is the largest purchaser of mental health services in the state. It purchases services provided by individual practitioners, hospitals and nursing facilities. Such services are medication, psychiatry, inpatient and long term care. Mental health services are also purchased by county 708 boards, local municipalities and the city of Chicago and Cook County, which recently began providing services under a newly designed 1115 waiver.

Illinois currently utilizes both regular Nursing Facilities and Nursing Facilities designated as IMDs in serving individuals with SMI . In order to be in compliance with the Olmstead Act, the use of these facilities must be greatly reduced and limited to defined clinically necessary purposes with an aim of community transition.

## Section 2: Vision, Values and Principles

**Vision:** All individuals with diagnoses or at risk of mental illnesses have access to a mental health system that is based upon identified needs, with fully funded and coordinated care, and are able to live, work and participate in communities of their choosing.

### Values

- Through the resiliency of the human spirit, individuals with diagnoses of mental illnesses are capable of recovery
- System of care must be comprehensive, culturally competent, trauma and evidence informed, and holistic in approach
- Housing, employment and peer services are essential to recovery
- Excellence in services require a person-centered and community integrated environment approach
- Mental health treatment works
- Recovery from a mental illness is the expectation not an exception
- Each individual whas many strengths, capacities and talents that can be empowered and employed to advance recovery

### Principles

- The direct and active involvement of individuals with lived experience is essential to the planning, provision and monitoring of the mental health system.
- Funding for housing needs to support a reasonable array of community choices, not only located in very low-income areas.
- Employment services are a core mental health service.
- Individuals with mental illness will be connected to the services they need regardless of the setting in which they initially present (primary care, criminal justice, schools).

## Section 3: System Strengths and Gaps

### 3A. System Strengths

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Illinois has a solid foundation on which to build necessary mental health services and supports. DHS/DMH and its partners have worked to create a system of care that is grounded in the principles of recovery and person centered care which includes many evidence based and emerging best practices. Collaborative efforts between leadership within the Governor's office, state agencies and stakeholders have resulted in the development of funding streams used to create housing resources. Similar collaborative relationships between state agencies have also developed braided funding to support the IPS program. The state has shown a commitment to a recovery-oriented system of care through the development of positions within state leadership, regions and direct care providers, where Certified Recovery Support Specialists (CRSS) have a voice in the direction of policy, the monitoring of quality and the provision of services. A solid infrastructure has been developed to provide technical assistance in the areas of WRAP and IPS.

Community mental health service providers have a long history of working closely with DMH to engage in specific activities to assure the continuity and coordination of care for individuals being discharged from state psychiatric hospitals, with some providers generalizing these practices to discharges from community hospitals, nursing facilities, emergency departments, jails or homeless shelters. Likewise the state requires facilities licensed under the Nursing Home Care Act serving residents with serious mental illness diagnosis to develop and maintain linkages to community mental health providers. The proposed regulatory changes are expected to provide for a more integrated approach across community based and residential services to ensure a smoother transition to the community when warranted. In some counties a data link between the jail and the local mental health agency has been established to enhance identification and coordination of services for jailed and released individuals with mental health needs. Similarly, mental health courts in some Illinois communities provide coordinated services and transition between the judicial and mental health systems. Over the past decade, state agencies and community providers have also made a focused effort on coordinating and, when possible, integrating services for individuals with mental health needs as well as substance use disorders, primary care, employment or housing needs.

In addition, there are providers and facilities beyond the direct administrative responsibilities of DHS/DMH that are skilled and experienced and can contribute significantly to the changes desired in mental health services necessary to fulfill the latest conceptualizations and expectations about what constitutes good, modern mental health care. These include not only private mental health practitioners, clinics and hospitals, but also nursing facilities and mental health services provided by local and municipal governments.

### 3B. Gaps

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There is currently no centralized data collection process across all agencies to capture the service needs of individuals with mental illness, nor are there defined outcomes or performance measures. . A system-wide collection of service needs and the development of standardized outcomes are critical in order for the state to develop a mental health system that will meet the needs of the individuals and produce desired outcomes.

As implied in the discussion of system strengths above, although there is some limited continuity and coordination of care across some service venues, there is ample room for improvement across many of the venues. The system requires enhancements, financing and incentives for more standardized and routine coordination amongst the full range of possible service venues, especially for young adults transitioning from child-system service venues to venues which serve adults.

Adequate funding and improvement in outreach, screening assessments and early identification of mental health service needs, including those who may have difficulty accessing services, such as caregivers, is needed to help ensure that individuals needing services are directed toward the most appropriate venue to meet their needs.

In particular, increased access to the core services of psychiatry, medication and crisis services, including mobile crisis, is needed in most areas of the state. Variability in access needs to be minimized while also



permitting the delivery of all mental health services to be tailored to the distinct characteristics of the state's different areas, such as urban, suburban, small town and rural settings. There must be sufficient services across the state to meet the mental health service needs for all Illinois citizens, including the uninsured and those with co-morbid conditions.

For the dignity of the individuals served and for the benefit of our state's communities, provision of services in the most integrated setting possible is not only appropriate, but is believed by some to be more economical. Venues that aim only at symptom control or maintenance, rather than on the development of skills which could allow an individual to successfully manage in less restrictive service settings, while appropriate in some instances, should not be the norm. The development and use of less restrictive settings could facilitate transition to more integrated settings and possibly lessen reliance on hospital or institutional care. Moreover, the availability of a sufficient amount of services or specialized services could permit individuals with higher needs, such as individuals that are justice-involved, have co-morbid disorders, or histories of destructive or violent behaviors, to be effectively served in less restrictive settings. Further, community integration may support efforts to reduce stigma toward individuals with mental illness as studies suggest proximity is a key factor in stigma reduction.

We must guard against making cost the only major driver in developing the best care plan for an individual. At the same time, we must take a realistic look at the total cost of maintaining an individual in a variety of care venues. All government funded programs needed to support an individual must be included—from mental health services, to supported employment, food stamps, subsidized transportation, etc.

Effective support for individuals with mental health needs require services beyond simply those deemed as “medically necessary” or “Medicaid billable”. Effective support of individuals with mental health needs require rehabilitative, habilitative, and prevention services. A continuing, long-standing gap for individuals with mental health service needs is ready access to affordable housing (with housing subsidies if needed). This support is needed across the state and for individuals who may be moving out of long term care facilities as well as others needing housing. Once an individual resides in permanent supported housing, funding must be available for services that may not be “rehabilitative” in nature, such as assistance with personal care, social opportunities and property management.

While resources have been developed and do exist in some areas, access to certain services and levels of care remain a problem. It is noted that inpatient psychiatric beds have reduced drastically in the last several years and are not accessible proportionally across the state. Individual Placement & Support, Assertive Community Treatment or Community Support Teams, and skilled benefit counseling programs are non-existent in a large portion of the state.

Closely related to access is the challenge with funding for services and supports. While Illinois has worked to secure federal resources, the budgetary reality of the state's resources must be considered. Illinois relies heavily on fee for service Medicaid, which can incentivize a focus on numbers of units of service provided, as opposed to what is appropriate for an individual. The General Revenue Funding used to purchase services for those individuals not eligible for Medicaid has been drastically reduced to the extent that the majority of these individuals are only receiving crisis services. In fact the State no longer reimburses community centers for individual or group counseling for the non-Medicaid population and very minimal case management is covered. In addition to a lack of funding for those not on Medicaid, certain Medicaid rates do not cover the cost.

The evidence based practice models that we value require a significant amount of training, supervision and monitoring to ensure that the expected results are achieved; costs that are not reimbursed by the distinct Medicaid service rates. While evidence-based practices should be established service delivery norms, Illinois must also encourage innovative approaches that aim to solve unique emerging challenges or that bridge geographic, cultural, or systemic divides.

Illinois is spending very little money on workforce development. Areas that need to be concentrated on include non-clinical support services, evidence-based and evidence-informed practice models, peer services, effective clinical supervision, cultural and linguistic competence and public assistance requirements and options.

## Section 4: Goals, Objectives and Activities

### 4A. Strategic Priorities

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Establishment of strategic priorities for the future of the Illinois public mental health system must take into account the context of planned changes, and especially the changes anticipated by not only the national implementation of the Affordable Care Act, but also by policy that has been promoted by the Governor's office and the Illinois legislature to transition 50% of Seniors and Persons with Disabilities (SPD) into managed care by 2015. The expansion of managed care provides an opportunity to integrate primary healthcare and behavioral healthcare to achieve better health outcomes for the SPD population. As these changes unfold, the role of behavioral health authorities, such as DHS's Mental Health and Alcohol and Substance Abuse Divisions, may have to be restructured, adjusted or refocused to ensure consistency of service standards and regulations across all providers, including those under managed care, or a role in addressing consumer and provider appeals regarding services under managed care. In addition, with the growing interest in achieving more integration of services, including mental health and substance use, physical and behavioral health services, the role of these behavioral health authorities, as well as providers, are expected to significantly change and evolve.

