

PRELIMINARY DRAFT AS OF 7-03-19@7:30pm

**FY 2020-FY2021
COMMUNITY MENTAL HEALTH
SERVICES
BLOCK GRANT APPLICATION**



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

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State Information

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

X FY 2020-FY2021

STATE NAME: ILLINOIS
DUNS #: 067919071 Expiration: 4/28/19

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

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

FROM: July 1, 2018 TO: June 30, 2019

FY 2020-21 MENTAL HEALTH BLOCK GRANT APPLICATION EXECUTIVE SUMMARY

The Illinois Department of Human Services-Division of Mental Health (DMH) is responsible for facilitating, coordinating, and purchasing a comprehensive array of services that provide effective treatments to people most in need of publicly funded mental health care. The policies and practices of the DMH focus on fostering coordination and integration of services provided by DMH funded community agencies, private hospitals, and state hospitals across Illinois. A variety of collaborative initiatives serve to increase coordination with other state agencies whose services are accessed by individuals receiving mental health services. The FY2020-FY2021 Mental Health Block Grant Plan reflects these coordination efforts as well as an emphasis on developing and directing care which is consumer and family driven. DMH continues to transform the mental health service delivery system in Illinois to one that is recovery-oriented. These efforts include increasing consumer and family involvement in planning and implementation activities and expanding the focus on planning and implementation of evidenced-based practices. A wide array of stakeholders representing consumers, family members of individuals with mental illnesses, advocates and public service agencies purchasing or providing treatment to individuals with mental illnesses participate in these efforts. The anticipated outcome is the continued enhancement of activities that support the recovery-orientation of the mental health system and address the needs of consumers and their families.

During FY2019 and continuing into FY2020-FY2021, the priorities of the DMH include: (1) Facilitation and coordination of an effective array of clinical and support services. (2) The provision of services in the least restrictive manner including screening and crisis services for individuals at risk of hospitalization that contribute to reducing the use of hospitalization and identification of individuals who are experiencing psychosis for the first time as a priority population for community-based services.(3) Advancement of the recovery vision including Wellness Recovery Action Planning, expansion of the scope and quality of consumer and family participation, and promotion of the utilization of the Certified Recovery Support Specialist (CRSS) credential. (4) Continuing development of System of Care concept and infrastructure for children, adolescents and their families in Illinois. (5) Enhancement of capacity for community living consistent with the Olmstead Decision, as stipulated in Implementation Plan of the Williams vs. Quinn Consent Decree. (6) Partnership with state agencies and statewide organizations in initiatives which respond to ongoing consumer needs such as the criminal justice system, alcoholism and substance abuse services, vocational and employment services, housing opportunity, and services for military personnel. (7) Bi-directional Integration of Primary Health Care and Behavioral Health Care and the maximization of benefits to adults with SMI and children with SED through Affordable Care. (8) Continuing consultation and

partnering with the state Medicaid agency, DHFS, the IDHS Community Health and Prevention Division (CHP) and the Illinois Children’s Mental Health Partnership to address the behavioral health needs of women in pregnancy, single mothers with young children, and early childhood interventions. (9) Enhancement of collaborative efforts with state and local partners to address the mental health needs of adults involved with the criminal justice system and youth in the juvenile justice system. (10) Advancements in the use of data to inform and guide decision-making. The FY2020-21 Plan has been organized to comply with the priorities and format established by the SAMHSA.

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PLANNING STEP I

Framework for Planning-Assessment of the Mental Health Service System

Description/Overview of the State's Mental Health System

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

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 204 community mental health agencies 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. Some services are also funded through a capacity grant mechanism. DMH also operates seven state mental health hospitals and one treatment detention facility. In addition, DMH supports services provided through long term care facilities and in residential settings.

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. While DMH provides some funding, the services provided in these diverse treatment settings are 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. Illinois leads the nation in its provision of technical assistance through certified IPS fidelity trainers, which are geographically based throughout the state to ensure access to support for all IPS providers.

- **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.

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

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

The Community-Based Mental Health Service System

Community services are considered the cornerstone of the mental health delivery system. Services provided and purchased by the DMH are geographically based. The DMH is geographically organized into five service regions. Through these regions, the DMH operates seven state hospitals and contracts with 204 community-based outpatient/rehabilitation provider agencies across the state. These Service Regions are responsible for planning, coordination and general oversight of mental health services, assisting in developing the capacity and expertise of providers, and increasing the quality and the quantity of participation from persons who receive mental health services. Two

regions are in the Chicago Metropolitan area and surrounding suburbs, and three regions cover the central, southern and metro-east southern (East St. Louis region) areas of the State.

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

Being part of the IDHS umbrella has provided an opportunity for the DMH to address a number of challenges within the shared mission of one Department, including: disability determination for persons with serious mental illnesses (SMI), prevention, early intervention, integration of vocational and educational services for children with serious emotional disturbances (SED), coordination and development of Mental Illness and Substance Use (dual diagnosis) services, and, through the coordinated intake process, an opportunity to enhance case finding, early identification, and outreach efforts.

DMH's Forensic and Justice 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 found 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 708 boards, the City of Chicago and other municipalities, and Cook County). Over the years, DMH has worked

actively to establish and maintain relationships across these systems with the goal of integrating mental health services under its purview with the services provided or purchased by other agencies.

Description and Overview of Child and Adolescent Services

DMH's Child and Adolescent Services (C&A) consults and collaborates on the design and quality of services for children and adolescents with social, emotional, and behavioral disorders who depend on public funding. Statewide, children and adolescents receive services through a network of 157 community-based mental health providers. The emphasis is on social, emotional, and behavioral skill development organized to meet the unique needs of children and youth with serious mental health needs and their families and on evidence informed practice as components in the systemic transformation process. C&A collaborates with the Illinois State Board of Education, the Department of Child and Family Services, the Illinois Department of Juvenile Justice, DHS/Division of Alcoholism and Substance Abuse, the Illinois Department of Healthcare and Family Services, the Illinois Children's Mental Health Partnership, to implement Systems of Care statewide. The Illinois Departments of Children and Family Services (IDCFS), Illinois Department of Healthcare and Family Services (IDHFS) and Juvenile Justice (IDJJ) also have statutory responsibility to provide mental health services in some instances. No single agency is responsible for ensuring the integration of behavioral health care services across all child-serving systems.

The Growth of Community-Based Services

Within Illinois there are numerous private practitioners, community mental health agencies, community hospitals providing inpatient psychiatric care, and community long-term care facilities providing services to individuals with serious mental illnesses. Over the past 40 years, the locus of treatment for persons with mental illness has shifted from institutions to community-based settings. In FY1973, 8% of the DMH's budget was allocated for community services. Today 70% of DMH expenditures have been allocated for community-based services.

The Illinois Mental Health Collaborative for Access and Choice

DMH began contracting with an Administrative Services Organization (ASO) in FY2008 to assist with implementing DMH established policies and procedures in a variety of areas. The ASO known as the Illinois Mental Health Collaborative for Access and Choice, or The Collaborative serves as an administrative arm to the Division. Tasks performed by the Collaborative include:

- Operating and Maintaining a Consumer Warm Line and a Consumer Family Care Line.
- Collaborating with DMH on the development and maintenance of an integrated Management Information System (MIS).
- Completion, dissemination, and posting of a variety of mental health reports, manuals, and handbooks, a consumer and family handbook, and a study guide for the CRSS credential.

The work of the Collaborative has been very valuable to DMH in terms of performing administrative and supportive tasks that support the vision for a recovery-oriented service system.

Community Integration from Long Term Care

There are a substantial number of individuals with serious mental illnesses who require long-term care services. Some require this level of care because of functional limitations associated with their mental illnesses, and others require it for functional limitations associated with both mental illness and medical needs. In either case, the lack of viable community alternatives and supportive services for persons in this situation may necessitate their admission to and continued care in longer term care facilities. The Illinois Department of Public Health (DPH) is responsible for monitoring the licensing requirements of nursing facilities and the Department of Healthcare and Family Services (DHFS) oversees Medicaid funding. The DMH has made a concerted effort to assist community providers and these two state agencies to understand the service needs of persons with serious and disabling mental illnesses. DMH has been working to develop community-based alternatives to accommodate the needs of this population in transitioning to the community through the Williams Consent Decree (See Section C-17 for further information.)

Collaborative Planning in Mental Health and Substance Abuse Prevention and Treatment

DMH and the DHS Division of Substance Use Prevention and Recovery (DSUPR) have worked together over the years to collaborate, develop and implement initiatives focusing on consumers with co-occurring disorders. These collaborations have included co-location projects at four state hospitals and sharing service delivery site resources, which allowed DSUPR-funded providers to perform screening and assessment for consumers on-site, and to provide consultation to DMH staff regarding the substance abuse treatment needs of consumers when these services were warranted. This approach resulted in the development of more hospital staff training and expansion of the role of the providers to perform linkage and engagement activities.

DMH continues to implement Wellness Recovery Action Planning (WRAP) which is seen as bridging the gap between traditional mental health treatment and traditional substance abuse treatment for individuals with co-occurring disorders. The use of WRAP principles of self-determination, personal responsibility, and empowering support are a means of addressing an individual's divergent needs. In reference to children and youth, DSUPR has been a leading participant in the DMH Family Driven Care initiative and has collaborated with DMH in providing training on trauma informed prevention, treatment and recovery as well as adolescent and family co-occurring disorders and their treatment.

1. Strengths and Needs in the Service System

The consistent vision for mental health services in Illinois is a well-resourced and transformed mental health system that is person centered and community driven; that provides a continuum of culturally inclusive programs which are integrated and effective;

a range of direct and support services (including prevention, early intervention, treatment and supports) that support healthy lifelong development through equal access and promote recovery and resilience. The fundamental belief (credo) is that:

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

-The expectation is recovery

-The individual is central

Accordingly, 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. 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. In Child and Adolescent services, the emphasis is on resilience and evidence informed practice as components in the systemic transformation process. Specific system strengths and gaps are noted below.

SYSTEM STRENGTHS

A person-centered, recovery focus

Illinois emphasizes the concept of recovery for all individuals suffering with mental illnesses. 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, who have lived experience with mental illness, have a voice in directing policy, monitoring quality, and providing services to their peers.

Commitment to Evidence-Based and Evidence-Informed Practices in Illinois

Evidence-based practices are interventions for which there is consistent scientific evidence showing that, when implemented with fidelity to the model, individual outcomes improve. 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, engagement and treatment (Assertive Community Treatment), housing (Permanent Supportive Housing), employment (Individual Placement Services), 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.

A pledge to work together

Collaborative efforts across state agencies that support adults and/or children with mental health conditions abound. Examples include a collaborative effort between IDCFs, DMH, and IDHFS to provide crisis services to youth with serious emotional disturbances and the 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. 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. The Illinois Joining Forces Foundation has established nineteen Veterans Support Communities across the State for the purpose of local resource utilization that spans physical and behavioral healthcare, as well as broader social determinants of health for service members, veterans, and their families.

Transition to Managed Care

Managed Care has been successfully implemented in Illinois. As the number of individuals whose care is reimbursed by MCOs has grown, the amount of services reimbursed directly by the SMHA public mental health system has decreased. In February 2017, Illinois initiated a reboot of the Illinois managed care system which began in 2011-12. About two million Illinois residents - nearly two-thirds of Illinois residents on Medicaid – were part of managed care plans. The new plan extended managed care to approximately 85% of all Illinois residents. The managed care reboot also shifted managed care in Illinois to a more value-based system, and an overall decrease in managed care companies, in an attempt to reduce administrative burden through simplified processes for providers.

Coordination of Care

Illinois Public Act 096-1501 (Medicaid Reform) requires the provision of coordinated care for adults and children who receive Medicaid-funded services. This may spur the development of innovative service models to improve health care outcomes, use of evidence-based practices, and encourage meaningful use of electronic health records (EHRs)

A focus on technology

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. 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.)

SYSTEM WEAKNESSES

Fragmentation of 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-also creates the potential for a key weakness as individuals and families may need to interact with a range of agencies to access services. This fragmentation results in some 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 encounter the criminal justice system for lack of more appropriate alternatives.

Insufficient resources

Insufficient funding 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 which are not reimbursed by Medicaid.

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. Recruitment and retention of a sufficient number of culturally competent/sensitive staff and those with the language proficiencies to meet the needs of the ethnic populations served is also an issue.

Assessing Needs in the Service System

Several independent sources of data suggested by members of the Illinois Mental Health Planning and Advisory Council (IMHPAC) are relevant to an assessment of the mental health service needs of individuals with mental illnesses and children and adolescents with serious emotional disturbances residing in Illinois:

The 2017 National Survey of Children’s Health reports the following estimates for the State of Illinois:

- 14.2% of children in Illinois ages 3-17 years have received treatment and counseling from a mental health professional. An additional 2.1% were estimated to need to see a mental health professional but did not.
- Of those who received or needed mental health care, the Survey reported that 36% had a problem getting it, including 11.5% that “had a big problem getting it” (an estimated 41,314 children).

- In response to: “How often does this child’s health insurance offer benefits or cover services that meet this child’s mental health or behavioral needs, age 3-17years” the estimates are: 37.7% - Always, 24.8% - Usually, and 37.5%- Sometimes or Never.
- The Survey focuses ADD/ADHD as a Child Health issue and reports that 6.1% of Illinois children were estimated to have the condition in 2017 based on survey responses; 3.3% were rated as Mild by their parents and 2.8% as Moderate or Severe; 4.3% have the condition and are taking medication and 1.8% have the condition but are not taking medication for it. 3.2% of Illinois children (Pop. Est.=75,578) received behavioral treatment for ADD/ADHD.
- The Survey, under Family Health and Activities, reports the mental health status of 4% of fathers and 4.2% of mothers in Illinois as either Fair or Poor.

The 2017 SAMHSA Behavioral Health Barometer

Behavioral Health Barometer: Illinois, Volume 4: Indicators as measured through the 2015 National Survey on Drug Use and Health, the National Survey of Substance Abuse Treatment Services, and the Uniform Reporting System is one of a series of national and state reports that provide a snapshot of behavioral health in the United States. This report presents national data about the prevalence of behavioral health conditions. The data includes the rate of serious mental illness, suicidal thoughts, substance use, and underage drinking. The report also highlights the percentages of those who seek treatment for these conditions. This array of indicators provides a unique overview of the nation’s behavioral health at a point in time as well as a mechanism for tracking change and trends over time. Behavioral Health Barometers for the nation and for all 50 states and the District of Columbia* are published as part of SAMHSA’s larger behavioral health quality improvement approach

Youth Mental Health and Service Use -Depression: In Illinois, an annual average of about 115,000 adolescents aged 12–17 (11.2% of all adolescents) in 2014–2015 had experienced a Major Depressive Episode in the past year. The annual average percentage in 2014–2015 was higher than the annual average percentage in 2011–2012.

Youth Mental Health and Service Use -Depression: Treatment for Depression: In Illinois, an annual average of about 40,000 adolescents aged 12–17 with past year MDE (39.2% of all adolescents with past year Major Depressive Episode) from 2011 to 2015 received treatment for their depression in the past year.

Adult Mental Health and Service Use -Serious Thoughts of Suicide: In Illinois, an annual average of about 378,000 adults aged 18 or older (3.9% of all adults) in 2014–2015 had serious thoughts of suicide in the past year. The annual average percentage in 2014–2015 was not significantly different from the annual average percentage in 2011–2012. In 2014–2015, Illinois’s annual average percentage of adults aged 18 or older with past year serious thoughts of suicide was similar to the corresponding national annual average percentage.

Mental Health and Service Use -Serious Mental Illness: In Illinois, an annual average of about 343,000 adults aged 18 or older (3.5% of all adults) in 2014–2015 had SMI in the past year. The annual average percentage in 2014–2015 was not significantly different from the annual average percentage in 2011–2012. In 2014–2015, Illinois’s annual average percentage of past year serious mental illness (SMI) among adults aged 18 or older was similar to the corresponding national annual average percentage (4.1%).

Mental Health and Service Use-Mental Health Service Use Among Adults with Any Mental Illness (AMI):

In Illinois, an annual average of about 679,000 adults aged 18 or older with AMI (45.3% of all adults with AMI) from 2011 to 2015 received mental health services in the past year. From 2011 to 2015, Illinois’s annual average of past year mental health service use among adults aged 18 or older with any mental illness (AMI) was similar to the corresponding national annual average percentage (42.9%).

Mental Health and Service Use-Adult Mental Health Consumers Served in the Public Mental Health System in Illinois, by Age Group and Employment Status (2015): Among adults served in Illinois’s public mental health system in 2015, 68.4% of those aged 18–20, 42.5% of those aged 21–64, and 74.6% of those aged 65 or older were not in the labor force. Of all adults 18 and over served in the Public Mental Health Service System, 17.9% were Employed, 36.1% were Unemployed, and 46.0% were not in the Labor Force.

Homeless Persons with Mental Illness

In reference to homeless persons in the State, the HUD Continuum of Care Homeless Assistance Programs Point -In Time Count completed on January 25, 2018 identified 2,352 persons as being Severely Mentally Ill. Of these, 1,225 were domiciled in Emergency Shelters, 547 were in Transitional Housing, and 580 were Unsheltered. The 2019 count is not yet available.

Shortages of Mental Health Professionals

The Rural Health Information Hub (formerly the Rural Assistance Center) provides information on health professional shortages in rural areas. In a map of Illinois, showing Mental Health shortage areas by County in 2017: only four of the 102 counties in Illinois were identified as not having a shortage of mental health professionals (McHenry, Woodford, Grundy, and Champaign), 11 counties were identified as having a shortage in parts of the county (Winnebago, Lake, Kane, DuPage, Cook, Will, Kankakee, Peoria, Tazewell, Sangamon, and St. Clair); and the remaining 87 counties were entirely in a Mental Health Professional Shortage Area (HPSA).

Comments by Council Members and Stakeholders:

The following recommendations were developed and in some cases excerpted from member comments:

- Hospitals need additional support and phone consultation on cases in the emergency room from a central support agency to strengthen the community treatment in areas where there are insufficient number of psychiatrists.
- Interdisciplinary treatment, outreach, and support approaches need to be offered and staff training in them needs to be available in all communities across the State. Currently such teams are centered in Chicago’s Uptown area and a few other areas with larger mental health agencies in the State. To prevent residential placement or hospitalization, access to services within natural settings to improve access to an array of evidence based services should be as available as possible statewide.
- Building and improving provision of services by individuals with lived experience of mental illness for individuals and families is a need to be emphasized. Public education about the Certified Recovery Support Specialist (CRSS) credential, ongoing training for those that have achieved it, increasing the number of available positions into service provision for CRSS and developing clear paths to a sustained career are some areas to be addressed. The state could benefit from further evaluation of written and studied Medicaid rate methodologies to use CRSS in the workforce and needs to effectively create a state business model to employ more persons with lived experience, a group of individuals who are often unemployed or underemployed, and use their particular set of skills to fit, supplement. and complement other specialized skill sets and training in the field.
- Family members who have an individual with a mental illness also can be professionalized as has been shown in Massachusetts. Understanding and better utilizing that model and existing Certified Family Partner Professional (CFPP) certification could be valuable. (“Professionalized Family Members”)
- Strategic planning for the development of a CRSS and CFPP workforce will yield positive results. Potentially, used more effectively with the right training, the use of such staff can unlock a skilled workforce in a field that has rapid turnover and an increasing number of vacancies. There are strengths in this workforce group and potentially a willingness, skill, and interest to do the work that is required to help people remain in the community. That set of core beliefs, knowledge, and set of tasks can help the lead the entire field to learn what is important to keep people housed and in the community.

FY 2020-FY2021 DRAFT PLANNING TABLES

Please note that information about targets for FY2020 and FY2021 will be missing from many of the following tables. As we have not yet obtained substantive data prior to and during SFY2019 which is identified by SAMHSA as the year for establishing baseline measures, we are currently unable to project FY2020 and FY2021 data targets at this time.

Plan Table 1.1 Design of Public Mental Health Services

1. Priority Area: Continue to develop and improve the array of clinical and support services available for	2. Priority Type MENTAL HEALTH SERVICES
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adults and children.	
3. Population(s) SMI, SED:	
4. Goal of the priority area: <i>Assure the clinical quality and effectiveness of community-based mental health services available to adults and youth and assure the comprehensiveness of the public mental health service system design.</i>	
5. Objective: Conduct ongoing evaluation of the quality and outcome of community-based services in Illinois.	
6. Strategies to attain the objective: <ul style="list-style-type: none"> • Identify, develop and establish outcome measures (indicators) for the evaluation of community services. • Design a system to process the components and data of the evaluation. • Implement the system. • Analyze the resulting data to: (a) inform the publicly funded community service system; (b) facilitate decision making and planning; and (c) improve the quality and effectiveness of services and service delivery. 	
7. Annual Performance Indicators to measure goal success: Indicators: (1) Number of outcome measures ready for use. (2) Percent of providers that demonstrate their capacity for use of the outcome measures in reporting.	
a) Baseline measurement (Initial data collected prior to and during SFY2020): N/A	
b) First-year target/outcome measurement (Progress to end of SFY 2020):	
c) Second-year target/outcome measurement (Final to end of SFY 2021):	
d) Data source: DMH information system	
e) Description of data: Registration data is submitted directly to the DMH information system which is operated by the DMH's Administrative Services Organization (ASO). Claims data, which is submitted to the state Medicaid agency Healthcare and Family Services (HFS), is returned to the ASO after processing where it is stored with registration information in the DMH data warehouse. This information is used as a basis for developing reports, for analytic purposes, and is the basis for reporting the data used to populate the majority of the URS tables. Data for specific outcome measures will be processed through this system.	
f) Data issues/caveats that affect outcome measures: None	

Plan Table 1.2-1 Evidence Based Practices: Assertive Community Treatment (ACT)

1. Priority Area #2: Promote Provision of Evidence Based and Evidence-Informed Practices	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s) SMI, SED	
4. Goal of the priority area: <i>Promote Evidence Based Practices for individuals served in DMH funded agencies and advance the implementation of evidence-informed practices in the child and adolescent service system.</i>	
5. Objective 1: Continue to reach expected outcomes for individuals in need through provision of Assertive Community Treatment (ACT).	
6. Strategy to attain the objective: Development of a set of outcome measures designed to assess the progress of individuals served.	
7. Annual Performance Indicators to measure goal success: Indicator: Number of persons with SMI receiving Assertive Community Treatment in FY2020 and FY2021 (National Outcome Measure).	

a) Baseline measurement (Initial data collected prior to and during SFY2019):
b) First-year target/outcome measurement (Progress to end of SFY 2020):
c) Second-year target/outcome measurement (Final to end of SFY 2021):
Data Source: DMH funded providers by contract must submit demographic, clinical information and claims data for all individuals receiving services funded using DMH dollars. The DMH provides data specifications to assure consistency of reporting.
e) Description of data: Providers of ACT services submit monthly reports of team capacity to DMH, which is monitored for system sufficiency. This information is used as a basis for developing reports, analytic purposes, and is the basis for reporting the data used to populate the URS tables.
f) Data issues/caveats that affect outcome measures: Most ACT Teams currently operate within areas where individuals are served through Managed Care Contracts. The claims data related to MCO funded care is currently not available to the State Mental Health Authority, and thus individual outcomes from ACT cannot be accurately measured at this time. Through the State's work on the HHS transformation, plans are underway to improve the interoperability of the data systems and it is believed that DMH will in the future be able to track outcomes of individuals.

Plan Table 1.2-2 Evidence Based Practices-Individual Placement and Support (IPS)

1. Priority Area #2: Promote Provision of Evidence Based and Evidence-Informed Practices	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s) SMI, SED	
4. Goal of the priority area: <i>Promote Evidence Based Practices for individuals served in DMH funded agencies and advance the implementation of evidence-informed practices in the child and adolescent service system.</i>	
5. Objective: During FY2020 and FY2021, maintain and support the statewide implementation of Evidence Based Supportive Employment.	
6. Strategies to attain the objective: (1) During FY2020 and FY2021, continue the development of the state infrastructure required to support implementation and sustainability of IPS Evidence Based Supported Employment. (2) During FY2020 and FY2021, continue to develop the integration of physical and behavioral health with employment supports and peer support statewide. (3) By the end of FY 2021, through the provision of additional funding resources, continue the implementation of IPS Evidence Based Supportive Employment which targets an additional 500 consumers acquiring competitive employment in their local communities.????	
7. Annual Performance Indicators to measure goal success: Indicator: Number of consumers receiving supported employment in FY2020 and FY2021. (National Outcome Measure)	
a) Baseline measurement (Initial data collected prior to and during SFY 2019): 3,413 individuals were served in SFY2018 and 3,775 individuals are expected to be served in SFY2019.	
b) First-year target/outcome measurement (Progress to end of SFY 2020): ???	
c) Second-year target/outcome measurement (Final to end of SFY 2021): ???	
d) Data source: Data for this indicator are generated through a special web-based database created specifically for the DMH SE initiative. Fidelity and outcomes data are submitted to the DMH SE coordinator.	
e) Description of data: As always, DMH has developed specifications for reporting that DMH funded providers must use when submitting data.	
f) Data issues/caveats that affect outcome measures: DMH only reports data for teams that have been found to exhibit fidelity to the evidenced based practice model. DMH is working to	

promote fidelity in all IPS agencies and thereby expand the database.

Plan Table 1.3: FIRST.IL/MHBG FEP SET-ASIDE

<p>1. Priority Area: FEP Set-Aside: Implementation of FIRST IL Specialized Programming and Evidence – Based Services for persons experiencing First Episode Psychosis/Early Serious Mental Illness</p>	<p>2. Priority Type: MENTAL HEALTH SERVICES</p>
<p>3. Population(s) SMI, SED, OTHER:</p>	
<p>4. Goal of the priority area: <i>Sustain and expand the infrastructure for evidence-based clinical programs for persons with ESMI.</i></p>	
<p>5. Objective: Sustain 15 Coordinated Specialty Care teams currently in the State.</p>	
<p>6. Strategies to attain the objective: Provide education, training, and ongoing consultation to staff involved in FEP programs that includes:</p> <ul style="list-style-type: none"> • Strategies for Outreach and community-based education to attract and retain clients who have recently begun experiencing symptoms of psychosis or serious mental illness; • Assessment and individualized treatment planning with these individuals in the most supportive and least intrusive manner; • Psychiatric evaluation and medication management • Individual Placement and Support (IPS) programs geared towards accessing employment, job retention, and smooth transitional experiences in work life that can increase self-esteem, confidence, and stability in persons experiencing early episodes of serious mental illness. • Supportive education that helps the individual to initiate or continue in his/her educational process. • Family and Individual Psychoeducation • Counseling and Case Management • Cognitive Behavioral Therapy for Psychosis • Analyze needs of geographic areas to identify the best location of a new program • Determine the potential for success and the capacity of the candidate provider based upon criteria for Providers Selection previously formulated by the DMH FEP Team 	
<p>7. Annual Performance Indicators to measure goal success: Indicator #1: (a) Number of sites in the State with funded ESMI Programs. (b) The total FEP Set-Aside expenditures by the State for each site</p>	
<p>a) Baseline measurement (Initial data collected prior to and during SFY 2019): 15 funded sites at the end of SFY2018.</p>	
<p>b) First-year target/outcome measurement (Progress to end of SFY 2020) 15 Funded sites</p>	
<p>c) Second-year target/outcome measurement (Final to end of SFY 2021): 15 Funded Sites</p>	
<p>d) Data source: The DMH contractual process for this initiative included specified goals, performance measures and performance standards for each participating provider. Data is collected from participating FEP sites on an ongoing basis by statewide coordinators of the program using the Enrollee Outcomes form which documents the program strengths, the barriers encountered, and the outcomes in terms of number of referrals and number of clients enrolled at each participating site.</p>	

e) Description of data: The Enrollee Outcome Form lists all active sites in the State. Records of contracts and funding awards for each agency are maintained by the DMH Fiscal Office. Quarterly Report Performance Forms track Training, Module Advancement, and Employment and IPS/Supported Ed Involvement. Quarterly Expenditure Reports are also completed by our FEP Set-Aside agencies and provided to DMH.
f) Data issues/caveats that affect outcome measures: The full potential of the FEP Program may be affected by federal restrictions on eligible diagnosis.

5. Objective #2: Improve and maintain quality of clinical services received by FIRST-IL clients
6. Strategies to obtain objective; (1) Continue training in key clinical approaches including as CBT-p, Family Psychosocial Education (FPE), Case Management, Counseling (See strategies for Objective #1) and ongoing technical assistance. (2) Provide advanced CBT-p training for experienced provider staff and team leaders to develop mentoring expertise and peer consultation. (3) Provide training events in Fidelity to the CSC model with follow-up consultation and supportive collaboration.
7. Indicators:(1) Number of training events held each year to increase clinical competence and expertise in the delivery of FEP services in community agencies statewide.
a) Baseline measurement (Initial data collected prior to and during SFY 2019):
b) First-year target/outcome measurement (Progress to end of SFY 2020):
c) Second-year target/outcome measurement (Final to end of SFY 2021):
d) Data source: Records of teleconference calls and attendance are maintained by statewide coordinators.
e) Description of data: See Above
f) Data issues/caveats that affect outcome measures:

Objective #3 Increase number of FIRST-IL enrollees statewide.
Strategies to obtain the objective: <ul style="list-style-type: none"> • Expand outreach efforts and provide public information about FIRST-II. • Each FEP Site to achieve five Marketing and Outreach events per month • Each FEP Site will achieve a minimum of five new Enrollees per Fiscal Year.
Indicator #3: Number of clients meeting criteria for FEP enrolled in team services statewide.
a) Baseline measurement (Initial data collected prior to and during SFY 2019): 251
b) First-year target/outcome measurement (Progress to end of SFY 2020): 300
c) Second-year target/outcome measurement (Final to end of SFY 2021): 350
d) Data source: Enrollment data from each participating site aggregated by statewide coordinator retrieved from Enrollee Outcome Form at Baseline and every 6 months.
e) Description of data: Number of persons meeting eligibility criteria for FEP program enrolled at each site. Minimum of 5 additional FEP Enrollees per Site Per year
f) Data issues/caveats that affect outcome measures: The full potential of the FEP Program may be affected by the federal restrictions on eligible diagnosis.