In order to ensure the mental health system in Illinois has adequate services and supports, the State must ensure access to the necessary array of clinical services as well as housing, employment and peer services, and must ensure the development of other non-traditional services and supports. These services must be based on consumers' perception of need and choice as well as the research. Access must be considered both in terms of capacity and in terms of geography. However, our haste to develop non-traditional settings should not ignore how current treatment settings could be modified or converted to meet future needs. Existing infrastructure should not be summarily dismissed.

Because access is resource dependent, the State must also ensure that adequate funding exists to support these necessary services. This includes making certain that all federal funding dollars are maximized, that other sources of revenue are explored, and that the State fulfills its responsibility as a steward of the public money by ensuring the resources are allocated wisely and produce the expected outcomes.

Since outcomes depend in large part upon the quality of services provided, the state must ensure adequate investment into workforce development. This requires an investment in training, development of supervision, and adequate outcome monitoring. Strategies to combat high turn-over rates among staff, and to ensure that agencies are able to hire individuals with the variety of competencies to span across all areas are needed. Illinois must also take measures to increase access to CRSS credentials for those who are interested, while ensuring that promotion of the credential does not result in the loss of the unique role of individuals with lived experience, or limit the opportunities of those without the CRSS credential to serve in valued and valuable peer support roles.

As additional EBPs, evidence-informed and promising practices emerge, the state must position itself to utilize these whenever possible. This means developing and utilizing a mechanism for identifying, defining and promoting new models, and developing the necessary state infrastructure to enable implementation and achievement of expected outcomes.

Finally, Illinois must address the barriers that can occur across state agencies as well as collaborate across all public and private settings where mental health services are provided. This includes developing systems to share data, and working across agencies to decrease redundancies and improve communication. In addition, approaches and processes need to be developed and implemented to enhance the coordination and linkages across all mental health service venues, as well as a common and clear understanding of the role of each service venue and consideration of whether modifications in roles will lead to better mental health services.

# Mental Health Five-Year Strategic Plan Task Force Veterans' Services Committee Report

## Introduction

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Service Members of the United States Armed Forces, Veterans, and their Families (SMVF) make enormous sacrifices in service to our country, and they continue to face substantial challenges as they return and transition into society. Most veterans as they transition back into civilian life have a positive and successful transition, and do so without the need for special supports. However, some veterans can have unique issues that make that transition back into civilian life difficult.

The costs of military service can be substantial, and many SMVF are struggling with the lasting effects of the visible and invisible wounds of war. Decades later, veterans from prior conflicts continue to have problems due to an inadequate response to their needs following their service. Further, complexities in navigating the multiple and often uncoordinated service systems have complicated access to those supports that could be available. Specific challenging aspects of reintegration for veterans include:

- Veterans can have significant mental health concerns related to their service.
- The stress military families experience is made worse by multiple deployments.
- Homelessness can also be a significant challenge for veterans and their families.
- Veterans experience disproportionate unemployment.
- Among the most pervasive and potentially disabling consequences of these costs is the threat to the psychological health of our nation's fighting forces, our veterans, their families and their survivors.

There is consensus around the belief that America needs to systematically improve its response to the needs of SMVF and these improvements need to occur now. An enhanced system of supports would address dimensions of availability, accessibility, accommodation, affordability and acceptance to provide the right help for a successful reintegration.

## Section 1: Background

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The Veterans Committee of the Mental Health Strategic Planning Task Force was established as a standalone committee on November 28, 2012. Over the past two years, a number of veterans' initiatives have been underway to strategically identify and coordinate veterans' services. The Committee agreed to incorporate the previous work of the Illinois delegation to the SAMHSA Service Members Veterans and Their Families (SMVF) Technical Assistance Center's (TAC) Policy Academy, and Illinois Joining Forces (IJF), Behavioral Health Workgroup. Accordingly, the Vision, Values and Principles as well as the strategic priorities, goals and objectives contained herein reflect a significant consensus amongst the stakeholders involved. The SAMHSA SMVF TAC works with the States to strengthen their behavioral health systems servicing SMVF. Illinois Joining Forces is the statewide initiative by the Illinois Departments of Veterans' Affairs (IDVA) and Military Affairs (IDMA) (National Guard and Air Guard) to better serve SMVF throughout the state.

IJF will bring together, under a common umbrella, a force field of public, non-profit, and volunteer organizations to continually foster increased awareness of available resources and better partnership and collaboration between participating organizations.

### 1A. Population Description

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Approximately, one million SMVF currently live in Illinois. Further, Veterans Administration projections show that due to the aging populations of prior conflicts, by 2022 the veterans' population will be less than 580,000 dropping from more than 750,000 currently living in Illinois. However, it must be remembered that

contemporary policy analysis in assessing service needs now include service members who may not be eligible for veteran status (e.g. non-activated or deployed service men and women) including family members who are significantly affected by the range of needs of their loved ones who have served in the military. As a result, these statistics do not reflect the entire Illinois SMVF population from whom service needs can be projected.

Approximately, 76,000 troops have returned home to Illinois from duty in Iraq and Afghanistan, representing a new kind of veteran, and they are in need of a new approach: they are younger than the majority of veterans in Illinois; there are more female service members than ever before; they face high rates of unemployment; and they suffer unique physical and mental wounds. That number is expected to increase significantly as more veterans return home, and many are dealing with mental and physical injuries stemming from their military service. The Department of Veterans Affairs estimates that of all veterans, 18 die from suicide each day.

A snapshot of these new Illinois veterans shows:

- **Age:** 78% are in their 30s or younger.
- **Employment:** Illinois had the 4th highest unemployment rate of all states for new veterans in 2010, at 13%.
- **Gender:** Women comprise 17% of new veterans, more than ever before. A higher percentage of female veterans (18%) are not in the labor force compared to male veterans (11%). Nearly half of female veterans (47%) with children are raising them alone, nearly twice the rate of male veterans (25%).
- **Physical Wounds & Mental Health:** 26% of veterans who were deployed since 9/11 were deployed more than once, leaving them more vulnerable to invisible wounds such as Traumatic Brain Injury and/or PTSD.
- **Geography:** New veterans are concentrated in and around Chicago, near the Great Lakes Naval Base, and around St. Louis, near the Scott Air Force Base. Large numbers also reside mid-state and in north-central Illinois. 50% live in the Chicago area and 17% live in the St. Louis area.
- **Income:** 46% earn less than \$30,000 annually.
- **Education:** 67% have a high school diploma, and 22% have a college or professional degree.
- **Military Experience:** The majority served in the Army, followed by the Air Force. The top three Army occupations were logistics, infantry, and medical while the top two Air Force occupations were support, and maintenance.

This newest cohort of veterans is a unique population with particular needs. They face a challenging context upon return: an economy with few job openings, systems of care that have grown accustomed to serving older and predominantly male veterans, and a personal reluctance to seek help. The newest veterans may also suffer from mental and physical injuries that act as barriers to reintegration into civilian life, such as the signature wounds of Post Traumatic Stress Disorder and Traumatic Brain Injury resulting from the heightened use of improvised explosive devices during the Global War on Terror. These veterans require sufficient supports to prevent the long-term negative effects that many previous veteran cohorts have suffered.

## 1B. Current System Structure

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Within Illinois there are approximately 500 Illinois not for profit organizations servicing SMVF. This number is in addition to the numerous federal and state organizations dedicated to serving the military community. Within this “Sea of Goodwill” the current system presents challenges of eligibility, redundancy, and coordination. It is common knowledge that significant gaps exist within and across the service system. Navigation to access services is cumbersome; often discouraging those in greatest need. Additionally, access can be hampered by lack of awareness, distance and provider cultural competence.

On the positive side, evidence based practices have been vetted to determine the best treatment for conditions identified. The Veterans Administration has made significant inroads to combat veteran homelessness and to integrate behavioral health into primary care. Benchmarks and quality indicators have been established by the Veterans Administration which has helped to improve both access and quality. Nevertheless, gaps in service between the VA and community behavioral health providers create access

barriers. Problems with access inhibit veteran choice. Barriers of stigma, military cultural competence, and service excellence contribute as obstacles for effective engagement of SMVF.

Institutional barriers can range from ignorance to bureaucratic insensitivity. Veterans interfacing with social service organizations often complain about the detachment, lack of caring, and follow up of persons responsible to help them. One veteran described his experience as “running into unfriendlies.” In other cases where there is good knowledge and empathy towards veterans, there is often a lack of access to resources, especially in rural areas of the state. Furthermore, the timelines from best practice development to dissemination and implementation is slow.

## Section 2: Vision, Values & Principles

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### 2A. Vision

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*Service Members, Veterans and their Families (SMVF) will be empowered through a Behavioral Health Alliance of partnerships and resources, for increased access and choice to enjoy satisfying and fulfilling lives in their communities.*

As noted above, the group agreed to adopt the vision previously developed by the work of the SAMHSA SMVF Policy Academy and the Illinois Joining Forces Behavioral Health Workgroup.

### 2B. Values

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The Veterans Committee agreed to adhere to several core values:

- **“No Wrong Person”** – this core value addresses the needs of all categories of persons who have served in the military. Similarly, this value extends to family members of persons who have served.
- **“Programs should be person centered and not program centered”** – to enhance the process of engagement and acceptance and to facilitate positive response to outreach.
- **“Freedom of choice when accessing services”** – Veterans should be served where they want to be served.