Plan Table 1.4 Access Data/ Consumer Satisfaction Survey

1. Priority Area: Use of Data for Planning	2. Priority Type: MENTAL HEALTH SERVICES
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3. Population(s)-SMI, SED,
4. Goal: <i>Use Quantitative data to assess access to care and perception of treatment outcomes to provide data for decision support.</i>
5. Objective: Continue to improve and maintain quality data collection and reporting.
6. Strategies: (a) Assess access to care by tracking the number of individuals who received treatment partitioned by race, gender and age. (b) Conduct an annual consumer satisfaction survey that includes national outcome measures (NOMs) and report results. (c) Establish and maintain a functional data sharing system that will include mental health service data for persons funded through Medicaid Managed Care system (MCOs).
7. Annual Performance Indicators to measure goal success: Indicator #1: Number of adults and number of children/adolescents receiving services from DMH-funded community-based providers.
a) Baseline measurement (Initial data collected prior to and during SFY 2020): DMH Data = 63,070 at the end of 2018; 72,000 projected for FY2019.
b) First-year target/outcome measurement (Progress to end of SFY 2020): ??
c) Second-year target/outcome measurement (Final to end of SFY 2021): ??
d) Data source: DMH funded providers by contract must submit demographic, clinical information and claims data for all individuals receiving services funded using DMH dollars. The DMH provides data specifications to assure consistency of reporting.
e) Description of data: Registration data is submitted directly to the DMH information system which is operated by the DMH's Administrative Services Organization (ASO). Claims data, which is submitted to the state Medicaid agency Healthcare and Family Services (HFS), is returned to the ASO after processing where it is stored with registration information in the DMH data warehouse. This information is used as a basis for developing reports and for analytic purposes, and is the basis for reporting the data used to populate the majority of the URS tables
f) Data issues/caveats that affect outcome measures: No access to MCO data

Plan Table 1.5 Justice

Priority Area: Maintain effective systems to serve the forensic needs of justice-involved consumers of services.	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s) SMI, SED, OTHER:	
4. Goal of the priority area: <i>Maintain a system of care to address the mental health needs of consumers with criminal justice involvement.</i>	
5. Objective; Provide an alternative to incarceration for youth with SED and link them to community-based services that addresses their unique needs and strengths.	
6. Strategies to attain the objective: Maintain the Mental Health Juvenile Justice Initiative.	
7. Annual Performance Indicators to measure goal success: Indicator: Number of youth served by the MHJJ Program statewide.	
a) Baseline measurement (Initial data collected prior to and during SFY 2020): 693 enrolled in FY2018; Continuing target of 200 for FY2019	
b) First-year target/outcome measurement (Progress to end of SFY 2020): ?	

c) Second-year target/outcome measurement (Final to end of SFY 2021): ?
d) Data source: MHJJ Program Data Base maintained internally by DMH oversight staff
e) Description of data: Aggregate the number of youth receiving services from the Mental Health Juvenile Justice program across the year that will be compared to data from subsequent years.
f) Data issues/caveats that affect outcome measures: None

Plan Table 1.6 Recovery/Consumer Services

1. Priority Area: Expansion of the scope of consumer and family participation through advancement of the recovery vision and family driven care.	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s) SMI, SED OTHER:	
4. Goal of the priority area: <i>Establish and enhance the public mental health system of care based upon principles of Recovery and Resilience in which consumers and families are knowledgeable and empowered to participate and provide direction at all levels of the system and peer-run programs are increasingly utilized.</i>	
5. Objective #1: Continue work to increase the number of Certified Recovery Support Specialists and to facilitate their deployment statewide.	
6. Strategies to attain the objective: Strategy #1: Support the role of Certified Recovery Support Specialists and their deployment statewide by hosting training for consumers and providers to help increase agencies' understanding of the role, value, function, and advantages of hiring CRSS professionals and by providing competency training events for individuals interested in the CRSS credential.	
7. Annual Performance Indicators to measure goal success: Indicator #1: Number of training events held each year to increase stakeholder understanding of the CRSS credential and to increase competency in CRSS domains.	
a) Baseline measurement (Initial data collected prior to and during SFY 2020: Nine training events in FY2018; Nine targeted in FY2019.	
b) First-year target/outcome measurement (Progress to end of SFY 2020):	
c) Second-year target/outcome measurement (Final to end of SFY 2021):	
d) Data source: Document each training event and aggregate by year for comparison across years.	
e) Description of data: Training agenda and attendance sheets documenting participation for each training event held.	
f) Data issues/caveats that affect outcome measures:	

5. Objective #2: Increase the use and efficacy of the WRAP model
6. Strategy #2: Enhance competency and encourage WRAP trained and certified facilitators to provide an increasing number of WRAP® classes in the State.
7. Annual Performance Indicators to measure goal success: Indicator #2: (a) Number of WRAP Refresher trainings offered statewide each year (b) Number of WRAP participants each year

a) Baseline measurement (Initial data collected prior to and during SFY2020):
b) First-year target/outcome measurement (Progress to end of SFY2020):
c) Second-year target/outcome measurement (Final to end of SFY 2021):
d) Data source: Document each training event and aggregate by year for comparison across years.
e) Description of data: Training agenda and attendance sheets documenting participation for each training event held.
f) Data issues/caveats that affect outcome measures: None

5. Objective #3: Continue to inform and empower consumers and families.
6. Strategy #3: Conduct a series of statewide teleconferences designed to disseminate important information to adult consumers and families across the State.
7. Annual Performance Indicators to measure goal success: Indicator #3: Number of statewide teleconferences held each year. Number of participants per teleconference.
a) Baseline measurement (Initial data collected prior to and during SFY 2020): Ten (10) statewide teleconferences in SFY2018 and 10 targeted for FY2019.
b) First-year target/outcome measurement (Progress to end of SFY 2020):
c) Second-year target/outcome measurement (Final to end of SFY 2019):
d) Data source: Document each teleconference event and aggregate by year for comparison across years.
e) Description of data: Teleconference agendas
f) Data issues/caveats that affect outcome measures: None

Table 1.7 Community Integration

1. Priority Area: Advancement of Community Integration	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s) SMI, SED, OTHER:	
4. Goal of the priority area: <i>Complete the successful transition of individuals with diagnosed SMI who are residents of long term nursing homes, from this level of care to the less restrictive settings, ideally, independent living in the communities with appropriate and necessary support services.</i>	
5. Objective: Transition up to 400 additional Williams Class Members before the sunset of the Consent Decree.	
6. Strategies to attain the objective: Through FY2020, and perhaps beyond, through the provision of open market units rent subsidies Permanent Supportive Housing (PSH), Cluster Housing PSH models, 24 hour supervised residential settings and Community Integrated Living Arrangements (CILA), implement the transition of residents (Williams Class Members) from 24 designated Nursing Facilities (NF) (statewide) categorized as Institutes for Mental Disease (IMD) to permanent supportive housing or other housing alternatives that are safe, affordable housing and provide support services in communities of preference in a manner consistent with the national standards for this evidence based supportive housing practice.	
7. Annual Performance Indicators to measure goal success: Indicator: Number of consumers who transition from long term institutional settings/IMDs who access appropriate permanent supportive housing or other housing options. (National Outcome Measure)	

a) Baseline measurement (Initial data collected prior to and during SFY 2020): The number of consumers transitioned by the end of SFY2018 = 315 Class Members were transitioned. 400 Class members projected by for FY2019.
b) First-year target/outcome measurement (Progress to end of SFY 2020):
c) Second-year target/outcome measurement (Final to end of SFY 2021): TBD NOTE: The Williams vs. Rauner Consent Decree was originally slated to sunset in 2016. The activities of this Consent Decree continued through FY2019. Continuation after the FY2020 fiscal year will be dependent on negotiations between parties and the court decision. The goal for FY2019 has been to meet the projected two-year cumulative transition total of an additional 800 Class Members.
d) Data source: Individuals who receive a permanent supportive housing/bridge subsidy are not required to be registered, enrolled or engaged in mental health treatment services. Therefore, it was necessary to create a special database to track access to and receipt of permanent supportive housing bridge subsidy.
e) Description of data: The data for this indicator will be generated from permanent supportive housing applications of individuals in longer term institutional settings which are stored in the special database, as well as a special PSH outcomes database.
f) Data issues/caveats that affect outcome measures: Continuation after the FY2020 fiscal year will be dependent on negotiations between parties and the court decision.

Plan Table 1.8 Mental Health and the Military

1. Priority Area: Coordination and facilitation of mental health services for Illinois Servicemembers, Veterans, and their Families (SMVF).	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s) OTHER Service Members, Veterans, and their Families (SMVF) requiring mental health services:	
4. Goal of the priority area: <i>Collaborate with military and state agency partners to improve access to home and community-based mental health services for service members, veterans, and their families.</i>	
5. Objective #1: Sustain a coordinated system of care	
6. Strategies to attain the objective: a). Develop and maintain partnerships with the Department of Veterans Administration, the Illinois Departments of Veterans' Affairs (IDVA), and Military Affairs (IDMA), and other agencies and organizations meeting regularly to develop, establish and maintain a coordinated system of care. b). Develop an inventory of existing behavioral health system providers and services to provide a referral system. c). Build a coordinated crisis service intervention system between the VA and community providers, with special emphasis on suicide prevention.	
6. Annual Performance Indicators to measure goal success: Indicator #1: The number of collaborative meetings attended by DMH staff representatives that have agendas aimed at completing the strategies and coordination of services.	
a) Baseline measurement (Initial data collected prior to and during SFY2020): By the end of FY2018, twelve collaborative meetings were attended by DMH representatives that have agendas aimed at completing the behavioral health inventory and coordination of services. Twelve (12) meetings were projected for FY2019.	
b) First-year target/outcome measurement (Progress to end of SFY 2020):	

c) Second-year target/outcome measurement (Final to end of SFY 2021):
d) Data source: Meeting Minutes and records of DMH staff members assigned to this collaborative task.
e) Description of data: See Above.
f) Data issues/caveats that affect outcome measures: None.

Objective #2: Improve quality of community mental health services to servicemen, veterans, and their families
Strategy to obtain the objective: Educate and train community providers in military and veteran clinical cultural competence.
Indicator #2. The resumption of Military and Veteran 101 Clinical Cultural Competency Workshops. the number completed during the fiscal year, and the number of participants each year.
a) Baseline measurement (Initial data collected prior to and during SFY 2020): N/A
b) First-year target/outcome measurement (Progress to end of SFY 2020):
c) Second-year target/outcome measurement (Final to end of SFY 2021):
d) Data source: Calendar dates of these events and attendance records of each.
e) Description of data: See Above.
f) Data issues/caveats that affect outcome measures: None.

Objective #3: Build Veteran Service Communities (VSC) throughout the state that can ensure access to Behavioral Health Services.
Strategy #3: Partner with the Department of Veterans Administration My VA Communities initiative. This initiative is a relationship building effort to ensure Veterans Administration facilities are connected and engaged with their local communities and is an ongoing effort of The Illinois Division of Mental Health coordinating through Illinois Joining Forces Behavioral Health Working Group to ensure SMVF have access to Behavioral Health Services.
Indicator #3: (a) Number of Veterans Service Communities in the State with active Behavioral Health services at end of each fiscal year.
a) Baseline measurement (Initial data collected prior to and during SFY 2020): 2 VSCs at the end of FY2018; 19 so far in FY2019.
b) First-year target/outcome measurement (Progress to end of SFY 2018):
c) Second-year target/outcome measurement (Final to end of SFY 2019):
d) Data source: Meeting Minutes and records of DMH staff members assigned to this collaborative task.
e) Description of data: See Above.
f) Data issues/caveats that affect outcome measures: None.

Plan Table 1.9 Integrated Health Homes

1. Priority Area: Work collaboratively to enhance and improve service coordination through the establishment of Integrated Health Homes.	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s)- SMI, SED,	
4. Goal: <i>Through the implementation of the plan cited in the DHFS application for the</i>	

<i>1115 Waiver, develop and maintain care coordination in community mental health service agencies ensuring that persons with serious mental illness and their families can receive fully integrated and seamless services in their community.</i>
5. Objective: Assist community mental health providers to successfully meet integrated Health Home certification requirements.
6. Strategy: Provide education, focus, technical assistance, and consistent ongoing support for community mental health centers to become integrated health homes.
7. Annual Performance Indicators to measure goal success: Indicator: Number of community mental health providers meeting the requirements for certification as Integrated Health Homes.
a) Baseline measurement (Initial data collected prior to and during SFY 2020): N/A
b) First-year target/outcome measurement (Progress to end of SFY 2020): TBD
c) Second-year target/outcome measurement (Final to end of SFY 2021): TBD
d) Data source: TBD
e) Description of data: TBD
f) Data issues/caveats that affect outcome measures: No access to DHFS or MCO service data

C. ENVIRONMENTAL FACTORS AND PLAN

1. The Health Care System, Parity and Integration

Responses to Questions 1 and 2 below are Required

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

2. Describe how the state provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

The expansion of Medicaid in Illinois has been accomplished. The Illinois Department of HealthCare and Family Services (IDHFS), as the State’s Medicaid Authority, has the continuing mandated responsibility to monitor access to Medicaid services, and the Illinois Department of Insurance is monitoring coverage for mental health services under healthcare reform. Continuing inter agency discussions regarding strategies and mechanisms to monitor the implementation of ACA, evaluate if Qualified Health Plans (QHPs) and Medicaid are offering sufficient services, and evaluate the consistency of services with the provisions of Mental Health Parity Addiction Equity Act (MHPAEA) are taking place, however this responsibility does not fall under the purview of DMH.

The DMH does however continue to collect enrollment/registration data for individuals enrolled in various Medicaid managed care initiatives. This data may permit DMH, at some point, to compare the services received by individuals under Medicaid Managed Care and other Medicaid programs to those individuals for whom DMH purchases services.

Most services provided by DMH-funded providers are Medicaid reimbursable, although some services are still purchased through a capacity grant mechanism. MHBG Funds are being used only to purchase services not covered elsewhere. These services are not Medicaid reimbursable.

Behavioral Health/Primary Health Integration. The importance of the integration of mental health and substance abuse services with primary health care has continued to be supported and advocated by DMH, DSUPR (the Division of Substance Use Prevention and Recovery) and HFS. All three entities have collaborated on various initiatives aimed at increasing integration across the state. These have included a focus on a State Plan Amendment to develop Integrated Health Homes, Brief Intervention and Referral to Treatment (SBIRT) as well as prior collaboration on an Emergency Room Diversion program and other initiatives. Medicaid managed care programs implemented over the past few years by HFS have also emphasized behavioral health and primary health care integration. Some mental health agencies have demonstrated significant progress toward Primary Care Behavioral Health Integration and have plans that demonstrate expanding their integration across the child and adolescent and adult populations they serve. Screening and referral for prevention and wellness education, health risks, and recovery supports are largely dependent on the policies and practices of individual provider agencies. This information is not collected at the state level. However, the DMH Office of Recovery Support Services reviews and monitors the level of support for recovery across agencies statewide, and advocates for employment of CRSS credentialed staff and the use of non-credentialed individuals with lived experience to provide peer support.