### 2C. Principles

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- **Universal Assessment** – “Have you or your loved one ever served in the military?” We believe that this is the one question which should be asked by all organizations when assessing the needs of military members or their families. This rubric encompasses the universe of military service and allows agencies to stratify subsets of service by type, duration, and degree of involvement in order to properly refer individuals to the most appropriate services and resources. Doing so avoids confusion about who is a veteran.
- **Military Culture Competency** should extend not only to the individual practitioner but also into the organizational structure in which they are embedded. In this way, military cultural competence is continuously sustained institutionally as well as individually.
- **Primacy of Service Integration is preferred wherever possible.** Integrated service reduces time from assessment to intervention, minimizes travel barriers and creates improved communications between multidisciplinary providers. A prime example of such integration is where primary and behavioral healthcare occur within one system.

## Section 3: System Strengths and Gaps

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### 3A. System Strengths

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- “Sea of Good Will” – Support for SMVF comes from all quarters, including community organizations, politicians, faith-based organizations, and many individuals also want to help
  - A wide range of organizations are interested in working with the Veteran population and receiving cultural competence training; e.g., Illinois has a large network of fraternal organizations that have been supportive of veterans initiatives
  - Political Support: Governor supports SMVF initiatives; bi-partisan cooperation on initiatives
- Strong programs and agencies already serving SMVF
  - IPS Program (evidence based employment system for persons with serious mental illness)
  - Robust state system of care for people with addictions that can be accessed
  - State social service agencies (i.e., family and child serving agencies; housing agencies; day care agencies) have developed strategies and activities to build their capacity
  - Strong National Guard presence; conducting regional activities (e.g., for Families of the Fallen)
  - Strong advocacy entities, such as Health and Disability Advocates (which is taking an integrated look at Veteran benefits and non-governmental benefits)
  - Overall systems knowledge and organizational ability
- Problem-solving culture – Statewide history of addressing problems in non-traditional, problem-solving ways
  - Strong collaboration and partnerships that have been developed over time
  - Structural support for innovative problem-solving, specialty/treatment courts and continuum of services for Veterans in criminal justice system
  - Behavioral health community’s resiliency and recovery-oriented approach
  - Local VA system more open to partnerships than ever before
- Large VA system and engaged SMVF population
  - Large and diverse Veteran/military population with multiple VAs and VISNs
  - Resources in state agencies and VA for SMVF -e.g., independent living services
  - Veterans are serving as service providers
- Strong research capability

### 3B. System Gaps

<b>Gap Analysis Themes</b>	
<b>Service Delivery</b>	<ul style="list-style-type: none"> <li>• Need for greater integration with other systems of care that serve Veterans (closing the gap)</li> <li>• Build capacity to deliver the right amount of service at the right time</li> <li>• Timely access to services</li> <li>• Appropriate service setting</li> <li>• Range of services to address different needs/types of care</li> <li>• Trust factor – need for people who can validate the services (e.g., peer services)</li> <li>• Inadequate public transportation makes accessing services difficult for SMVF</li> <li>• Improvements needed to increase access to behavioral health services in rural areas</li> <li>• Need to integrate Alternative Interventions with other treatment modalities</li> <li>• Focus on a more holistic approach</li> <li>• Integration with primary care is limited, especially down-state</li> </ul>

<b>Education and Training</b>	<ul style="list-style-type: none"> <li>• Need to increase military culture competency through trainings on SMVF behavioral health issues</li> <li>• Need ongoing needs assessment to understand population needs (including families)</li> <li>• Raise awareness among SMVF and organizations of resources available</li> <li>• Definition of “Veteran” not clearly defined/understood by SMVF and providers</li> <li>• Cross-train agencies to ask (“Have you or your loved one ever served in the military?”), and refer to resources</li> <li>• Involve more non-traditional providers; e.g., NAMI, peers, etc.</li> <li>• Need for a system that recognizes there are different definitions of types of care – and provides a range of services to address the needs</li> <li>• Insufficient availability and awareness of resources; more outreach and education is required</li> </ul>
<b>Data</b>	<ul style="list-style-type: none"> <li>• Need to streamline data – should be focused on choice and need</li> <li>• Need more data to better engage families, provide services</li> <li>• Need ongoing continuous needs assessment</li> <li>• Need to create universal benchmarks and quality indicators</li> <li>• Data should support development and tracking of a Quality Improvement Plan for veteran’s Services</li> </ul>
<b>Financing</b>	<ul style="list-style-type: none"> <li>• Increase funding for behavioral health services</li> <li>• Clearly define eligibility for benefits</li> <li>• Identify available funding and who has the funding</li> <li>• Convertibility/portability of a funding stream = increased access to services = genuine choice! (e.g., Access to Recovery vouchers)</li> <li>• Funding for behavioral health services is limited and eligibility for benefits are unclear</li> <li>• Identify portable funding streams to ensure genuine choice (e.g., Access to Recovery vouchers)</li> </ul>

#### Section 4: Strategic Priorities

- **Strategic Priority 1:** Provide sufficient home and community-based services to give consumers real options in care settings.
- **Strategic Priority 2:** Improve access to care.
- **Strategic Priority 3:** Reduce regulatory redundancy.
- **Strategic Priority 5:** Ensure care is effective, efficient, and appropriate regardless of the setting in which it is provided.
- **Strategic Priority 6:** Ensure quality of care in all care settings via the use of appropriate clinical outcomes.
- **Strategic Priority 8:** Increase awareness and availability Alternative Interventions (non-medical) which serve SMVTF.

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# Mental Health Five-Year Strategic Plan Task Force Forensic Services Committee Report

## Section 1: Background

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The following report distills the work, efforts, and recommendations of the Forensic Subcommittee for the Mental Health Services Strategic Planning Task force. Included in this report are guiding values and principles for a system of care for forensic and justice involved adults and juveniles with behavioural health needs, descriptions of existing programs, feedback from individuals in recovery, and goals and strategies for enhancing and building a system of behavioural health care that addresses the needs of forensic and justice involved individuals. The individuals providing input and serving on the Forensic Subcommittee included representative leadership from state agencies, the recovery community, mental health and justice advocacy, DMH, Universities, the Judiciary, the Illinois Jail Association, AFSCME, Cook County Department of Corrections, Service Providers, and the Center of Excellence for Behavioural Health and Justice. Consumer participation on the Forensic Subcommittee included three individuals who had previously been hospitalized in forensic settings, three individuals employed as DMH Recovery Support Specialists in state hospital forensic units, and one DMH regional recovery staff person. A focus meeting was held among consumer members of the committee to review the key priorities developed by the overall committee membership. The feedback obtained from the focus group informed the development of the final goals and strategies in this report.

Subcommittee Co-Chairs: The sub-committee was co-chaired by Jon Maki, John Howard Association (JHA), Maureen McDonnell, Treatment Alternatives for a Safe Community (TASC), and Dr. Anderson Freeman, Department of Human Services Division of Mental Health (DHS/DMH).

### 1A. Population Description

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**Adult Forensic:** Currently, there are critical challenges in addressing the needs of both the forensic and non-forensic justice involved adult populations. In forensics the critical challenges are described in the following data and information about the DMH forensic system. From FY07 to FY12 forensic admissions have increased from 581(FY07) to 625(FY12) and the average daily census increased from 621 to 649. In FY12 Individuals with misdemeanors made up over 36% of the forensic referrals Statewide and over 50% of the Metro area referrals which includes Cook County (the highest volume referring court system) and Winnebago County Court. Many of these individuals present with chronic and severe mental illness, have histories of poor compliance with outpatient care, and are marginally adjusted in their communities. Outpatient services are only available to a small percentage of these individuals who are able to follow through with forensic and mental health service appointments. In FY12 the average census of long term patients in a forensic status in DMH hospitals was 365 which was an increase from 354 in FY11. Their average length of stay was over 1400 hospital days. The growing number of long term forensic patients, most in NGRI status, has reduced programming capacity for more frequently court referred individuals in UST legal status and contributed significantly to hospital forensic waiting lists. Because of static factors (i.e. history of sex offenses, arson, past violence, etc) related to NGRI index offenses and the lack of specialized programming and supports in the community, the judiciary is resistant to approving the conditional release of these patients. Currently, only 80 individuals that were conditionally released under NGRI statutes are served in the community.

**Adult Justice Involved/Non-Forensic:** Just as important as the forensic population are individuals that are not mandated under forensic statutes. As a consequence of the large number of court referrals in a misdemeanor status, jails are inundated with large populations of individuals with severe mental illness and behavioral health disorders. Examples of the numbers in jails include Cermak Health Services in Cook County Jail where psychiatric services are provided to 1400 of 9600 detainees and the data from the Jail Data Link Program that reflects, of the eight participating County jails reporting, an average of 14% of their populations at any time are identified as having received outpatient or inpatient mental health services prior to detention. In addition, the Cook County Adult Mental Health Probation program serves as many as 700 felony and misdemeanor probationers yearly. Throughout the state of Illinois the estimated percentage of individuals with mental illnesses in all county jails and the Illinois Department of Corrections ranges from 14 to 16 percent based on

agency clinical leadership feedback. This is consistent with recent national research indicating that 14.5% of the male and 31% of the female jail population at several jails had serious mental illness.<sup>1</sup> In addition to jails, prisons, and probation information, it is reasonably assumed that shelter and homeless populations have large percentages of justice involved individuals with behavioral health needs.