The integration of Primary Health Care and Behavioral Health has received attention in the past two years and continues to be a priority for DMH. Developments and key activities that have been related to this area have included the following initiatives:

Promoting Integration of Primary and Behavioral Health Care in Illinois (PIPBHC-IL) In collaboration with Centerstone Illinois/Southern Illinois Healthcare Foundation, Chestnut Health Systems/Chestnut Family Health Center, and LifeLinks Mental Health/Southern Illinois Healthcare Foundation) this grant-funded project will integrate primary and behavioral health care for an estimated 1,635 of individuals with serious mental illness and a variety of co-occurring illnesses or disorders. Through this grant we will:

- 1) Promote full integration and collaboration in clinical practice between primary and behavioral health care in three largely rural counties, each having at least one significant population center
- 2) Support the improvement of integrated care models for primary care and behavioral health care to improve the overall wellness and physical health status

- of adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED);
- 3) Promote and offer integrated care services that include screening, diagnosis, prevention, and treatment of mental and substance use disorders, and co-occurring physical health conditions and chronic diseases.
 - 4) Use lessons learned throughout the five-year implementation project to support statewide planning and implementation of integrated health homes.
 - 5) Create a learning collaborative or Center of Excellence to support all Illinois providers who are interested in exploring PIPBHC-IL implementation.

A minimum of 220 consumers will be served in Year 1 (SFY2020); a minimum of 1,635 consumers will be served throughout the five year project's lifespan.

Health and Human Services Transformation

Illinois is one of the largest funders of health and human services (HHS) in the country. With \$32 billion spent across its HHS agencies (including the DMH and HFS), amounting to more than 40% of its total budget, the State is deeply invested in the health and well-being of its 12.9 million residents and 3.2 million Medicaid members. There is an urgent need to get more from this investment: the State must improve health outcomes for residents while slowing the growth of healthcare costs and putting the State on a more sustainable financial trajectory.

The HHS transformation seeks to improve population health, improve experience of care, and reduce costs. It is grounded in five themes:

- Prevention and population health
- Paying for value, quality, and outcomes
- Rebalancing from institutional to community care
- Data integration and predictive analytics
- Education and self sufficiency

The initial focus of the transformation effort has been on behavioral health (mental health and substance use) and specifically the integration of behavioral and physical health service delivery due to the urgency of the issue as well as the potential financial and human impact. There is also a large financial payoff in improving behavioral health: Medicaid members with behavioral health needs (referred to henceforth as “behavioral health members”) have historically represented 25% of Illinois Medicaid members but account for 56% of all Medicaid spending

The focus on behavioral health has been informed by the State's *Healthy Illinois 2021* plan (<http://www.healthycommunities.illinois.gov/>), which encompasses the State Health Assessment (SHA), the State Innovation Model (SIM) grant awards, and the State Health Improvement Plan (SHIP). Together, these initiatives aim to align plans, processes, and resources to improve the health of Illinois residents. Illinois' two State Innovation Model

(SIM) design grant awards from the Center for Medicare and Medicaid Innovation - a Round One award in 2013 and a Round Two award in 2015 – helped the State to create focused and measurable health improvement strategies and identify behavioral health as a priority. Together, the SHA, SIM, and SHIP work were foundational to the Illinois’ HHS transformation. Stakeholders have identified several priorities for transformation efforts, including the need to reduce the current siloes in behavioral health care to enable a more efficient system that emphasizes greater integration of physical and behavioral health. This Transformation process is designed to develop a Health and Human Service System in Illinois which functions across the life span. Many members of the facilitation team are involved in the process and have been working to ensure systems of care values and principles are embedded into the work.

The 1115 Demonstration Waiver application, submitted on October 5, 2016 and approved by the Centers for Medicaid and Medicare on May 7th, 2018 was a critical planning component of a broader strategy to help achieve the above goals. The State has already started to integrate physical and behavioral health by carving-in behavioral health into the managed care system and developing a set of proposed State Plan Amendments (SPAs) that support integration.

The demonstration, as proposed, had six overarching goals:

1. Rebalance the behavioral health ecosystem, reducing overreliance on institutional care and shifting to community-based care
2. Promote integrated delivery of behavioral and physical health care for behavioral health members with high needs
3. Promote integration of behavioral health and primary care for behavioral health members with lower needs
4. Support development of robust and sustainable behavioral health services that provide both core and preventative care to ensure that members receive the full complement of high-quality treatment they need
5. Invest in support services to address the larger needs of behavioral health members, such as housing and employment services
6. Create an enabling environment to move behavioral health providers toward outcomes- and value-based payments

Together, the first five goals enable significant progress toward achieving goal 6: the shift to outcomes- and value-based payment models. This shift is instrumental for achieving true transformation of Illinois’ healthcare delivery system and ensuring the system is restructured with the member at the center. Meeting these goals will improve the quality of behavioral health care across the State and set the stage for payment models that reward providers for outcomes rather than volume.

Healthy Illinois 2021: Together with other key stakeholders, DMH participated in the development of the *Healthy Illinois 2021 Plan*, an effort led by the Governor’s Office and the Illinois Department of Public Health (DPH). Participants in the process included State agencies, provider associations, community organizations, payers, advocacy groups, educational institutions, and others. Specifically, a workgroup was established to assess

needs and make recommendations on Physical and Behavioral Health Integration, and this group was led by DMH staff.

Additional activities in this arena are:

- The Williams vs. Pritzker Settlement is resulting in an effort to provide optimum services to members of the class who are transitioning to the community from long term care and require primary health care and medical treatment.
- DMH continues to explore and emphasize options for more extensive collaboration with Health Resources and Services Administration (HRSA) funded Federally Qualified Health Centers (FQHCs) particularly in rural areas where the integration of services offers greater access for rural residents.
- DMH continues to emphasize the importance of assisting adult consumers in the completion of applications for Medicaid benefits as individuals with serious mental illnesses who are Medicaid recipients are entitled to the range of health services covered in the Illinois Medicaid plan.

Medicaid Expansion: Legislation enacted by the Illinois General Assembly and signed by the Governor in July 2013 expanded Medicaid coverage to persons below 138% of the Federal Poverty Level. Coverage became available to adults with annual income below 138 percent of the federal poverty line, which is \$15,860 for individuals and \$21,408 for couples. The measure was expected to enroll 342,000 people by 2017. Prior to this, Medicaid was only available to children, their parents or guardians, adults with disabilities or seniors. Enrollment for the newly eligible population began on October 1, 2013 with coverage starting on January 1, 2014 Current enrollment in Medicaid is: _____.

DMH/DSUPR Collaborative Efforts

Over the years, the SMHA, DHS/DMH and the SSA, DHS/DSUPR have co-located their Central Offices in both Chicago and Springfield, affording closer collaboration across the two divisions in policy and planning work. DHS/DMH requires a team member specializing in substance use services on every multi-disciplinary Assertive Community Treatment team and requires screening for substance use issues upon intake across its funded providers. DHS/DMH and DHS/DSUPR created a specialized crisis residential model for individuals with co-occurring mental illness and substance use disorders who experienced a crisis that required 24-hour supervision and created a braided funding model to support this approach. Treatment funded by DHS/DSUPR in Illinois emphasizes services that are consumer-oriented, geographically accessible, comprehensive, bridging continuing care responsibilities between all levels of an integrated system of care.

Mental Health Parity in Illinois

In August 2011, the Governor signed the Illinois Behavioral Health Parity Law that brought state law into line with the federal MHPAEA requiring mental health coverage to be comparable with other physical health coverage. This law added addiction health care and autism health care to the definition of behavioral health care and is applicable to any

plan of a small employer (with 2-50 employees) as well as larger employers required by federal law.

Insurance companies in Illinois must now provide the same coverage for mental health and substance abuse disorders that they provide for all other conditions. Insurers are prevented from including additional barriers within the policy – such as financial requirements, treatment limitations, lifetime limits or annual limits – to treatments for mental, emotional, nervous, and substance abuse disorders if no such stipulations exist for other health conditions. Illinois’ new law exceeded the requirements of the federal mental health parity law and was recommended by the Governor’s Health Care Reform Implementation Council.

The Illinois Behavioral Health Parity Law:

- Added substance use disorders to the list of mental illnesses covered by the parity law
- Added that medical necessity criteria with regard to substance use disorders will be determined in accordance with criteria established by the American Society of Addiction Medicine.
- Required insurers to cover treatment for Substance Use Disorders in a residential facility
- Prohibited non-quantitative treatment limitations that are not used on a comparable basis for medical surgical benefits
- Provided that lifetime limits on coverage can only be applied to mental health benefits if lifetime limits are also imposed on medical-surgical coverage and such lifetime limits are imposed in the same manner to mental health benefits as medical-surgical benefits; and that annual limits on coverage can only be applied to mental health benefits if annual limits are also imposed on medical-surgical coverage and such annual limits are imposed in the same manner to mental health benefits as medical-surgical benefits.
- There can be only one deductible.

2. *Health Disparities*

Enrollment/registration data collected by DMH includes race, ethnicity, gender, age, the primary language spoken by individuals accessing services and whether the individual requires an interpreter to receive services. LGBTQ status is not currently collected. DMH providers submit information as part of their agency profile with regard to the languages spoken by agency staff and are required to submit claims for all DMH purchased services provided to enrolled/registered individuals. A special code has been developed to track individuals and services provided to individuals for whom oral interpretation (translation) and/or sign language is required to provide appropriate service to individuals accessing treatment. Under the Medicaid Community Mental Health Services Program Rule (59 Ill Admin Code132) Certified Comprehensive Community Mental Health Centers (CCMHCs) are required to “ensure the availability of services

that are culturally and linguistically appropriate and responsive to the needs of clients served, including but not limited to children/youth, military families, those in the criminal justice system, and the LGBTQ population.”

DMH continues to actively monitor access to services partitioned by race, ethnicity, gender, age, and the match between primary language spoken by individuals accessing services and agency service staff. When disparities are identified, DMH can initiate planning to address these issues. One of the primary goals of DMH strategic planning is assuring that vendors providing mental health services are culturally and linguistically competent and at least minimally culturally and linguistically capable.

The state also requires all vendors to develop cultural competency plans to “comply with Title VI of the Civil Rights Act of 1964, Americans with Disabilities Act of 1990, Americans with Disabilities Act Amendments Act of 2008, Illinois Human Rights Act, the 1970 Constitution of the State of Illinois and any laws, regulations or orders, federal or state, which prohibit discrimination on the grounds of race, sex, color, religion, national origin, age, ancestry, marital status, disability, or the inability to speak or comprehend the English language”.

3. Innovation in Purchasing Decisions

Evidence Based Practices are emphasized in purchasing and policy decisions. DMH regional staff work closely with provider agencies and are responsible for tracking and disseminating information about Evidence Based Practices (EBPs). The provision of evidence-based supportive employment through the Individual Placement Services (IPS) model, Assertive Community Treatment (ACT), and Permanent Supportive Housing (PSH) are consistently tracked. DMH policy requires adherence to national fidelity standards for EBPs and purchasing decisions are largely made in reference to local needs and the capacity of provider agencies to provide services at the level of fidelity required. DMH has used information about EBPs and fidelity standards educationally in working with partner agencies, such as IDHFS, the State Medicaid agency, in revising the Illinois Medicaid Rule accordingly. Services are purchased either directly or indirectly to maintain the EBP or to build provider capacity to meet fidelity standards and increase service delivery. For example, DMH closely monitors agencies that have ACT teams to ensure fidelity to the ACT model. As a result, some agencies that determined that they did not have the capacity to deliver the evidence-based ACT model, chose to adopt the step-down model of the Community Support Team (CST) instead. If teams do not meet fidelity standards, they are not reimbursed for delivering the Evidence Based Practice. Agencies not meeting fidelity for ACT must provide alternative modalities for less reimbursement.

The following value-based purchasing strategies are used in Illinois:

- Leadership support, including investment of human and financial resources.
- Use of available and credible data to identify better quality and monitor the impact of quality improvement interventions.

- Provider involvement in planning value-based purchasing.
- Gaining consensus on the use of accurate and reliable measures of quality.
- Quality measures focused on consumer outcomes and also on process issues and care
- Statewide teleconferences to educate consumers and empower them to select quality services
- Emphasis on quality as a priority across the entire state infrastructure.
- Ongoing assessment of the impact of purchasing decisions.

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (Required for MHBG) **The FIRST-IL Program (The 10% Set-Aside)**

Planning and Initial Implementation

The DMH First Episode Program Planning Workgroup began meeting on a weekly basis in May, 2015 to discuss and finalize an approach to implement evidenced based early intervention for persons who present with First Episode Psychosis. DMH engaged the Best Practices in Schizophrenia Treatment (BeST) Center, Department of Psychiatry, at Northeast Ohio Medical University (NEOMED) to provide technical assistance and consultation to the DMH First Episode Program Planning Workgroup on program design considerations and the feasibility of implementing the model in a practical manner that could meet the needs of individuals with FEP and result in successful outcomes. An initial two day BeST Center consultation at the state and provider community levels was planned and subsequently held on September 29th and 30th, 2015 in Chicago. Key issues that were addressed in consultation sessions included: discussing and finalizing the diagnostic categories associated with FEP; reviewing the pros and cons of planning for the integrated use of IPS and ACT with a team approach for persons with FEP versus embedding individuals with expertise working with the FEP population on existing teams; sustainability, outreach and education, and site selection for implementation. DMH providers provided consultation with regard to how they could participate in the initiative, including agency resources and agency/staff strengths.

The actual roll-out of the FEP program in Illinois was completed within a relatively short time. In February 2016 an Application for Funding designed to gather additional information with regard to agency strengths and commitment to designating staff and agency resources for the FEP initiative was sent to agencies that participated in the planning and others that were identified as having potential for success in organizing and providing FEP services. By May 2016, eleven agencies had responded positively to the Application For Funding and had become listed sites. Final planning and decision-making for the roll-out was carried out in a 2-day consultation event with the BeST Center that included the providers in June 2016. At the end of August, the BeST Center consultant team returned to Chicago to provide FIRST Overview Training, Family Psychoeducation Training (FPE), training in Individual Resiliency Therapy (IRT), Supported Employment/ Education (SEE), and Case Management Training (CM). Prescriber- only training was provided by conference calls with the BeST

Center psychiatrist in late September and early October. By the end of September 2016, Weekly Team Meetings and Monthly Team Leader Calls had started. Client outreach began internally at the agencies first and some agencies had already initiated contacts with local colleges.

The Illinois vision is based on FEP programs generally starting slowly because it takes time to identify and engage individuals who experience FEP in the treatment setting. Initially, most FEP programs do not require full-time staffing, and team members may have responsibilities in addition to the FEP program for a significant phase-up period. Pulling together diverse services that may be available in the community, but that are not able to be offered in an integrated way by a FEP treatment team is a very helpful and cost-effective way to start a FEP program. Agencies without a needed service may contract with other providers for specific treatment services and/or share personnel or other resources with other providers.