**Justice Involved and Forensic Youth:** The Illinois Department of Human Services/Division of Mental Health (DHS/DMH) places a strong emphasis on providing effective mental health and recovery services to at-risk and justice-involved youth. These youth may come from the community or from other systems including the Illinois Department of Juvenile Justice (IDJJ) and the Illinois Department of Children & Family Services (IDCFS). Estimates suggest that as many as 70% of justice-involved youth are affected with a mental disorder, many of whom have issues so severe as to impair their ability to function or grow into a responsible adult. These include those youth identified as sex offenders, those with substance abuse histories and youth with mental illness transitioning out of DCFS or being released or paroled from DJJ. Addressing the needs of this population presents numerous challenges, due to the need for more robust case management services prior to discharge, a limited number of residential placement options, and a general lack of mental health and substance abuse service availability throughout the state. In addition to the youth in IDJJ During the period 2002 - 2012, The MHJJ program handled 15,005 referrals that also included youth from all county juvenile detention centers. A total of 9,870 referrals were screened, 7,296 found eligible, and 5,837 were served. The goal of the MHJJ initiative is to provide a community-based alternative to incarceration for Illinois juvenile detainees with serious mental illness. Youth under age 18 who have been adjudicated as UST or NGRI are referred to DHS. NGRI referrals are rare with youth and currently there are 21 youth receiving inpatient forensic care at Streamwood Behavioral Health Center and 22 receiving outpatient forensic services.

## **1B. Current System Description (see service grid before at end of section)**

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DMH Forensic Services oversees and coordinates the inpatient and outpatient placements of adults remanded by Illinois County Courts to the Department of Human Services under the 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). Inpatient services are provided at 5 state hospitals with secure forensic Units. Four of these hospitals with forensic units are operated under DMH and one is operated under the Department of Developmental Disabilities (DD) for individuals with mental retardation. The average forensic census in FY12 was 603, with an average of 250 individuals in unfit to stand trial (UST) legal status and 357 individuals in Not Guilty by Reason of Insanity (NGRI) or extended UST (USTG2) legal status. In regards to non-mandated justice involved individuals with behavioral health needs, DMH has also been centrally involved in several key programs and initiatives that have impacted large numbers of justice involved individuals including the Jail Data Link Program, the Cook County Community Reintegration Initiative (CRC), the Veterans Reintegration Initiative (VRI), the Transformation Transfer Initiative, the Illinois Mental Health Court Association, and the Illinois Center of Excellence for Behavioral Health and Justice. All these efforts of DMH in working with both the forensic and justice involved population involvement have laid the groundwork for a more comprehensive and effective system of care and treatment that stresses best practices, recovery, diversion, and appropriate use of inpatient and community resources.

Other services that describe the system of care for justice involved adults and juveniles include street level law enforcement police Crisis Intervention Teams, Adult and Juvenile Re-Deploy, Problem Solving Courts, Mental Health Probation, DMH Inpatient and Community Forensic Programs for Adults and Juveniles, and special Mental Health and Juvenile Justice initiatives provided during detention and incarceration for Adults and Juveniles. In addition to specifically designed services for justice involved individuals, there is also a range of community based mental health and substance abuse services made available if the individual has health benefits through private insurance, Medicaid, or SSI. A critical gap in the mental health service system is drastically reduced service levels for individuals who are not funded.

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<sup>1</sup> Steadman HJ, Osher FC, Robbins PC, Case B, Samuels S; Prevalence of serious Mental Illness Among Jail Inmates, Psychiatric Services 60:761-765,2009.

## Forensic System Committee Grid

AGE RANGE and POPULATION	TYPE OF PROGRAM AND NUMBER SERVED
Male/female adults age ≥ 18 adjudicated UST or NGRI	<b>Secure Inpatient State Hospital Forensic Units</b> —Overall Inpatient DMH Forensic System: Average census 603, 250 UST, 357 NGRI/USTG2, 100% plus average occupancy, 52 in civil beds. DHS administers and operates five state psychiatric hospitals that have forensic inpatient programs. Four of these hospitals are under DMH and one is under the Department of Developmental Disabilities and serves individuals with mental retardation. Forensic services in these inpatient units are mandated under Illinois Statutes for Unfit to Stand Trial (UST) (725 ILCS, 104-16), Not Guilty by Reason of Insanity (NGRI) (730 ILCS, 5/5-2-4).
Male/female adults age ≥ 18 adjudicated NGRI	<b>Special Community Conditional Release Programs: MHCCI and Stepping Stones (6 Adults)</b> —Supervised forensic and recovery based transitional residential for up to 2 years.
Male/female adults age ≥ 18 NGRI and USTG2	<b>Non-programmed Community Nursing Home, Residential and Independent living Services for Conditional Release (63 Adults)</b> —Array of residential and outpatient services after conditional release.
Male/female adults age ≥ 18 adjudicated UST	<b>Forensic Outpatient</b> —Community agencies and Metro Forensic Program (35 adults). DMH administers and coordinates forensic outpatient placement of adults for fitness restoration services.
Male/female adults age ≥ 18 and up incarcerated in IDOC	<b>Mental Health Services in IDOC</b> —Estimate 16% of 48,000; (7,800 adults). IDOC provides mental health professionals, psychiatric services, psychotropic medication, screening and evaluation of offenders experiencing psychological crises, and evaluation of offenders convicted as guilty but mentally ill on a 30-day basis. Also provides sexual assault intervention and prevention.
Adult offenders age ≥ 18	<b>Adult Redeploy Illinois Prison Diversion Program</b> —Illinois has 10 county program sites. There were <b>207</b> individuals diverted from IDOC in FY11. The program encourages evidenced-based practices for working with offenders. Mental health issues are noted on the screening form. Two sites currently target individuals with serious mental illness. Data is not currently available on the outcomes for individuals with behavioral health disorders.
Male/female adults age ≥ 18	<b>PAS Screening for Nursing Home at Discharge</b> —Screening for nursing home placement at discharge from IDOC.
Adults and transitional youth age ≥ 17	<b>Mental Health Services in County Jails: Cermak Health Services</b> —Cermak Health Services in Cook County Jail provides psychiatric services to <b>1,400</b> of <b>9,600</b> detainees. It is estimated that in all Illinois County Jails <b>14% to 16%</b> of detainees have serious mental illness. In 8 County Jails reporting through the DMH Jail Data Link Program (see below), average 14% of their populations at any time are identified as having received outpatient or inpatient mental health services prior to detention.
Adults age ≥ 17 on probation	<b>Cook County Adult Mental Health Probation (Medicaid-certified provider)</b> —The Mental Health Unit serves approximately <b>700</b> clients who are placed on felony or misdemeanor probation for various offenses. The majority of cases (65%) are felonies, with the balance being misdemeanors.
Adult female detainees or	<b>Cook County Jail Department of Women’s Justice Services (DWJS)</b> —In 2007

bonded out age ≥ 17	to date, 1,010 women have received services in the day reporting component and 737 in the jail residential component. The purpose of the Sheriff's Female Furlough Program (female day reporting) is to provide gender-responsive programs and services to enable women offenders to lead drug-free lives using the integrated model of treatment.
Adults and transitional youth age ≥ 17	<b>DMH Jail Data Link Program—6,175</b> jail detainees were found to be eligible for MH linkage in FY12. <b>458</b> transitional youth, age 17-23, were also found eligible. Eight agency-based case managers covering Cook, Will, Peoria, Jefferson, Rock Island, Winnebago, St. Clair, and McLean Counties provide identification of detainees with serious mental illness and community linkage using web-based technology that cross-matches each jails census with DMH cases.
Male/female adults age ≥ 18	19 mental health courts statewide serve over <b>200</b> participants. These judiciary-led therapeutic courts collaborate with state's attorney, public defenders, treatment providers , probation, case managers, and others to establish individualized treatment and treatment compliance of voluntary participants.
Male adults age ≥ 18	<b>Maximum Security Sex Offender Treatment Program (Rushville, Illinois)—</b> DHS operates one facility under the Sexually Violent Persons Commitment Act (725 ILCS 207/): Treatment and Detention Facility—Adult Males Sexually Violent Persons Program, Maximum Security (510 SVP Beds).
Male/female youth age 10-17 adjudicated UST or NGRI	<b>Secure Community Inpatient, Streamwood Behavioral Health—</b> Approx. 130 admissions annually.
Male/female youth adjudicated UST or NGRI	<b>OUTPATIENT Community agencies—</b> Approx. 55 youth served annually as above. The Division provides outpatient forensic restoration and NGRI services for juveniles through Metro Forensic Services and the Northwestern University MHJJ contract.
Male/female youth age 13-21 incarcerated at any of the 8 Illinois Department of Juvenile Justice (DJJ) sites	<b>TRAUMA SERVICES—</b> Approx. 75 youth served annually. Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) Trauma Therapy (DMH and DJJ).
Male/female youth age 13-21 who are incarcerated at any of the 8 Illinois Department of Juvenile Justice (IDJJ) Facilities	<b>Juvenile Justice RE-ENTRY—</b> Approx. 129 new referrals annually. The Juvenile Justice Mental Health Re-Entry program (DMH) provides evaluation, referral, linkage, case management, and advocacy services to these youth.
Juvenile offenders age 12-18 who fail to comply with probation orders to seek treatment, and offenders who have relapsed after residential or outpatient treatment.	<b>JUVENILE INTENSIVE SUBSTANCE ABUSE TREATMENT—</b> Treatment counselors serve juvenile offenders who fail to comply with probation orders to seek treatment, and offenders who have experienced relapse after residential or outpatient treatment. The project is funded in part by the Office of Alcoholism and Substance Abuse of the Illinois Department of Human Services.
Juvenile male offenders age 13-21 who have a history of sexual offending and are assessed as needing sex offender treatment	<b>Sex Offender Treatment Program—</b> More than 10% of DJJ population. In Illinois, between state fiscal years 2000 and 2010, total admissions to the IDJJ dropped 19% to 2,162. The Sex Offender Treatment Program (SOTP) consists of two components; the Sex Offender Treatment Unit (SOTU) at Illinois Youth Center in Kewanee and the specialized Sex Offender Unit (SOU) located in the Cook County

	Juvenile Parole District (CCJPD), which provides post-release supervision, case management, and treatment services.
Demonstration project to help juvenile offenders age 13-21 make successful transition back to their home communities	<b>RE-ENTRY Demonstration Project</b> —In Chicago, Youth Outreach Services (YOS) will help about 225 youth. In Madison and St. Clair Counties, Children’s Home + Aid will serve about 75 youth over the 3 years of the program. The Illinois Juvenile Justice Commission initiated this demonstration project to reduce the recidivism and improve the outcomes of juvenile offenders. The project will provide intensive reintegration services to help youth transition back into their home communities.
Youth age 13-17 in detention, on probation, released from DJJ	<b>MHJJ/DIVERSION Mental Health and Juvenile Justice</b> —During the period 2002-2012, the MHJJ program handled 15,005 referrals (duplicated). A total of 9,870 referrals were screened, 7,296 found eligible, and 5,837 were served. The goal of the MHJJ initiative is to provide a community-based alternative to incarceration for Illinois juvenile detainees with serious mental illness.
Youth age 13-17 at risk of being sent to a correctional facility within the Illinois Department of Juvenile Justice because of committing a serious crime	<b>REDEPLOY ILLINOIS –JUVENILES/DIVERSION</b> — Administered by the Bureau of Youth Intervention Services, Redeploy Illinois is designed to provide services to youth between the age of 13 and 18 who are at high risk of being committed to the Department of Corrections. In 6 years of providing services, the program diverted 882 youth from commitment.
DCFS youth up to age 18	<b>Therapeutic Youth Homes</b> — <b>Therapeutic Youth Homes</b> provide a structured, stable, and therapeutic living arrangement for children in DCFS care. The Home works primarily with children and young adults between the ages of 7 and 18 who have histories of severe trauma, abuse, and neglect.
Children up to age 21 experiencing a mental health crisis	<b>SASS/ CRISIS INTERVENTION</b> — SASS provides intensive mental health services for children and youth who may need hospitalization for mental health care. Total number of youth served in SASS for FY12 was approx. 17,000-18,000. The SASS program is a three-state agency program. SASS services from as young as needed; sometimes as young as 3 or 4 years old. DCFS provides services to individuals up to age 21, DMH provides SASS services up to age 18, and HFS serves ages 18-21 depending on the type of coverage the family has. SASS will work with the guardian and child for at least 90 days.
Severely mentally ill children/ adolescents age 13-17 in need of residential treatment or of specialized community mental health services	<b>Individual Care Grant (ICG)</b> —Approx. 375 youth served in FY2012 and 400 in FY2011. ICG is a grant to assist parents or other private guardians in paying some of the costs of residential treatment or of specialized community mental health services for severely mentally ill children.

## Section 2: Vision and Core Principles

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Given the system challenges, cross system impacts, and contextual realities of limited resources in a period of budget crisis, the DMH Forensic Sub-Committee's strategic plan report would like to state the following vision, core principles, and clarifying statements.

**Vision:** *Having a quality healthcare system which gives high priority to meeting the needs of individuals involved in the justice system with behavioral health needs.*

1. **Priority Principle:** A behavioral healthcare and criminal justice system which gives high priority to meeting the needs of individuals involved with the justice system and ensuring that they get what they need, where and when they need it.
2. **Diversion Principle:** A behavioral healthcare care system that addresses the needs of individuals who are justice involved must offer diversion alternatives from jails and detention centers in order to avoid unnecessary criminalization of individuals with behavioral disorders.
3. **Quality Principle:** A behavioral healthcare care system that meets the needs of individuals who are justice involved must provide quality recovery based, trauma informed treatment and care, in whatever setting that is responsible for the individuals care.
4. **Access Principle:** A behavioral healthcare care system that meets the needs of individuals who are justice involved must provide access to adequate resources to facilitate proper care including health benefits, specialized and proven programs and practices, and a properly credentialed and trained workforce. This includes services as close to the individual's community as possible with considerations to public safety, family support, and exposure to community environments that would undermine recovery.
5. **Continuum Principle:** A behavioral healthcare care system that meets the needs of individuals who are justice involved must provide a continuum of care that moves individuals towards the least restrictive setting for care and is based on an understanding of each individuals' service needs. This includes services as close to the individual's community as possible with considerations to public safety, family support, and exposure to community environments that would undermine recovery.
6. **Resource Principle:** A behavioral healthcare care system that addresses the needs of individuals who are justice involved must provide adequate resources to provide essential treatment services, whether within the community or institutional setting,
7. **Collaboration Principle:** A behavioral healthcare care system that meets the needs of individuals who are justice involved while seeking to utilize and expand existing programmatic opportunities and advocacy partnership across agencies, organizations, levels of governmental responsibility.
8. **Accountability Principle:** A behavioral healthcare care system that meets the needs of individuals who are justice involved must provide services in a cost effective, efficient, and accountable manner with consideration for the limitations in available resources while maximizing and targeting the use of monetary resources from federal programs and grants including funding made available under the Affordable Care Act.

## Section 3: System Strengths and Gaps

### 3A. System Strengths

As detailed in Section 1B, Illinois has a foundation on which to build a system of care for individuals that are justice involved with behavioral health needs. Evidence based practices have been established in the areas of housing (PSH), employment (IPS) and peer services (WRAP). Collaborative efforts between leadership within the Governor's office, state agencies, judiciary, law enforcement, and Sheriff's Association have resulted in critical and important initiatives such as Law Enforcement CIT, Problem Solving Courts, and Re-Deploy Illinois. MHJJ initiatives impact on justice involved youth in all Illinois juvenile detention centers and Illinois Department of Juvenile justice. The state has shown a commitment to a recovery-oriented system of care through the development of positions within state leadership, regions and direct care providers, where Certified Recovery Support Specialists have a voice in the direction of policy, the monitoring of quality and the provision of services. A solid infrastructure has been developed to provide technical assistance in the areas of WRAP and IPS.

### 3B. System Gaps

Inadequate community mental health funding and past deinstitutionalization have contributed to high numbers of individuals who need essential behavioral health services coming into contact with the state's jails, prisons, and courts, with tragic results for persons with serious mental illness in our society. Recent severe budgetary shortfalls have further diminished Illinois' capacity to treat individuals with behavioral health disorders in their communities. As a result, law enforcement, and the courts encounter increasing numbers of individuals whose behavioral health needs have not been properly addressed. This criminalization of individuals with behavioral disorders has undermined the core purposes of both the behavioral health care and criminal justice systems. It is increasing costs and weakening both systems' ability to deliver effective services. In addition, budgetary constraints have also impacted statutorily mandated services for individuals in a "forensic legal status". These are individuals who are referred to the Illinois Department of Human Services under the Illinois Statutes for Unfit to Stand Trial or Not Guilty by Reason of Insanity. The state's diminished capacity in respond to the treatment needs of an increasing number of individuals in a forensic status also impacts other systems such as jails when state hospital admissions are delayed, and courts when statutory legal timelines are not met.

Highlighted are some of the service gaps that reflect the need to build a system that provides needed services, better integrates services, and enhances or brings existing services to scale.

#### Forensic and Justice Involved Adults: Service Gaps

- Key agency and community staff are not trained in trauma informed care and recovery principles.
- Bed capacity for forensic admissions is inadequate leading to a 60+ jail waiting list.
- Long term forensic patients have significant discharge barriers.
- The number and percentage of forensic court referrals with misdemeanor charges has increased annually.
- Jail Data Link and linkage staff are only available in eight counties.
- Limited community conditional release residential program capacity relative to need including a lack of supportive housing.
- Provider outpatient forensic resources limited with No mechanism to bill for outpatient forensic services.
- Wrap around services needed for some forensic consumers to support outpatient treatment compliance.
- Transition psychiatric medication resources are inadequate for detention and correction facility discharge needs.
- Lack of Information sharing between Counties, Mental Health providers and IDOC.
- Limited provider resources for Problem solving courts.