The statewide program has been named FIRST.IL. Outreach, engagement, treatment, and coordination of support services are currently ongoing at each site. Each participating agency site has an identified team leader, and a team that consists of at least one therapist, one case manager, an administrative lead from agency administration, and a medication prescriber. In agencies that provide supported employment services, IPS Specialists are also on the team. Each agency has responded to uniform requirements of contracting with DMH while uniquely developing their team compositions and strengths in their service environments which range from the urban Chicago Metropolitan Area to county-based rural service agencies in Greater Illinois.

By the end of SFY2018 the program had expanded to 15 sites and reported a cumulative enrollment of 201 clients who met criteria of eligibility for the program.

The participating sites and the cumulative number of referrals and enrollees reported by each site are presented in the table below:

Agency	Number of Referrals As of 6/27/2019	Number of Clients Enrolled As of 6/27/2019
Advocate Illinois Masonic Behavioral Health Services, Chicago	58	30
Bridgeway MHC,	46	15
Centerstone	49	26
Chestnut Granite City	61	25
Chestnut Bloomington	11	2
Grand Prairie	88	21
Human Resources Development Institute	61	11
LifeLinks	35	8
Memorial Behavioral Health	65	12
Robert Young Mental Health Center	57	21
Trilogy	141	21

Thresholds – Chicago	88	28
Thresholds – Westmont	68	15
Transitions of Western Ill	13	7
Human Service Center of Peoria	29	9
TOTAL	870	251

Use of Set-Aside Funding

From the outset, the intent of DMH was to introduce emerging evidence based practices for FEP as a component of the services and activities that reflected the values, goals, and objectives inherent in the Vision and Mission of the Division of Mental Health and the SAMHSA requirements for the use of the dollars.

Set-Aside dollars are paid for:

1. The time and costs of assigning a clinician to become the designated agency staff person with expertise in clinical content and service delivery of ESMI services. Each agency was required to designate or hire at least a 0.5 FTE staff person with requisite clinical credentials to coordinate required service components for clients, to be able to reach out and engage clients in the community, and to provide therapeutic clinical services.
2. The time and costs of assigning a senior level agency staff member to a leadership role in ensuring that functions and operational integrity of the ESMI program are carried out at the agency and in collaboration with the Division of Mental Health.
3. Training, technical assistance, consultation events and sessions to develop expertise in evidence-based clinical approaches most helpful to individuals with ESMI.
4. Development of marketing materials and tools to be used for outreach and engagement of persons with ESMI and their families.

Building upon the training, infrastructure, and service delivery established through the 2015 funding, the dollars from the Ten Percent Set-Aside have been used to promote:

- Expansion of programming (using the model described above) to agencies in Region 5 (southernmost in Illinois) and generally increasing the number of agencies in the State that will have ESMI programs.
- Providing additional funding to agencies to facilitate improved implementation of program components as needed.
- Providing for DMH staff persons to furnish guidance and expertise in developing, monitoring, coordinating, and providing technical assistance to agencies in carrying out programming. In short to become the DMH experts for the provision of evidence-based services to individuals (and families as appropriate) who experience first and early episodes of a serious mental illness
- Increasing agency participation in: (1) ongoing focused training in ESMI approaches and in related evidence-based components. (2) structuring technical assistance and consultation to meet emerging needs in the areas of program development, service delivery, outreach and engagement approaches, financial supports for treatment, and program sustainability.
- Purchasing special services that are not Medicaid reimbursable.

Non-billable costs are covered by the Illinois Mental Health Block Grant Set-Aside funds. Illinois pays agencies actual costs for those expenses related to training and non-billable time per their submitted invoices up to the maximum of their contract.

The DMH contractual process for this initiative included specified goals, performance measures and performance standards for each participating provider. This combination of data and measures is being utilized to determine the impact of the FIRST.IL initiative.

Several perceived challenges that are being addressed in training and consultation include:

- Working with participating providers to modify the treatment paradigm from a singular focus on agency services for persons with serious and continuous mental illness to include the engagement of persons in acute distress and encountering mental illness for the first time in their lives.
- Assuring the financial support required for agencies to be able to sustain their programs and to serve those individuals who should be served but lack the resources to pay for their services.
- The three new Agency Sites in Illinois have had very little experience in conducting the outreach and engagement activities that are required in the ESMI program. Adaptation and the development of skill in these areas takes significant time and slows down the implementation process.
- Coverage for CSC programming by private insurance has been problematic and only some ESMI services are being paid. In Illinois, current legislation is being considered aimed at improving and streamlining coverage by private insurance.

5. Person Centered Planning (PCP) -Required for MHBG

The Wellness Recovery Action Plan (WRAP) model has been a keystone of person-centered planning and recovery in Illinois and is well-established and operational in the State. Through WRAP classes in community agencies and the introduction of the principles of WRAP at consumer forums and conferences, thousands of consumers throughout the state have benefited from receiving orientation and education in the principles and components of this evidence-based practice in recovery-oriented services. A recently recognized evidence-based practice, WRAP® is a multi-week program led by certified facilitators. WRAP® teaches people living with mental illnesses how to identify and use illness self-management resources and skills that help them stay well and promote their recovery. Studies show that WRAP® improves participants' quality of life and reduces their psychiatric symptoms. Increasing access to WRAP® Facilitator Training in Illinois is an important priority. DMH Recovery Support Services (RSS) provides annual WRAP® Facilitator Training, has trained over 400 people to deliver WRAP® statewide since 2002, and is continuously working to increase the number of trained facilitators who are providing WRAP® classes. The community support services WRAP® facilitators provide are Medicaid-reimbursable, making WRAP® an affordable program for many agencies. *As of June 2018, 526 individuals had been trained and certified as WRAP Facilitators in Illinois. Of those, 214 (40.6%) were actively participating in Refresher Training.*

CCMHCs provide care to individuals with or at risk for SMI/SED by using a person-centered approach to care performed by an interdisciplinary team. They serve individuals who have complex needs as a result of child welfare, justice or multisystem involvement, medical co-morbidity, homelessness, dual disorders and ensure the connectivity of services in their service area for individuals across the life span. Services are provided in the client's natural settings whenever possible.

Consumers and caregivers participate in planning and policy work groups and committees including the Illinois Mental Health Planning and Advisory Council (IMHPAC). They provide both formative ideas and feedback in a variety of planning venues in the State..

6. *Program Integrity-Required*

The Division of Mental Health has a long history of targeting the use of mental health block grant dollars to purchase services for individuals who are uninsured and toward the purchase of services that are non-Medicaid reimbursable. Continuing capacity for purchasing mental health services covered under the state benchmark for the uninsured population will need to be evaluated as state projections regarding the uninsured population are finalized and as the budgets for FY2020 and FY2021 are established for the use of general revenue funds to purchase services for these individuals. Although Mental Health Block Grant funds have historically been utilized to serve this population, it is estimated that would not be sufficient to fully cover service provision.

All DMH vendors are required to register/enroll all individuals for whom services are purchased using DMH dollars. DMH contracts require vendors to utilize dollars associated with specified funding streams for specific services. Information regarding family and individual income and household size are required data elements. The use of block grant dollars is governed by contracts, called Community Service Agreements, that are executed with each provider with whom the Division contracts. The contracts clearly state the service for which block dollars are allocated and the rules for reporting expenses associated with the services purchased.

The state has a number of individuals that are responsible for program integrity activities:

- DMH Fiscal Services is responsible for receiving expenditure reports with regard to how contracted vendors expense block grant dollars. All DMH vendors are required to submit audited financial reports to the DMH on an annual basis.
- DMH clinical and community services managerial staff are responsible for developing policy with regard to the services purchased from DMH vendors.
- Decision support staff develop policy regarding the reporting of services purchased from DMH vendors.

DMH assists providers in meeting compliance standards through the use of a comprehensive Provider Manual that is posted on the DHS/DMH Website and is

periodically reviewed and updated. Agencies are visited and monitored for compliance on a regular basis. Consultation is provided as part of post-payment review processes with providers, focused technical assistance may be offered, and findings may result in requests for recoupment of funds as appropriate and necessary. Additionally, DMH requires all providers to be certified and accredited through a nationally recognized accreditation organization.

7. Consultation with Tribes

This section is not applicable. Illinois has no Tribal reservations within its boundaries. Primary health care, community health and mental health services are provided to medically underserved members of federally recognized American Indian Tribes and family members residing in the City of Chicago area by the American Indian Health Service of Chicago, Inc. This agency operates as a non-profit charitable organization and is not funded through DMH.

The American Indian Health Service of Chicago, Inc. (AIHSC) was incorporated in the State of Illinois, City of Chicago on December 23, 1974. The organization's mission is dedicated to providing quality healthcare to the American Indian community and other underserved populations. As such, the organization provides accessible, preventive health care, and outreach services regardless of one's inability to pay. The services offered are: medical clinic, behavioral health clinic, alcohol and substance abuse out-patient counseling services and community education, diabetes clinic and community education, domestic violence and suicide prevention programs, HIV testing, education and prevention, and community outreach services /community health worker program.

The AIHSC was organized and operates exclusively as a non-profit charitable organization with IRS tax exempt status 501c3. The organization is one of 34 urban health centers for American Indians in the United States and the board of directors consist of eleven-member community-based volunteers of which 51 % are American Indians (PL 94-437, Indian Health Care Improvement Act, Title V: Urban Indian Health Programs). The organization is the only American Indian operated medical and behavioral health clinic in the state of Illinois.

AIHSC has identified three primary goals of service:

- To provide health and family services to American Indian people without healthcare services who are unable or unwilling to receive health care from other providers in the city;
- To provide culturally sensitive primary, secondary and tertiary prevention intervention for the Chicago area American Indian community; and
- To provide integrated case management programming to the clientele.

8. *Primary Prevention-Required for Substance Abuse Only*

This section is not applicable to the MHBG. This section will be addressed in the SABG submission by the DHS Division of Substance Use Prevention and Recovery (DSUPR).

9. *Statutory Criteria for MHBG (Required)*

Criterion I: The Comprehensive Community Based Mental Health System:

- ✓ The array of core services available to adults and youth with serious mental illnesses who are enrolled in Medicaid and the crisis services are available to all consumers.
- ✓ Commitment to a recovery orientation by mental health system stakeholders.
- ✓ The focus on consumer and family driven care
- ✓ Commitment to the implementation of evidence-based practices and, for children commitment to evidence informed practices and the dissemination of information regarding the implementation of evidence-informed practices that lead to resilience.
- ✓ Involvement of consumers and families in planning, implementing and evaluating the initiatives and ongoing activities of the public mental health system.
- ✓ Successful efforts to reduce hospitalization. Screening and crisis services for individuals at risk of hospitalization that contribute to this success remain a high priority for DMH.
- ✓ Collaborations with other divisions of the IDHS and with other state agencies have been a successful strategy for improving and enhancing services throughout the system.
- ✓ Collaborative efforts, pilot projects, and vocational/employment supports to address the needs of youth with serious emotional disturbance transitioning to adulthood, including those transitioning from correctional settings and the child welfare system.
- ✓ The state health care coverage program that offers comprehensive, affordable health insurance for children in Illinois assures that every uninsured child, regardless of income or medical condition has access to health care, including mental health services. Additionally, healthcare coverage is extended to parents living with their children 18 years old or younger and relatives who are caring for children in place of their parents.

Services are mostly funded through MCOs under Medicaid. Clients are assisted through case management in obtaining those services not available on-site at CMHCs.

Significant decreases of admissions in state hospitals are the result of attention to the issue of local area utilization of state hospital resources and continuity of care. The statewide reduction of bed utilization is based upon the principle that reduction must occur within a context that assures that clinically effective care remains continuous and that alternative and supportive community services are in place. A variety of strategies

have resulted in a significant reduction in civil admissions to state hospitals. The reduction in admissions has allowed a reduction in the size of all facilities and closure of several with the concomitant increase in the provision of services in the community to persons who would otherwise have been hospitalized in state hospitals. Paralleling the downsizing of state hospitals, and fostering the movement to the community, Illinois has developed a network of community mental health agencies covering all geographic areas of the State. These providers share the goal of providing the necessary basic services to maintain persons with serious mental illness in the least restrictive setting possible. The reduction in admissions and bed utilization has historically been the result of a continuing impact of a succession of initiatives:

- Screening of admissions to state hospitals has had the broadest impact in significantly reducing the rate of hospitalization. Pre-Admission Screening has been implemented across the State for many years.
- Community Based Programs for High Users: High users (3+ admissions in a year) of psychiatric hospitalization have been targeted since FY1994 through the implementation of ACT teams in the geographic areas that have the highest concentration of heavy utilization.
- Building Community Services: Several initiatives have had a substantial and sustained impact on the public mental health system of care. Community mental health providers screen consumers prior to admission to state hospitals. When consumers are discharged or triaged from a state hospital they are enrolled with a care management provider to assure linkage to needed treatment and support services. Reductions in state hospital utilization have resulted in funds becoming available for the development of community-based services designed to maintain individuals in the community and to provide inpatient services when required in community hospitals.
- Entitlements. A significant factor in avoiding re-hospitalization is assuring the availability of medical and financial support to consumers upon their discharge from the state hospital. DMH has instituted policies to ensure that state hospital staff work with individuals to determine their potential eligibility for Medicaid services and expedite the process to increase consumer access to medical benefits upon discharge from the state hospital. Community mental health agencies also work with consumers around this issue. Decreased Rate of Civil Readmissions

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

Criterion 2: Mental Health System Data Epidemiology

- ✓ Consistent implementation of a Management Information System (MIS) and a data warehouse to provide improved and expanded access to data which is vital to support decision making.
- ✓ Through external and internal resources our databases and analytic capabilities have steadily grown to an extensive array of computerized information that provides an important resource for analyzing service provision and service needs
- ✓ Maintenance and further expansion of the clinical outcomes analysis system (DATSTAT) for children/adolescents that can generate multi-level data reporting.

The “Prevalence and Access” Gap

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

Adults

Illinois has followed the CMHS definition and methodology for prevalence estimation for adults that was published in final notice form in the Federal Register Volume 64, Number 121, June 24, 1999. The methodology provides a calibrated point estimate of the 12-month number of persons who have Serious Mental Illness, age 18 and older in Illinois. This does not include persons who are homeless and institutionalized. The prevalence estimate provided by CMHS is 5.4%. Based on the adult population for Illinois, it is estimated that in FY2012 there were 526,080 adults with serious mental illnesses residing in Illinois. Information on the number of persons served in FY2012 is derived from the Uniform Reporting System (URS) Tables 2A and 2B. The number of individuals with Serious Mental Illnesses (DMH eligible population) reported as receiving services from DMH-funded agencies in FY2012 was 100,377. When viewed in conjunction with the prevalence rate estimates provided above, DMH has been purchasing services for approximately 20% of the adult population who need mental health services. Of course, some individuals in need of services, may be receiving those services from providers who do not contract with DMH for service delivery and who consequently do not report these services.

Recently, The CBHSQ Report, dated July 20, 2017 provides prevalence estimates for adults with Serious Mental Illness by State based upon the 2012-2014 NSDUH surveys. The Prevalence Estimate for Illinois is given as 3.42%. We will continue to plan based upon the 5.4% estimate until we can more fully evaluate this new information. We have been unable to locate recent prevalence information for children and adolescents with SED in Illinois.

Children and Adolescents

For an estimate of Children and Adolescents with Serious Emotional Disturbance, Illinois has used the 7% estimate provided in the CMHS notice in the Federal Register, Volume 63, Number 137, July 17, 1998 based on the midpoint of the number estimated at the lower limit of a level of functioning of 50 (LOF=50) and the number estimated at the

upper limit of that level of functioning (LOF=50 to 60). The figure has been updated by CMHS using 2011 census information to 111,117 or 7% of the population of children and adolescents aged 9 to 17 based on a 18.2% (FY2011) poverty rate. The number of youth with Serious Emotional Disturbance (eligible population) reported served in FY2012 was 35,670. When viewed in conjunction with the prevalence rate estimates provided above, DMH is purchasing services for approximately 32% of the child/adolescent population that needs mental health services. As with the adult estimates, some individuals in need of services, may be receiving those services from providers who do not contract with DMH for service delivery and who consequently do not report these services.

In the next two years Illinois proposes to build on its strengths and address gaps in services to continue the creation of an evidence-based, recovery-focused, consumer- and family-driven system of mental health for the 21st century. Consistent with these expectations, DMH has identified the critical priorities in planning for the next two fiscal years.

Criterion 3: Children's Services

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

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

Illinois has had a continuing commitment to develop and implement service models for persons with mental illnesses who are homeless, such as the innovative use of PATH funds. Illinois has continually increased services including expanded intensive outreach to homeless individuals with serious mental illnesses.

In 1988, the Federal Stewart B. McKinney Act was enacted into legislation to address the crisis of homelessness among the nation's population of individuals who are homeless and who have serious mental illness. In 1991, this Block Grant evolved into a federal formula funding award titled Projects for Assistance in Transition from Homelessness (PATH). In FY2017 Illinois was awarded \$2,704,000 and recently submitted an application for FY18 for \$2,704,272. Illinois currently has 13 agencies and 17 programs which are located in the cities of Rockford, Joliet, Chicago, East St. Louis, Peoria, Springfield, and Vienna. Based on the environmental landscape of the service providers' respective communities, a variety of strategies are utilized to identify and access individuals and families who are vulnerable and underserved, conducting outreach and engagement in the streets, and other services to aid in the fight to end homelessness. The number of persons served statewide in the past several years has steadily increased from 3,358 in FFY2013 to 4,041 in FFY2015.

PATH program services in the state are:

Outreach and engagement, including:

- Participation on two (2) Mobile Assessment Units
- Involvement in city/federal initiatives to outreach and engage chronically homeless individuals
- Street outreach on the streets, under viaducts, in parks/forest preserves, libraries, shelters, soup kitchens, food pantries, jails/prisons, hospitals, and abandoned buildings
- Operating a daily Drop-in Center
- Distributing program information at high schools for youth (18 years and older) who are experiencing homelessness

Comprehensive community mental health services, case management and crisis intervention

Screening and diagnostic assessments, individual/Family Counseling and group therapy

Access to community resources (e.g.: dental, vision, clothing, food pantries, bus/train cards)

- Connection with hospitals/clinics, transportation to appointments and benefits representatives
- Referrals/linkage to primary healthcare services and substance abuse treatment programs
- Securing personal documentation (e.g.: birth certificates, state ID's and social security cards)
- Assistance in obtaining employment, educational and vocational opportunities
- Provision of hygienic items, clothing and resources for survival in hot and inclement weather
- Completion of applications for public entitlements and benefits (SSI/SSDI, Medicaid, SNAP)

- Linkage w/landlords, moving expenses, 1x security deposits and payments to avoid eviction.

Additionally, since 2009, the Illinois PATH Program has provided outreach through the Illinois Department of Corrections, in response to the growing number of individuals returning to the community from periods of incarceration who met the criteria of eligibility. Individuals have been referred to the program and engaged in services upon release.

Rural

Residents of rural areas face barriers not encountered by urban residents: There are fewer community mental health providers in rural areas thus limiting the consumer's choice of a provider, access to inpatient psychiatric treatment is limited, and the stigma of mental illness is worse in rural areas due to it being nearly impossible to maintain privacy and anonymity. The DMH Region offices serving Greater Illinois are committed to developing and implementing service models for persons with mental illnesses who reside in rural areas. DMH participates in a range of collaborative initiatives such as the Governor's Rural Affairs Council and works with nearby universities to develop and evaluate programs designed for the needs of rural residents. Direct services that include crisis/emergency services, outpatient services, psychiatric services, care management, PSR, and residential services are provided in rural areas across the state. The State recognizes the value of advanced technology in communication to give Illinoisans living in rural communities increased access to psychiatric care. Public Act 95-16 signed by the Governor in July 2007 requires the Illinois Department of Healthcare and Family Services to reimburse psychiatrists and federally-qualified health centers (FQHCs) for mental health services provided via telepsychiatry.

Current DMH Initiatives to Address Problems and Concerns in Rural Communities:

- To augment the limited supply of psychiatrists, DMH is working with professional associations to make available the services of specialty professionals such as Psychologists with prescribing authority and Advance Practice Nurses with psychiatric specialization
- DMH is looking into ways to expand tele-psychiatry, which could be particularly beneficial to rural areas
- DMH no longer restricts the Medicaid certification of mental health providers, resulting in the number of providers growing more than 20% in the last 5 years
- DMH and DSUPR are coordinating to streamline their administration and eliminate unnecessary requirements for providers
- DMH is looking at ways to improve partnerships and coordination among community mental health providers, state operated hospitals, and private hospitals to assure better access to appropriate treatment.
- DMH is continuing to work with DSUPR and the Department of Healthcare and Family Services (HFS) on a new model for integrated behavioral health and

general health care. This new model would consist of Integrated Health Homes coordinating behavioral health and primary health care.

The DMH collaborates 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.

Criterion 5: Management Systems

10. Substance Use Disorder Treatment (SABG Only)

This section is not applicable to the MHBG. This section will be addressed in the SABG submission by the DHS Division of Alcohol and Substance Abuse (DASA).

11. Quality Improvement Plan

Quality Improvement Mission and Vision

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

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

Quality Reviews, Standards and Provider Audit Requirements

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

- Certification Reviews: Performed by the DHS Bureau of Accreditation, Licensure, and Certification (BALC). These reviews verify that the sites and services of providers are meeting standards for Medicaid certification. These reviews are performed at least every 3 years, more often if significant findings are discovered in an earlier review.
- Clinical Practice and Guidance Reviews: Provided annually as a DHS/DMH collaborative effort to guide providers in meeting best-practice standards, including recovery principles.
- Fidelity Reviews: A review by DHS/DMH providing feedback to providers on fidelity to specific service definitions, with the goal of ensuring that providers are maintaining fidelity and identifying areas that need improvement.
- Post-payment Reviews: A review of Medicaid and Non-MCO services following payment of services billed examining documentation, including medical necessity for such services. This review is provided by the Collaborative. Findings resulting in a request for recoupment are subject to an appeals process.

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

Performance Measurement

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

The DMH regularly produces reports reflecting service trends, system performance, and financial status. The use of surveys reflecting views of consumers and caregivers is an important element in improving services and service delivery. The DMH website and The Collaborative website includes links regarding conferences, presentations, training, registration/enrollment requirements and issues, financial issues, monitoring tools, and clinical issues, among them utilization management.

The Division has developed a number of state specific indicators and measures that are regularly monitored and reviewed. The National Outcome Measures have been

incorporated into this process. Many of these indicators and measures are described in the priorities, goals and indicators section of this application.

12. Trauma

Currently DMH encourages providers to seek out education and training in the treatment of post-traumatic stress disorders, to provide trauma-informed care, and to develop appropriate screening tools and referral mechanisms. Statewide implementation would require substantive funding which is not currently available.

Trauma Initiatives

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

Juvenile Justice

The DHS/DMH Juvenile Forensic Trauma Program, initiated in 2008, offers therapists who provide evidence-based, trauma-specific services to youth involved in the juvenile justice system consultation and provides the needed training and consultation to system partners to create an environment that is more trauma-sensitive and trauma-informed. Juvenile Forensic Trauma therapists are providing these evidence-based trauma services at two Illinois Youth Centers (Warrenville and Chicago) through Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), a cognitive behavioral-based treatment with demonstrated efficacy in helping adolescents recover from a variety of traumatic experiences. Juvenile Forensic Trauma therapists also provide training to the facility staff in the areas of adolescent development, trauma and adolescent brain development. This training is being provided to all staff at each of the sites.

Service Members, Veterans, and their Families

During FY2016, in coordination with collaboration partners an inventory of existing behavioral health system providers and services was developed and is being maintained. Work continued on evaluating the adequacy of the existing service network to ensure SMVF have access to needed services and facilitating a coordinated crisis service intervention system between the VA and community providers, with special emphasis on suicide prevention. Community provider capacity to serve SMVF was enhanced through Military and Veteran 101 Cultural Competency Training. Four workshops were planned, organized and convened which constitutes a labor intensive major achievement for the collaborating agencies.

DMH collaborates with the 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. *Military personnel returning from the wars in Iraq and Afghanistan are at increased risk of traumatic brain injury, post-traumatic stress disorder, depression, anxiety and other mental health symptoms as well as new-onset heavy drinking, binge drinking and other alcohol-related problems. Anxiety, depression and engagement in high risk behaviors, such as substance use, are more likely among adolescents in families with a deployed parent than among similar adolescents in non-deployed families (Chandra et al., 2009)* Given the increasing recovery needs among returning military personnel and their families, DMH and DSUPR have partnered with the Illinois National Guard and Illinois Department of Veterans Affairs in order to improve access to mental health services, alcohol and other drug treatment, and recovery support services among military personnel returning from deployment and their families.

DMH has worked to establish veteran contacts within each DMH regional office to facilitate coordination of SMVF services and continued relationships with the SAMHSA Service Members, Veterans, and their Families Technical Assistance Center. A Veterans' Care Management Referral System and a Veterans' Warm Line have been created to help ensure veteran referrals are properly accommodated.

During FY2018, efforts to build and maintain an effective system of care to meet the needs of service men and women, veterans, and their families has been ongoing. DMH participated in collaborative meetings that had agendas aimed at maintaining partnerships with the Department of Veterans Administration, the Illinois Departments of Veterans' Affairs (IDVA), and Military Affairs (IDMA), and other agencies and organizations; completing the behavioral health inventory of existing providers; monitoring the ongoing coordination of services; and facilitating a coordinated system of care. Emphasis has been placed upon coordination of a crisis intervention system with a focus on suicide prevention. There is an ever-growing network of community providers in a collaborative system of care.

DMH has conducted a survey that indicated a growing interest in the mental health provider network in veteran services and trainings to address questions regarding treatment for veterans as well as the availability of benefits. The survey was presented to the statewide network of community mental health providers that have a standing relationship with DMH. As respondents preferred actual attendance at these workshops, plans are underway for workshops in the Chicago area to be completed with face to face attendance. In southern more rural parts of Illinois, where distances are a factor there is interest in Webinars using the same curriculum, so that the training will be available across the State.

Building Veteran Support Communities (VSC) throughout the state that can ensure access to Behavioral Health Services is a continuing process. So far 19 Veterans Support Communities have been established in the state. Illinois Joining forces is the lead in

addressing this initiative. Illinois Joining Forces, IDVA, IDHS/DMH and other community partners are working to get the VSC's up and running but the process has been slower than anticipated, especially in Greater Illinois. Further information about the Illinois Joining Forces VSC initiative is provided in the summary below.

Illinois Joining Forces

DMH has actively participated in the formation and implementation of the Illinois Joining Forces Initiative and was active in the legislative process that created the Illinois Joining Forces Foundation. Public Act 098-0986, which became effective on August 18, 2014, created the Illinois Joining Forces Foundation, a not-for-profit foundation. Provisions in the law for incorporation, the appointment of a Board of Directors, and the collection of funds ensures the long-term sustainability of Illinois Joining Forces, now considered to be critically important for the support of the state's military and veteran communities.

The Illinois Joining Forces (IJF) is a joint Department of Veterans' Affairs (DVA) and Department of Military Affairs (DMA) effort to better serve veterans, service members, and their families throughout the state. IJF brings together, under a common umbrella; public, non-profit, and volunteer organizations to foster increased awareness of available resources and to better partner and collaborate with participating organizations. It has been estimated that Illinois alone has as many as 500 veteran- and military-related organizations but the lack of collaboration and coherence between them has resulted in veterans and service members being frustrated and unaware of the many resources available to them.

Illinois Joining Forces (IJF) Veteran Support Communities (VSC)

The essential structural components of a Veterans' Support Community (VSC) are:
Convening Authority- Local VSC determined leadership (or self-aligned) that is willing and has the capacity to convene regular VSC meetings or provide SMVF and IJF related information to their VSC network.

Core Partners - Willing and able partners that can as necessary a) represent IJF functional areas and b) integrate with IJF Working Group Subject Matter Experts (SME).

Peer Support - Peer Support capacity to assist SMVF in Growth and Wellness initiatives and programs.

Centralized Hub Organization - A Centralized Hub Organization where individuals and organizations can provide direct services and supports for SMVF within the VSC

Referral and Service Exchange Platform - A Referral and Service Exchange Platform where SMVF identified with IJF networks can be centrally referred for VSC decentralized services and supports.

Corporate Sponsorship - Corporate Sponsorship aligned and supportive of local VSC business development

At a minimum, VSC partners must have the capacity to service veterans in at least these six core functions:

Housing,

Employment
Financial Assistance
Education
Integrated Primary and Behavioral Healthcare
Women Veterans.

Once these core functions and services are represented, additional VSC attributes such as referral exchange platforms and the development of a peer-to-peer network can be established.

For additional information about Illinois Joining Forces see their Website at illinoisjoiningforces.org

Additionally, Illinois has approved the Certified Veterans Support Specialist (CVSS) credential. – A conversation is ongoing regarding the creation of a bridge for current CRSS credential holders who are veterans to be able to obtain the CVSS with minimal additional training and how to ensure that holders of the credential can receive compensation thru Medicaid which will require an amendment to the state spending/appropriations plan.

13. Criminal and Juvenile Justice

DMH Forensic Services oversees and coordinates the inpatient and outpatient placement 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. The average forensic census in FY14 was 663, with an average of 270 individuals in unfit to stand trial (UST) legal status and 393 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.

Individuals involved in the criminal and juvenile justice systems who qualify are currently being enrolled in Medicaid by both the Illinois Department of Corrections and the Illinois Department of Juvenile Justice. Coordination with the criminal and juvenile justice system is ongoing and includes planning around diversion issues, support for mental health services in correctional facilities, and addressing the needs of individuals re-entering their communities. Some of the services provided to this population include:

Assertive Community Treatment, MISA services (treatment for co-occurring mental illness and substance abuse disorders), and IPS (supported employment). Permanent supportive housing, and residential placement may be considered for some individuals who need access to these services. Current projects that DMH Forensics is working on include: (1) Forensic System Building regional workshops to improve the quality of collaboration; (2) Creating a state-of-art data base for mental health courts.