- Limited community resources for inmates paroled and released with SMI.
- Sex offenders with SMI have significant community placement barriers.
- IDOC Discharges with SMI and high risk behavior have limited options for residential placement.
- Transitional settings needed for highly stigmatized population needing placement from IDOC and DMH.

## Forensic and Justice Involved Youth: Service Gaps

- Additional inpatient resources for the most seriously mentally ill youth.
- Loss of flex funds to support Mental Health and Justice services for youth.
- Need for geographically accessible inpatient forensic services for youth.
- Need to expand services/homes for the 18-21 population being released from DJJ with no residential resources.
- Specialized therapeutic homes to meet the need of juveniles released from DJJ with sex offenses.
- There is no statute that governs the forensic process for juveniles.
- Transitional youth in adult jails need linkage and services

## Section 4: Strategic Priorities

### 4A. Strategic Priorities

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The Forensic Subcommittee identified the following issues that form the basis for formulating the recommendations in this report.

- **Issue 1:** There is a lack of preventative/intervention services in the community.
- **Issue 2:** Different local and state systems that come into contact with people who have behavioral disorders do not communicate well with each other or integrate their resources.
- **Issue 3:** Justice involved people with mental illness often lack access to living wage jobs, sources for necessary support, and affordable housing.
- **Issue 4:** At all levels, (stakeholders) are often unaware of how to appropriately and effectively respond to people with mental illness that are justice involved.
- **Issue 5:** Traditional detention and correctional environments, policies, and practices are not conducive to the treatment of juvenile and adults who have mental illness.
- **Issue 6:** The Forensic system, that mandates the care of individuals that are in Unfit to Stand Trial (UST) and Not Guilty by Reason of Insanity (NGRI), is not properly resourced, integrated, and population focused to address the increasing numbers of referrals from court jurisdictions.

# Mental Health Five-Year Strategic Plan Task Force Child and Adolescent Services Committee Report

## Section 1: Background

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### 1A. Population Description

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All children and adolescents birth through transition age (starting at 16 through transition to adult services) are the target population for this plan. All children and families with or at risk of behavioral health concerns should have access to a developmentally appropriate comprehensive array of services and supports leading to improved functioning at home, school, community and throughout life.

### 1B. Current System Structure

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The Child and Adolescent DMH Mental Health System in Illinois are administered by the Illinois Department of Human Services (IDHS), Division of Mental Health (DMH), Child and Adolescent Services (C&A). The Departments of Children and Family Services, Juvenile Justice and the Illinois State Board of Education also carry a level of statutory responsibility. The mental health services currently provided statewide to children and adolescents with social, emotional, and behavioral disorders who depend on public funding, are rendered through a network of community based mental health providers. However, there is not one governing body that ensures a statewide integrated system of behavioral health care across all child-serving systems.

## Section 2: Vision, Values & Principles

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### 2A. Vision

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We envision a universal health system for all children/adolescents regardless of payer that is family driven, youth guided, and culturally competent that supports optimal physical and mental health; where social and emotional wellbeing, behavioral disorders and substance use, are recognized as health issues; and where stigma and other barriers to services, supports, and recovery are eliminated.

### 2B. Mission

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We will provide the highest quality behavioral health service and a service delivery system that is culturally and clinically appropriate for the children, adolescents, young adults and families served. This mission will be accomplished through universal prevention and promotion of mental health, early interventions based on risk factors, and the use of an individual service plan that is based on an integrated and interconnected systems approach to service delivery that is grounded in evidence informed practices. This allows for individual emotional, cognitive and spiritual growth resulting in the building of resilience and the successful recovery and reclaiming of health.

### 2C. Values

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1. All major components of the interconnected systems model are aligned to integrate with Medicaid, and managed care models, which are currently being developed and will be developed in the future. Future health care delivery must ensure that Systems of Care principles are utilized, through the development of state wide implementation of consistent outcome measures, assessment tools, family supports and evidence informed practices.
2. All Child, Adolescent, and Young Adult services for individuals with or at risk for behavioral health challenges and their families are delivered through an individualized multi-system planning process grounded in a spectrum of effective strengths based, client centered, trauma informed, culturally and linguistically competent services.

3. All services are delivered across a continuum that is organized into a coordinated network of care, with the goal of building meaningful partnerships with families and youth that ensures the highest level of fidelity in service delivery resulting in successful outcomes at home, in school, in the community, and life.

The principles for which this plan is grounded in are consistent with the Systems of Care Principles that are provided in the attached Addendum.

## **Section 3: System Strengths and Gaps**

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### **3A. System Strengths**

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Over the past several years, DMH C&A services have engaged in multiple collaborative planning processes. This includes, but is not limited to, the Illinois United for Youth-Systems of Care Planning Process, Human Services Commission Workgroup on Rationalizing the Service Delivery System Sub-workgroup for Children's Behavioral Health, Illinois Mental Health Planning and Advisory Council Child and Adolescent Services, Illinois Children's Mental Health Partnership Strategic Planning Process, and Cross Agency Coordination Task Force on Transition Age for House Resolution 1117. As a result, we are poised to create a State of the Art Behavioral Health System in Illinois that ensures the highest level of fidelity and services delivery based on Systems of Care Values and Principles.

Current system strengths include the following:

1. The passage of PA-96-1501, in 2011 which requires the reform of the current Medicaid system by implementing the following strategies:
  - o At least 50% of all Medicaid and All Kids enrollees will be in a coordinated system of care.
  - o Reimbursement will be made using pay-for-performance, and risk-based capitation methods thereby creating incentives for plans to improve health care outcomes, disseminate and utilize of evidence-based practices, encourage meaningful use of electronic health record data, and promote innovative service models.
2. The requirement of the Illinois' Medicaid Reform legislation provides an opportunity to expand Care Coordination for youth.
3. The recent statewide planning processes including Illinois United for Youth and the Human Services Commission-Workgroup on Rationalizing the Service Delivery System, Sub-workgroup for Children's Behavioral Health that is providing a blueprint to improving and expanding services.
4. Contracted providers deliver treatment services in alignment with the Child and Adolescent Service System Program (CASSP) principles.
5. The current Screening Assessment and Support Services program is a multi-agency collaborative effort providing effective crisis services.
6. The Individual Care Grant program provides direct care to severely emotionally disturbed youth and adolescents that meet the criteria that is mandated by Illinois Administrative rule 135. The mission of the ICG is to ensure that child centered family focused treatment is provided for each youth who receives the grant.

### **3B. System Gaps**

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The current system structure is characterized by fragmentation and siloed systems that are difficult for children, adolescents and their families to navigate. Over the past year, DMH-C&A in partnership with other child serving systems have engaged in multiple planning efforts to identify a consistent set of system needs that identify challenges within the current structures.

System Gaps include a need for:

1. Additional care coordination and communication between levels of intensity and across service systems for children and their families.

2. Coordination and communication across all child service systems so that there is one door (or no “wrong door”) to access services.
3. A broad array of services designed to meet the unique needs of young adults’ transition to adult service delivery systems.
4. Enhancement of the current service delivery system to reduce psychiatric hospitalizations and residential placements.
5. Reducing the segregation of funding for services which may result in fragmentation of care.
6. Family-driven, youth-guided care.
7. Establishment of a more flexible array of services customized to the individual (including but not limited to respite care, therapeutic recreation, employment supports, peer supports, and other non-traditional services).
8. Establishment of an administrative framework that includes state, local and family voices.
9. Promote of services that are culturally competent and sufficient in scope and duration.
10. Maximization of service funding (e.g. blending, braiding, pooling, etc.) in support of the service array.
11. Ensure transparency in utilization and cost data across systems and ensure there is an active cross system Continuous Quality Improvement process.
12. Developing a workforce trained to provide intensive home based community behavioral support services.
13. Increasing support for prevention and early intervention services in order to save significant dollars spent on more intensive levels of care.
14. Increasing the number of medical professionals working in Behavioral Health including Child and Adolescent Psychiatrists, Advanced Practice Nurses, and Physician Assistants to provide consultation to primary care physicians.
15. Provision services in the most natural setting with transportation available when necessary.
16. Increasing Tele-psychiatry services to areas where access to Child and Adolescent Psychiatrists is limited.
17. Strengthening the implementation of the behavioral health portion of the federal Early Periodic Screening Diagnosis and Treatment (EPSDT) requirements to cover prevention and early intervention services for children and adolescents as mandated by the Affordable Care Act (ACA).

## Addendum

### Guiding Principles: Systems of Care Approach<sup>1</sup>

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1. Ensure availability and access to a broad, flexible array of effective, community-based services and supports for children and their families that address their emotional, social, educational, and physical needs, including traditional and nontraditional services as well as natural and informal supports.
2. Provide individualized services in accordance with the unique potentials and needs of each child and family, guided by a strengths-based, wraparound service planning process and an individualized service plan developed in true partnership with the child and family.
3. Ensure that services and supports include evidence-informed and promising practices, as well as interventions supported by practice-based evidence, to ensure the effectiveness of services and improve outcomes for children and their families.

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<sup>1</sup> Stroul, B., Blau, G., & Friedman, R. (2010). *Updating the system of care concept and philosophy*. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

4. Deliver services and supports within the least restrictive, most normative environments that are clinically appropriate.
5. Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their community, state, territory, tribe, and nation.
6. Ensure that services are integrated at the system level, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management.
7. Provide care management or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs.
8. Provide developmentally appropriate mental health services and supports that promote optimal social-emotional outcomes for young children and their families in their homes and community settings.
9. Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult service system as needed.
10. Incorporate or link with mental health promotion, prevention, and early identification and intervention in order to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents.
11. Incorporate continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.
12. Protect the rights of children and families and promote effective advocacy efforts.
13. Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics, and ensure that services are sensitive and responsive to these differences.

## Child and Adolescent Committee Information

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**Purpose of committee:** To develop a comprehensive strategic plan for the State's mental health services for the next five years.

**Membership by Agency:** Representation from all of the child serving systems in Illinois comprised of representatives from the Illinois Departments of Children and Family Services, Healthcare and Family Services, Juvenile Justices, Human Services Divisions of Alcohol and Substance Abuse, Mental Health, and the Illinois State Board of Education. Membership also included regional, local, and family membership as well as the following associations and agencies Illinois Mental Health Planning and Advisory Council, Association Community Mental Health Authorities of Illinois, The Child Care Association, Community Behavioral Health Association, The Children's Mental Health Partnership, Illinois Association of Rehabilitation Facilities, Community Counseling Center, and Chicago Public Schools.

**Sub-Committee:** Dr. Renee Mehlinger, Father James Swarthout, Dr. Constance Y. Williams, Lisa J. Betz, Ray Connor, Susan Ling, Carlendia Newton,

**Committee At Large:** Jaleel Abdul-Adil, Margaret Berglind, Lisa Betz, Michele Carmichael, Terry Carmichael, Shawn Cole, Sharon L. Coleman, Ray Connor, Ignacio Cuevas, Alisha Diebold, Eileen Durkin, Mark Fagan, Kellie Gage, Gaylord Gieseke, Beth Hanselman, Kristine Herman, Dr. Jennifer Jaworski, Marissa Kirby, Frank Kisner, Susan Ling, Colette, Lueck, Dr. Renee Mehlinger, Emily Miller, Carlendia Newton, Viviana Popler, Phyllis Russell, Dee Ann Ryan, Todd Schroll, Father James Swarthout, Dr. Cynthia Tate, Dr. Constance Williams, Markay Winston.

**Meetings:** October 18, 2012, October 31, 2012, November 14, 2012, December 5, 2012, December 12, 2012, and December 19, 2012,



**Focus:** Child and Adolescent behavioral health services.

**Supporting Planning Processes:** Illinois United for Youth-Systems of Care Planning Process, Human Services Commission Workgroup on Rationalizing the Service Delivery System Sub-workgroup for Children's Behavioral Health, Illinois Mental Health Planning and Advisory Counsel Child and Adolescent Services, Illinois Children's Mental Health Partnership Strategic Planning Process, and Cross Agency Coordination Task Force on Transition Age for House Resolution 1117

# Mental Health Five-Year Strategic Plan Task Force Administrative Issues Committee Report

## Section 1: Background

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An effective and efficient state mental health service delivery system must have the appropriate **structure/infrastructure** and capacity for service delivery, a **workforce** with the requisite competencies and skills to provide appropriate services, and the **information technology** to collect data to evaluate system performance to support the purchase and provision of high quality, cost effective and cost-efficient services for individuals and their families who need mental health services. Services should address the holistic needs of the individual, and be seamless across payers. Where possible, the delivery of evidence-based/evidence-informed and best and emerging practices should be the norm. The ability to efficiently gather and share appropriate information to assess mental health treatment outcomes and evaluate system performance at the system, provider, and consumer level is a necessity, while maintaining individuals' confidentiality and meeting HIPAA requirements. These concerns are the basis for the Charter that the Administrative Issues Committee used to frame its discussion with regard to state mental health system structure/infrastructure, workforce and health information technology issues. A corresponding vision, as well as priorities, goals and initial objectives for each of these strategic planning areas were developed to guide implementation of the planning effort during the five year period in which the mental health services strategic plan will be in force.

### 1A. Population and Prevalence Rates: Adults with Serious Mental Illnesses and Children/Adolescents with Emotional Disturbances

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**Prevalence Rates.** Illinois utilizes prevalence rates provided by the Substance Abuse and Mental Health Administration (SAMHSA) Center for Mental Health Services (CMHS). The CMHS definition and methodology for prevalence estimation for adults is published in the Federal Register Volume 64, Number 121, June 24, 1999. The methodology generates a calibrated point estimate of the 12-month number of adults who have Serious Mental Illnesses who are age 18 and older residing in Illinois. This does not include persons who are homeless and institutionalized. The prevalence estimate is 5.4%. Illinois uses a 7% prevalence estimate for children/adolescents with serious emotional disturbances based on methodology outlined in the CMHS notice in the Federal Register, Volume 63, Number 137, July 17, 1998 which is based on the average of the number of individuals estimated to have functional ratings at the lower limit (50) and the higher limit (60) of a range of functional ratings between 50 and 60.

Based on Illinois census figures, it is estimated that in FY2012 there were 526,080 adults with serious mental illnesses, and approximately 174,613 children/adolescents with serious emotional disturbances residing in Illinois. The number of adults receiving community based services directly purchased by DMH in FY 2012 was 100,377 and the number of children/adolescents receiving services was 35,670. Additionally 8,393 individuals were admitted to DMH state hospitals in FY 2012—many of these individuals also received community mental health services purchased by DMH. Note that these numbers do not include individuals receiving mental health services purchased solely by other state agencies (including one shared program for children/adolescents for which billing is submitted to the state Medicaid agency), county, local providers or private providers.

### 1B. Current Mental Health Services System Structure

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The **Illinois Department of Human Services (IDHS)** is the state agency that manages human service systems in the State, including management of the public mental health system through the **Division of Mental Health (DMH)**. The Division has the statutory mandate to plan, fund, and monitor community-based mental health services and inpatient psychiatric services provided in state hospitals. As such, the Division of Mental Health is the federally recognized State Mental Health Authority for Illinois. Mental Health services are however purchased or delivered by a number of State Agencies and DHS Divisions, as well as by local mental health

authorities in some areas of the state. Over the years the DMH has worked actively to develop and establish relationships across these systems with the goal of integrating mental health services under its purview with the services provided or purchased by other agencies/providers. 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. Planning and budgeting decisions are guided by the basic principle that individuals will receive services in the least restrictive, most clinically appropriate environment, with the best quality of recovery-oriented and evidence-based treatment and care possible.

The **Division of Mental Health** purchases services from 180 Community Mental Health agencies statewide. The Division also operates six state mental health hospitals and one treatment detention facility. **The Department of Healthcare and Family Services (DHFS)** purchases an array of mental health services. The DHFS behavioral health focus over the next five years includes six key areas: (1) care coordination, which is the centerpiece of Illinois' Medicaid reform efforts, (2) housing, (3) pre-admission screening/resident review, (4) community stabilizations strategies, (5) children's mental health services and (6) enhanced community services. **The DHS Division of Alcoholism and Substance Abuse (DASA)** has collaborated with DMH for many years to address services for individuals with co-occurring mental health and substance use disorders, and the **Division of Developmental Disabilities (DDD)** and the DMH share leadership tasks in addressing the needs of persons with Autistic Spectrum disorders (ASD) and individuals with co-occurring developmental disabilities. DMH and **Division of Rehabilitative Services** 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 through initiatives such as Individual Placement Services/Evidence-Based Support Employment (IPS/EBSE). The **Illinois Housing Development Authority** and DMH are working on a number of initiatives including the Williams vs. Quinn Consent Decree and permanent supportive housing. The availability of safe, decent, and affordable housing is a necessary component of a comprehensive community support system. The DMH works closely with **the Illinois Department on Aging (DOA)** to increase training opportunities in the geriatric field and to improve the quality and accessibility of services for elderly persons with mental illnesses. There are a substantial number of individuals with serious mental illnesses who require long-term care services, thus the DHS/DMH is collaborating with the **Department of Public Health and HFS** to address the issues for a substantial number of individuals in this population. The DMH Forensic Services collaborates with a range of agencies in the Criminal Justice System including: **the Illinois Department of Corrections, the Illinois Department of Juvenile Justice, Administrative Offices of the Illinois Courts, the Illinois Criminal Justice Authority, the Illinois State Police, the Illinois Sheriff's Association, the Cook County Department of Corrections, County Jails and Juvenile Detention Centers and local law enforcement** agencies and organizations. The DMH has pursued the Positive Behavioral Interventions and Supports (PBIS) model of collaboration between education (**the Illinois State Board of Education and the Chicago Public Schools**) and mental health primarily through work on System of Care Grants and through collaborative efforts with the **Children's' Mental Health Partnership**. DMH continues to work closely with the **Department of Children and Family Services (DCFS)** on a number of initiatives including Screening, Assessment, and Support Services (SASS) and 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.