Jail Data Linkage Project An innovative initiative referred to as the Jail Data Linkage Project that blends technological advancements and clinical systems integration by providing a County Jail and their respective community mental health providers with information as to which detainees have a history of mental illness, both inpatient and outpatient as documented by the Division of Mental Health was initiated in 1999. This initiative was based on findings published by the Bureau of Justice Assistance and other national experts who found that 6.1% of male and 15% of female detainees in the Cook County Jail, suffered from mental illness. The cross match between DMH records and jail census data is based on an automated match between the two data sources which is performed on a regular basis. The program is currently unfunded continues to be active only in Cook County.

Mental Health Courts: A key component of this mission is enhancement and development of Problem-Solving Courts through technical assistance, consultation, training, and information dissemination. The State of Illinois has 102 counties and, as of 2017, there were 60 counties with drug courts, 23 counties with mental health courts, and 15 counties with veterans courts. Several counties have multiple courts or have multiple counties participating in one problem-solving court. In 2017, the State of Illinois had 106 problem solving courts including 63 drug courts, 26 mental health courts and 17 Veterans courts. Five counties were discussing the possibility of starting a veterans court and have received training and technical assistance from Illinois Center of Excellence for Behavioral Health and Justice on how to start a veterans court. The Center of Excellence lost its grant earlier this year.

Problem-Solving Courts are comprised of teams of specially trained judges, attorneys, probation officers, and clinical specialists who provide wrap-around services and intensive monitoring of defendants who are in the criminal justice system as a result of substance abuse, mental health, or co-occurring disorders. Mental health courts move beyond the criminal court's traditional focus on case processing to address the root causes of behaviors that bring people before the court. These courts work to improve outcomes for all parties--the individuals charged with crimes, their victims, and their communities. Mental health courts, for certain defendants with serious mental illnesses, are specialized dockets that employ a problem-solving model for traditional criminal court processing. Participants are identified through mental health screening and assessments and voluntarily participate in a judicially supervised treatment plan developed jointly by a team of court personnel and mental health professionals. Adherence to the treatment plan or other court conditions is rewarded, non-adherence may be sanctioned, and success or graduation is defined according to predetermined criteria. The goals of mental health courts are increased public safety for communities, increased treatment engagement by

participants, improved quality of life for participants, and more effective use of resources for communities. A study found that mental health courts meet the public safety objectives of lowering post-treatment arrest rates and shortening periods of incarceration. Both clinical and criminal justice factors were found to be associated with these outcomes.

Cook County has a network of seven courts are post adjudicatory probation mental health court programs which target felony non-violent offenses, many of which are felonies resulting from repetitive criminal activity. These courts facilitate compulsory medical, psychiatric and substance abuse treatment through a sentence of Mental Health Court Probation (usually 2 years) as an alternative to incarceration in the Illinois Department of Corrections. The probationer is required to comply with the recommendations by the Mental Health Treatment Court team which include participation in specified evaluations and treatment programs, compliance with medication prescriptions, reporting to probation (weekly decreasing to monthly as ordered), appearing in Court as ordered, and participating in any vocational, educational or job training program as directed. Since the inception of these courts, a total of 779 defendants have been admitted and provided with comprehensive treatment services. Of the 572 cases finally disposed by June 10, 2015, 264 (46%) defendants were successfully terminated. At that time, there were 207 active participants in Cook County's Mental Health Courts.

These courts and other diversion initiatives are the results of effective partnerships and collaborations that includes consumers, family members of consumers, treatment providers, law enforcement and correction professionals, legal personnel and members of the judiciary. Working together, they help to integrate the effective elements of the mental health, substance use systems and criminal justice systems.

Mental Health Juvenile Justice (MHJJ) is a DHS funded initiative to help identify community services for minors who have severe mental illnesses being released from juvenile detention centers. This project is overseen through the DHS/DMH Forensic Services Program. Whenever any court personnel (Judge, attorney, probation officer, detention center staff) refers a minor who is in detention, a liaison (a masters level clinician from a community agency), with parental consent, will assess that child. Should that child have a major mental illness (with psychotic or affective disorders), the liaison will work with the family to identify appropriate community services (using a wraparound model that includes mental health, medication, substance abuse, special education and public health services). Next, the liaison identifies funding sources. MHJJ is funded from the state general revenue funds. DHS provides funding to the community agencies, with most agencies receiving funding for one liaison. MHJJ began at seven pilot sites in 2000 and has expanded to all Juvenile Detention Centers in Illinois. Since FY2007, DHS has been funding liaisons in 21 community agencies servicing 34 counties. In addition MHJJ also funds juvenile justice mental health re-entry liaisons that provide linkage and case management for youths exiting Illinois Youth Centers in the Department of Juvenile Justice. Similar to the MHJJ model, the IYC liaison links youth to appropriate services in their home communities and provides ongoing monitoring for a period of six months. MHJJ is a simple model that can be expanded to these and other juvenile

justice populations and is applicable in multiple settings (urban, suburban and rural) as it makes use of existing community services at no cost to the courts.

In FY2016, the MHJJ Program is expanding its eligibility criteria to include youth who are “at risk” of encountering the criminal justice system. This expansion includes: (1) Youth who are wards of the Illinois Department of Children and Family Services (DCFS) that have become justice involved who otherwise meet eligibility criteria and need the kind of services and monitoring, particularly for the courts, that MHJJ provides. (2) Youth with mental illnesses who may have had ancillary contact with police (e.g., school resource officers, station adjustments) that were not getting services and/or any type of intervention that could divert them from becoming more involved in the criminal justice system. (3) Youth with trauma histories/symptoms that have come into contact with the justice system or are at risk for such in keeping with the growing concern over how trauma has impacted many youth (with and without mental illness) in the juvenile justice system.

“At risk” youth have a mental illness or symptoms and may have had ancillary contact with police (e.g., school resource officers, station adjustments). They are not receiving necessary services and/or any type of intervention that could divert them from becoming more involved in the criminal justice system. Many of the agencies had programs that could cross refer into MHJJ to capture those youth. The program anticipates a slight increase, perhaps 15-20% in the number of youths referred.

14. Medication Assisted Treatment

This section is not applicable to the MHBG. This section will be addressed in the SABG submission by the DHS Division of Substance Use Prevention and Recovery (DSUPR).

15. Crisis Services

Illinois is aware of the importance of crisis services for individuals with mental illnesses and their families. The array of services purchased by DMH includes crisis intervention as well as capacity grants for staffing to assure the availability of such services. As reported in other sections of this application, Illinois has been a leader in the implementation and adoption of Wellness Recovery Action Planning. There is also a tacit understanding that individuals have in place Psychiatric Advanced Directives that provide instructions with regard to actions to be taken in the event that reliance on a trusted individual to make decisions regarding psychiatric care on their behalf becomes necessary. DMH implemented peer operated warm lines through its contract with Beacon-Value Options approximately seven years ago. The individuals operating these lines speak with literally thousands of individuals in a year. Policies and procedures determine when referrals to treatment are necessary and should be made. As also reported in another section of the application, DMH staff collaborate constructively with DPH on the annual Illinois Suicide Plan.

Regarding crisis stabilization, several DMH funded providers have implemented living room models, and DMH also purchases crisis residential beds for those individuals requiring these services. DMH has also been a leader in terms of working with law

enforcement entities around CIT and working with individuals with mental illnesses. NAMI Illinois has put into place family to family programs and has supported these activities over the years.

DMH also understands the importance of working with Emergency Departments with regard to individuals with mental illnesses in crisis situations who present for treatment. DMH crisis intervention funding may be used by contracted providers to provide crisis intervention services to individuals who present at Hospital Emergency Departments. Targeted funding in two areas in which DMH hospitals were closed over the past few years was allocated to assure continued access to crisis intervention services in Emergency Departments as well as other locations, and to assure availability of crisis residential and substance use residential services as well as community based services (e.g., acute community services) to individuals presenting with a crisis. These dollars were allocated in addition to the traditional crisis care services described previously.

16. Recovery

The DMH vision is Recovery is the expected outcome! With a vision, mission, and values based upon recovery, the provision of mental health care that is consumer and family driven is an important priority of the Illinois Division of Mental Health. The current emphasis is on involving consumers and families in orienting the mental health system towards recovery, and to improve access to and accountability for mental health services. DMH continues to work within a constricted financial environment in which the resources required to fully actualize new broad initiatives that expand consumer involvement and family driven care are not readily available.

However, a variety of initiatives that are available to all individuals receiving services regardless of funding that support consumer and family participation are continuing. These initiatives are described below:

- Under direction of DMH, the Collaborative, the DMH ASO, has established a statewide “warm line” as a “cutting edge” source of peer and family support. Staffed by five Peer and Family Support specialists, the toll-free number is operational Monday through Friday, 8am to 5pm except holidays and receives 60 to 120 calls per week. These professionals are persons in recovery, or family members of persons in recovery, who are trained to effectively support recovery in other individuals’ lives. Now in its ninth year, the Warm Line continues to deliver a necessary and meaningful service for residents of Illinois and is characterized by a unique blend of caring, empowering service and effective use of reliable, user-friendly technology. The Warm Line is now averaging 499 calls per month as compared to a monthly average of 324 in FY2014. The warm line has been a successful DHS/DMH investment by assuring the accessibility of a human connection at a time when it is needed. In addition to the Warm Line, consumers and family members may contact the Consumer and Family Care Line with compliments and complaints about the mental health services they receive. Each complaint is reviewed by the staff, referred to the appropriate agency or

- authority for investigation or resolution, and followed up. Written feedback is provided to consumers and family members on the progress or resolution of their complaints and assistance is offered to obtain further review or to appeal a decision as necessary.
- A concerted effort has been made to ensure that consumers are members of the Illinois Mental Health Planning and Advisory Council (IMHPAC) and play an important role in planning for mental health services. Representation by consumers and parents of children with serious emotional disturbances has increased. Consumers and/or family members co-chair the IMHPAC, as well as all IMHPAC sub-committees.

The Wellness Recovery Action Plan (WRAP) model is well established in Illinois. Through WRAP classes in community agencies and the introduction of the principles of WRAP at consumer forums and conferences, thousands of consumers throughout the state have benefited from receiving orientation and education in the principles and components of this evidence-based practice in recovery-oriented services. A recently recognized evidence-based practice, WRAP® is a multi-week program led by certified facilitators. WRAP® teaches people living with mental illnesses how to identify and use illness self-management resources and skills that help them stay well and promote their recovery. Studies show that WRAP® improves participants' quality of life and reduces their psychiatric symptoms. Increasing access to WRAP® Facilitator Training in Illinois is an important priority. DMH Recovery Support Services (RSS) provides annual WRAP® Facilitator Training, has trained over 400 people to deliver WRAP® statewide since 2002, and is continuously working to increase the number of trained facilitators who are providing WRAP® classes. The community support services WRAP® facilitators provide are Medicaid-reimbursable, making WRAP® an affordable program for many agencies. *As of June 2018, 526 individuals had been trained and certified as WRAP Facilitators in Illinois. Of those, 214 (40.6%) were actively participating in Refresher Training.*

- DMH Recovery Support Specialists work with stakeholders to design, plan and convene annual recovery conferences in each DMH region. These conferences frequently have a well-known and /or national speaker who delivers the keynote address and who sets the "tone of recovery" for the conference.
- DMH conducts a series of statewide teleconference calls designed to disseminate important information to consumers across the State. These calls provide a forum for discussion of service information, performance data, new developments, and emerging issues to promote consumers' awareness and knowledge and provide consumers with the tools they need to cogently and effectively participate in the development and evaluation of the service system. The goal of the Consumer Education and Support Initiative is to ensure that consumers of mental health services receive current, accurate and balanced information regarding changes in the service delivery system, empowering them to take an active, participatory role

in all aspects of service delivery. Ten teleconferences have been conducted annually. The aggregate participation on the calls in FY2018 was 3,515 (duplicated) consumers.

- CRSS is the professional credential for individuals providing peer recovery support services in Illinois. It is a competency-based credential, managed by the Illinois Certification Board. In order to obtain the CRSS, individuals must complete:
 - 100 hours of training/education
 - 2,000 hours on-the-job experience
 - 100 hours of supervision
 - CRSS exam

The CRSS is required for positions with the State of Illinois in state hospitals and region administration and as part of Medicaid reimbursed team services (ACT & CST) and BIP Enhanced Services. The CRSS credential assures competence in advocacy, professional responsibility, mentoring, and recovery support. Certified Recovery Support Specialists are persons with lived experience who provide mental health or co-occurring mental illness and substance abuse peer support to others using unique insights gained through personal recovery experience and have the ability to infuse the mental health system with hope and empowerment, and improve opportunities for others to:

- Develop hope for recovery
- Increase problem-solving skills
- Develop natural networks
- Participate fully in the life of the community.

As of August 2018, 233 individuals with CRSS certification were active in the State, an increase of 25 more individuals since June 2017, and all were in good standing with the Illinois Certification Board (ICB). This reflects a 218% increase in the number of CRSS certified individuals since October 2013 when 107 were reported active in the state. Information regarding this credential can be found at http://www.iaodapca.org/forms/crss/CRSS_Model.pdf

The DMH Office of Recovery Support Services continues to work with other system partners, including the ICB and the Mental Health Collaborative for Access and Choice (MHCAC), to:

- Disseminate public information about the credential;
- Develop training curricula, and study materials for those seeking to obtain their CRSS credential;
- Plan and conduct Webinars and other training events for provider agencies to help increase agencies' understanding of the role, value, function, and advantages of hiring CRSS professionals.

The aim of DMH is to steadily increase the number of agencies that hire CRSS professionals. In FY2016 DMH RSS is partnering with a Title XX provider to finalize a CRSS Provider Workbook.

17. Community Living and the Implementation of Olmstead

Housing

Illinois has expanded housing resources for individuals with mental illnesses by implementing Permanent Supportive Housing (PSH), a specific Evidence Based model in which a consumer lives in a house, apartment or similar setting, alone or with one other consumer upon mutual agreement. The criteria for supportive housing include: income level at 30% or below Area Median Income, housing choice, functional separation of housing from service provision, the consumer's right to tenure, choice of services, service individualization, and service availability. Housing is also integrated with housing for persons who do not have mental illness and affordable (consumers pay no more than 30% of income on rent). Ownership or lease documents are maintained in the name of the consumer, so tenant landlord relationships are maintained.

Permanent Supported Housing is provided in a manner consistent with the national standards for this evidence based practice. The DMH Bridge Subsidy model provides tenant-based rental assistance designed to act as a "bridge" from the time the consumer is ready to move into his or her own housing unit until the time he or she can secure a permanent rental subsidy. Consumers who have a serious mental illness or a co-occurring mental illness and substance abuse disorder whose household income is at or below 30% of Area Median Income (AMI) as defined by HUD are eligible to apply to the program. DMH has targeted a defined population of consumers, including: those in long term care facilities or at risk of being in a nursing facility, long-term patients in state hospitals, young adults aging out of the ICG/MI program or out of DCFS guardianship, residents of DMH funded supported or supervised residential settings, and those who are determined by DMH to be homeless. The goal is to promote and stabilize consumer recovery by providing decent, safe, and affordable housing opportunities linked with voluntary DMH-funded community support services.

The number of consumers benefitting from permanent supported housing has steadily increased, due in fact to the Williams and Colbert Consent Decrees. In total, more than 3,500 consumers of mental health services have received subsidies. DMH has substantively met its target number of Class Members for transition since the inception of the Consent Decree.