## **Section 2: Overarching State Mental Health Services System Vision and Principles**

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The Administrative Issues Committee of the Mental Health Services Strategic Planning Task Force recognizes that a high quality, effective state mental health services delivery must have a clear, unambiguous vision that supports the recovery of individuals with mental illnesses. The Committee has identified five overarching principles for state mental health service delivery:

- Individuals must have the tools to **recover** or to support their recovery
- **High quality effective** services should be provided **consistently** across the state regardless of the purchaser of services
- Services must be **flexible and tailored** to meet individual and family needs
- There must be an ability to **measure consistent (the same)\_outcomes** at the consumer, provider and service system level

- **Early identification** of need for services and **prevention** in addition to **treatment** is a priority and a necessity

Based on these principles, the Committee has developed the following overarching vision for mental health services structure/infrastructure for the state:

*“A coordinated, integrated and appropriately funded service delivery system that provides prompt access to care and effectively addresses prevention, early intervention and treatment”.*

Pursuant to the Administrative Issues Committee Charter, a vision, values, priorities, goals and initial objectives or action steps have been developed for each of the three strategic focal areas. These are presented below following a description of mental health service delivery strengths and gaps.

### **Section 3: System Strengths and Gaps By Strategic Priority Area of Focus**

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#### **3A. Workforce Issues**

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The Committee identified a number of strengths and gaps associated with workforce issues. **Strengths** include the certified recovery specialist and certified family partnership professional credentials that have been established; the focus on the provision of evidence-based and evidence informed practices, graduate and training programs in psychology and social work and curricula developed with a subset of universities within the state; the use of technology such as telepsychiatry to deliver service, collaborations between mental health and primary health care providers and newly introduced incentives for reducing hospital readmission rates.

**Gaps** include the lack of integration of services across other State Department/Divisions resulting in “silo-ed” service delivery, shortages of behavioral health professional staff such as psychiatrists due to reimbursement rates as well as the lack of interest of professionals in working in non-metropolitan based or rural areas.

#### **3B. Health Information Technology/Health Information Exchange**

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**Strengths** include the implementation of Electronic Health Records (EHRs) by some providers within the state, the establishment of the Office of Health Information Technology housed in the Governor’s Office, the receipt of a grant from the Substance Abuse and Mental Health Services Administration focusing on behavioral/primary health information exchange, and the use of technology such as e-prescribing; mobile and video technology are also used in some areas of the state. The Behavioral Health Integration Project (the SAMHSA grant) has begun developing needed HIT behavioral health infrastructure to promote the exchange of health information among behavioral health and medical care providers. There are also established vehicles for exchange of information between DMH and other state agencies such as HFS, DASA, DRS and there are established relationships between networks of primary and behavioral healthcare providers. Initiatives such as the DMH Jail data link program which focuses on linking individuals with mental illnesses who are involved with the criminal justice system with mental health providers and integrated care initiative such as the HFS Care coordination Entity Initiative and the DHS framework are also leading to increased sharing of information for treatment purposes.

**Gaps:** According to a recent survey, only 10% of behavioral health providers nationally have developed EHRs; the percentage is greater in Illinois however many agencies don’t have the capacity or resources to implement EHRs. Financial and human resource challenges continue to impact HIT/HIE activities at the local and state level. There is a lack of real time access to state wide data to obtain information to support strategic planning efforts or system development efforts. Redundancy and duplication in data collection in some arenas exist and there is a lack of uniformity in data definitions across agencies. Although state agencies use a single shared identifier, currently there is no consistent identifier that is used across all public-private behavioral health providers which results in an inability to gather information about clients who are uninsured; as well as services rendered and treatment outcomes. There is also a lack of interoperability of platforms across systems which impacts exchange of information, and funding (state/federal) has not been allocated to support HIT/HIE at the local or state level.

### 3C. Mental Health Services System Structure/Infrastructure

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**Strengths:** Many entities recognize the importance of mental health services as an element of holistic health care, and Rule 132, the Medicaid Mental Health rule is broad and complete in terms of the care that it authorizes. The community-based provider network is resilient and has the ability to collaborate and develop new partnerships. DMH has made a commitment to recovery principles that has been embraced. Consumers are involved in program design, service delivery, and management of services. An increasing number of legislators have an interest in mental health service delivery as well.

**Gaps:** Despite these strengths, the responsibility for mental health services across state agencies is not always clear; DMH is the federally recognized mental health authority however DMH is not recognized as such by all state agencies/ offices/ legislature/ Governor's office. This impacts the quality of care and cost savings. Consumers must interact with a range of agencies to access services. It is difficult to navigate systems resulting in fragmentation of service delivery and some families experience difficulty obtaining authorization for services. There is a lack of access to care for the indigent population due to lack of funding and availability of other resources. Dollars allocated for delivery of services to non-Medicaid eligible individuals have been eliminated/reduced resulting in limited services for these individuals. Some key necessary services/supports are not considered rehabilitative and thus are not Medicaid reimbursable. Stigma around mental health issues in some arenas still exist and recovery support principles may not be understood by all payers/purchasers of mental health services. There is also need for alignment between HFS and DHS/DMH regarding securing of Medicaid for eligible consumers.

### Section 4: Strategic Priorities

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The following vision, priorities, goals and objectives (initial action steps) have been developed based on the system strengths and gaps identified by the committee as described above.

#### 4A. Workforce Issues

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**Vision:** *A culturally/linguistically competent well-trained workforce*

Individuals receiving mental health services should have their needs addressed by a competent workforce that provides the right treatment, at the right time in the appropriate amount. The workforce must understand individuals' culture to provide appropriate and high quality services.

#### Strategic Priorities

- **Training.** The current and future workforce must be trained to provide appropriate services that are evidenced-based, evidenced-informed and that are based on promising practices where they exist, to meet the needs of individuals and their families who are seeking and/or receiving treatment.
- **Appropriate qualification/licensure of staff.** The workforce should have the appropriate qualifications and licensure to provide appropriate services to individuals.
- **Certification for provision of Evidence Based /Informed Treatment.** Agencies or individuals providing evidence-based and informed treatments should provide treatment that has fidelity to the service model. Only then will it be possible to obtain the expected outcomes that are aligned with the treatment model.
- **Legislative advocacy to garner funding/support for workforce needs.** Although some graduate programs have begun to develop curricula geared toward the needs of individuals seeking mental health services, continuing emphasis is needed to assure that the science behind effective treatment moves to the service and training arena. This requires resources.
- **Culturally and linguistic competent Workforce.** The workforce must understand an individual's culture to provide high quality, effective services.

- **Adequate reimbursement for qualified staff.** The workforce must receive adequate reimbursement for services provided. This may require new models of funding.
- **Monitoring of treatment outcomes.** Staff must hold certain qualifications to provide evidence-based services that lead to outcomes associated with service models. Outcomes factoring in the delivery of services by qualified professional should be assessed and monitored.

#### 4B. Health Information Technology/Health Information Exchange

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Information on treatment outcomes, services, prevalence estimates and population needs should be available to use as a basis for statewide mental health service system and service delivery planning and design.

**Vision:** *Availability of real time Information on services and outcomes that is used for planning, decision making and service delivery*

##### Strategic Priorities

- **Data must be collected on appropriate and universal outcomes across systems.** A set of key universal mental health outcomes should be established and collected for individuals with mental illnesses across all systems regardless of payer. The outcomes should be based on recovery oriented mental health outcomes such as the SAMHSA National Outcome Measures as opposed to singular HEDIS measures which focus on primarily on physical health outcomes and/or process measures.
- **Available state/federal resources to support HIE/HIT for behavioral health.** Federal or state resources have not been allocated to support health information technology or health information exchange activities for behavioral health providers at the local or state level. The behavioral health network is at a serious disadvantage in this arena. Without financial support and other resources, behavioral health providers will continue to face serious challenges with regard to integration with primary health and with maintaining a presence in the healthcare arena.
- **Adoption of health information principles/goals by systems, providers, consumers.** The ability to exchange information to support decision making for treatment purposes is critical. However, it is also critical that all individuals understand the impact of health information exchange, and that the rights of individuals receiving services are maintained.
- **Platforms for Health Information Exchange between regional information exchanges and state data exchanges are interoperable.** Integration with primary healthcare and other services requires the ability to exchange key information through systems that communicate easily and effectively with each other.

#### 4C. System Structure/Infrastructure

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The Administrative Issues Committee identified a number of system strengths and gaps in this strategic area of focus. However, rather than develop a list of priorities, and goals and objectives, the Committee identified one priority which if addressed would likely address system structure and infrastructure needs. The most salient issue is the lack of a recognized statewide authority that is responsible for planning and coordination of mental health needs.

**Vision:** *A coordinated, integrated and appropriately funded service delivery system that provides prompt access to care and effectively addresses prevention, early intervention and treatment.*

##### Strategic Priority

- **A recognized behavioral health authority** to coordinate/speak on/advocate for mental health issues housed in the Governor's Office. This authority should provide leadership with regard to mental health services and be empowered to coordinate provision of mental health services across agencies.



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