Williams vs. Pritzker (previously Williams vs. Rauner) Consent Decree

The *Williams vs. Rauner* Class Action lawsuit was filed in 2005 and settled in 2010. The suit targeted 4,500 resident of nursing facilities designated as Institutes for Mental Disease (IMD) – more than 50% of the residents had a diagnosed mental illness. The suit contends that the State violated the rights of residents by not affording them opportunities to move from these settings to the community, specifically to their own

leased held apartments. The Williams Implementation Plan may be accessed at:
<http://www.dhs.state.il.us/page.aspx?item=56446>.

State agencies named in the lawsuit are the Department of Human Services Division of Mental Health, Division of Alcoholism and Substance Abuse, the Department on Aging, the Department of Public Health and the Illinois Department of Healthcare and Family Services.

The Illinois Housing Development Authority (IHDA), the Corporation for Supportive (CSH) Housing and Governor's Housing Coordinators, in partnership with DHS, have worked with developers, real estate companies and landlords to increase housing stock to address the housing needs of Class Members. In the process of transitioning interested Class Members to community housing, it is expected that the chosen community service providers will assure the provision of transition coordination services that include: assistance with the housing search, developing a comprehensive individualized service plan that includes a risk mitigation plan and a 24 hour emergency back-up plan, assuring that entitlements are transferred and in effect, assistance with purchasing furniture and supplies and, most importantly, assuring linkages are completed for requisite services, including all needed mental health services as well as medical and other necessary services and supports.

The state is now entering into the ninth year of the original five-year settlement. Since implementation, 2,324 residents of SMHRFs/IMDs have been transitioned to the community. The majority of Class Members were afforded an opportunity to move into lease-held apartments made possible by the Permanent Supportive Housing model with a bridge subsidy. Others were transitioned to other housing options as appropriate to their needs. In SFY2018, the governor's introduced budget identified \$44.7 million dollars to build the infrastructure for transitioning Williams Class Members and to support the development of permanent supportive housing units with an array of service supports necessary for successful transitions. The final spending for FY2018 was approximately \$37.6 million dollars.

The FY2019 Governor's Introduced Budget includes \$44.6 million in General Revenue funds dedicated to expanding home and community-based services and other transitional costs associated with the consent decree implementation.

Eight community mental health centers provide a full array of services and supports, including Assertive Community Treatment (ACT) and/or Community Support Teams (CST) An additional seven agencies provide transition coordination services and case management only.

The Illinois Housing Development Authority (IHDA), the Corporation for Supportive (CSH) Housing and Governor's Housing Coordinators, in partnership with DHS, have worked with developers, real estate companies and landlords to increase housing stock. In the process of transitioning interested Class Members to community housing, it is expected that the chosen community service providers will assure the provision of coordination services during transition that include: assistance with the housing search;

developing a comprehensive individualized service plan that includes a risk mitigation plan and a 24 hour emergency back-up plan; assuring that entitlements are transferred and in effect; assistance with purchasing furniture and supplies; and, most importantly, assuring that linkages are completed for requisite services, especially needed mental health services as well as medical and other necessary services and supports.

IHDA currently manages the HUD 811 project-based vouchers. There are 195 HUD 811 units available for Class Members across the Consent Decrees, as well as individuals through the Front Door Diversion Project (diverting from admission to Long Term Care).

18. C&A Behavioral Health Services-(Required)

C&A SERVICES

The DMH Bureau of Child and Adolescent Services facilitates the delivery of the array of services for youth with SED and their families through the dissemination of knowledge, research, information, evidence-based practices, and data analytics. It has especially been active in the advancement of family driven care, the promotion of evidence informed practices, and the establishment of an online data system to monitor treatment progress and individual child and adolescent outcomes. DMH collaborates closely with a range of child-serving agencies and has provided consultation and support to interagency efforts in areas of social emotional development and consultation. In the past few years the Bureau has been active in overseeing the implementation of several local SAMHSA System of Care grants.

System of Care Planning

The DMH Bureau of C&A Services was awarded a Substance Abuse Mental Health Services Administration (SAMHSA) Statewide SOC Expansion Planning Grant in FY2011 to bring agencies together to plan a statewide system of care approach. Illinois United for Youth (IUY) is the System of Care (SOC) planning initiative that resulted from the Grant. IUY formulated a comprehensive strategic plan to improve and expand the service delivery system for Illinois youth with a focus on community-based interventions that are fully rooted in the Systems of Care Philosophy. IUY is leveraging the commitment of youth, their families, the child-serving state Departments, a myriad of stakeholders, and the collective experience gained from SAMHSA-funded local Systems of Care to work towards the adoption and integration of Systems of Care Principles across the service delivery systems for youth. A set of multiple strategies was identified and submitted to SAMHSA as “Pathways: Illinois Strategic Plan for Children’s Mental Health” Pathways established a framework grounded in System of Care principles and practices while assuring the flexibility that allows funders and operating agencies to implement change in manageable increments. Successful implementation relies on applying strategic planning efforts to multiple locations within the State, each with varying degrees of need, resources, infrastructure, funding and other supports. A central feature of the IUY Pathways approach is the establishment and availability of training,

technical support, and an infrastructure designed to inform stakeholders, persons in leadership positions, and the public about the benefits of the System of Care framework.

On February 18, 2016 the Governor signed an Executive Order creating the Governor's Cabinet on Children and Youth (aka Children's Cabinet). This Cabinet was charged with the creation of a strategic vision for education and health and human services by bringing together all state entities that interact with children into a central unit. It is a goal of this Cabinet to reduce the fragmented system that currently exists, while working to effectively identify and address any barriers to agency collaboration. This Cabinet will also provide funding and policy recommendations while promoting awareness of important issues facing children, adolescents and their families.

In April 2016, the six child serving systems in Illinois signed an Intergovernmental Agreement to address the mental health needs of Children and Adolescents that are at risk for psychiatric lock-out. This action is in support of Public Act 098-0808, and consistent with the unique population of focus that Illinois identified in our Systems of Care Expansion Implementation Cooperative Agreement. Two work groups were convened to meet the requirements under this Act. The first consists of content experts from the six child serving state agencies to put together the program plan and the second is a group of lawyers also representing the six child serving systems who are ensuring that the program plan is in line with current rules, so that any necessary changes can be initiated immediately. Their first accomplishment was to develop the Specialized Family Support Program Consent that allows the family to sign one consent to share information across the Departments. This "Universal Consent" is the first of its kind in Illinois and meets not only HIPPPA, but also FERPA and the Illinois Mental Health Confidentiality requirements. To date, the program group has experienced many accomplishments including the identification of the population of focus and the "front door" for entering the program. The draft program plan is reaching its final stage and will shortly be ready for approval of the Department Directors.

The roll-out of a Universal Assessment titled IM-CANS (Illinois Medicaid Child and Adolescent Needs and Strengths Assessment) took place in September 2016. Throughout FY2016, a core team of individuals representing the Departments of Children and Family Services, Healthcare and Family Services, and Human Services, worked collaboratively with John Lyons on the development of a Universal Assessment to be implemented in Illinois and utilized with all publicly funded children and adolescents regardless of payee. The initial roll-out included training with four "early adopter sites" that agreed to work with the State Departments on resolving the initial training and implementation glitches before the statewide training plan will be implemented. Based on this learning experience, the intensive training plan has been developed in support of the statewide roll-out. This Universal Assessment is titled the IM-CANS and will replace the mental health assessment completed as part of Illinois Medicaid Rule 132. The tool includes a physical health risk assessment so that physical health and mental health can both be addressed.

The Specialized Family Support Program (SFSP) is a 90-day program of crisis stabilization, community mental health, and assessment services, developed in response to the Custody Relinquishment Prevention Act (Public Act 98-0808). It is a collaborative effort between the Illinois Departments of Healthcare and Family Services (HFS), Children and Family Services (DCFS), Human Services (DHS), Juvenile Justice (DJJ), Public Health (DPH), and the Illinois State Board of Education (ISBE), designed to identify the behavioral health needs of youth at risk of custody relinquishment and to link those youth to the most appropriate clinical services. SFSP is an expansion of the Illinois behavioral health crisis response system for youth, jointly utilizing the resources found in the [Screening, Assessment and Support Services \(SASS\)](#), [Comprehensive Community-Based Youth Services \(CCBYS\)](#), and Intensive Placement Stabilization (IPS) programs.

Throughout the extensive reform efforts that are currently occurring in Illinois including the roll-out of the Health and Human Service Transformation Initiative, Governor's Children's Cabinet, and the EPSDT settlement, all of which will impact the development of a new service array and assessment process, the Division of Mental Health (DMH) has taken a leadership role to ensure Systems of Care values and principles are the foundation for the strategic planning and implementation process. DMH C&A Services is working strategically in Illinois to ensure that Systems of Care is utilized as the foundation and infrastructure within which the multiple transformation efforts will occur and ensure that it is not seen as a separate program or project.

Consistent with this extensive planning, the System of Care initiative aims to strengthen family-driven and youth-guided services, and strengthen the youth and family voice at all levels of policy and program development. This will be accomplished through: (a) supporting the capacity of youth to expand their platform and share their perspectives on mental health and the services they receive; (b) supporting the capacity of the Illinois Family Organization to expand their opportunities for engaging and supporting families of youth involved in the mental health system, and, (c) ensuring and encouraging participation of youth and families and their representative agencies in the IUY Stakeholders group and the IUY Facilitation Team.

N.B. vs. Norwood:

<https://www.illinois.gov/hfs/info/legal/Pages/N.B.vNorwood.aspx>

The N.B. v Norwood lawsuit was filed in 2011 on behalf of Medicaid-eligible children under the age of 21 in the State of Illinois seeking certain mental and behavioral health services under the Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") requirement of the Medicaid Act. It has also been alleged that the state has failed to meaningfully provide intensive community-based residential or outpatient care for children with mental illness and emotional or behavioral disorders. The class for this lawsuit is defined as: All Medicaid-eligible children under the age of 21 in the State of Illinois: (1) who have been diagnosed with a mental health or behavioral disorder; and (2) for whom a licensed practitioner of the healing arts has recommended intensive home- and community-based services to correct or ameliorate their disorder.

As of this writing, Court approval of the proposed Settlement Agreement is still pending. For more information on the Settlement Agreement, the fair hearing trial and the rights of Class Members, please see the documents listed on this website.

<https://www.illinois.gov/hfs/MedicalProviders/behavioral/sass/Pages/sfsp.aspx>

20. *Suicide Prevention*

The SAMHSA 2018 Behavioral Health Barometer for Illinois, reports that approximately 378,000 adults (3.9% of all adults in Illinois) per year in 2014-2015 had serious thoughts of suicide within the year to being surveyed. The percentage did not change significantly from 2011-2012. More than 1,000 persons die by suicide each year in the state and suicide fluctuates yearly between being the second or third leading cause of death for adolescents. Interest, organized efforts, and advocacy for suicide prevention in Illinois resulted in legislative action. In 2004, the Suicide Prevention, Education and Treatment Act (PA093-0907) was passed by the General Assembly and signed by the Governor directing the Illinois Department of Public Health (IDPH) to appoint the Illinois Suicide Prevention Strategic Planning Committee composed of representation of statewide organizations and local agencies that focus on the prevention of suicide and support services to survivors. To unify planning and suicide prevention efforts, an alliance was formed between a coalition of stakeholders and the strategic planning committee that was recognized in law by the General Assembly in 2008. The mission of the Illinois Suicide Prevention Alliance (the Alliance) as stated in the law is “to reduce suicide and its stigma throughout Illinois by collaboratively working with concerned stakeholders from the public and private sectors to increase awareness and education, provide opportunities to develop individual and organizational capacity in addressing suicide prevention, and advocate for access to treatment.”

Recently, the thrust of Illinois suicide prevention has been to develop training opportunities, increase public and professional awareness of state and local suicide prevention resources in Illinois, and increase opportunities for linkages. Activities have included a Webinar series on available Illinois resources such as LOSS (Loving Outreach to Survivors of Suicide); a statewide suicide prevention conference, a “Zero Suicide” workshop with Mike Hogan that resulted in a number of CMHCs and other providers signing on to implement this comprehensive approach; an event for addiction / substance abuse professionals co-sponsored with IODAPCA, and plans for working on training for Juvenile Justice professionals.

Illinois has submitted two grant applications in the past six months. (1) A Suicide Prevention Grant submitted on April 14, 2017, proposed a pilot project designed to bring five counties in Southern Illinois to Zero Suicide status. The focus of the application was on providing extensive clinical training to staff at two state hospitals and to a Community Mental Health Center covering the five counties from 3 sites. (2) A Zero Suicide Grant submitted on July 14, 2017 that focused on statewide training and education to achieve a Zero Suicide approach in state hospitals and community mental health services. As of this writing, there has been no response to either application.

In the past few years, providing continuity of care for mental health consumers in state inpatient facilities transitioning to the community has been a priority. In state hospitals, formal suicidal risk evaluations have been employed both upon admission and discharge. There has been an assertive effort to register and qualify consumers for Medicaid prior to their discharge so that they can access needed crisis services without having to be rehospitalized.

In reference to military personnel and their families, it is notable that representatives from the Veteran's Administration programs in Illinois have been active stakeholders and have attended Alliance meetings for the past several years. Recently, Illinois Joining Forces (IJF) has formally joined the Illinois Suicide Prevention Alliance (ISPA) and have become a standing committee of the Alliance in order to potentiate both ISPA and IJF resources.

The Alliance and IDPH are required to provide an annual report to the General Assembly. In FY2016 the Alliance updated the Suicide Prevention Plan which still remains in draft form and under review by IDPH and the Alliance.

Technical Assistance needs include consultation and training in Zero Suicide and the intensive 2-day training for clinicians in the State by the QPRT Institute on the QPRT (Question-Persuade-Refer-Treat) approach.

21. Support of State Partners (Required)

The State has experienced a new level of collaboration across State agencies with the development of the Health and Human Services Transformation led by the Governor's Office. Agencies involved are Department of Healthcare and Family Services, Department of Children and Family Services, Department of Human Services (the umbrella under which both the SMHA and the SSA operate), Department of Juvenile Justice, Department of Corrections, Department on Aging, Department of Public Health, Department of Veteran's Affairs, Illinois Housing Development Authority, Department of Innovation and Technology, Illinois State Board of Education and the Illinois Criminal Justice Information Authority.

Through the HHS transformation, the state agencies listed above, under the direction of the Governor's Office, have experienced an historic level of collaboration. Workgroups consisting of Executive level leadership from each agency have been established to identify gaps and design solutions across each area. This includes: Integrated Health Homes, Managed Care Contracting, Supportive Housing, Workforce Development, Supported Employment Services, Justice Involved, Residential IMD (for Substance Use and Mental Illness), Substance Use Disorder Case Management, Withdrawal Management, SUD Recovery Coaching, Crisis Services, Intensive In-Home Services for youth and families, Respite Care, Home Visiting, and a team to develop the standardized tools based on the CANS and ANSA.

In the second phase of this work, these teams also engaged an expansive and diverse set of stakeholders including providers, individuals served, trade organizations, and presented information in public meeting formats that allowed for significant input for the community at large, affording the opportunity for innovation and involvement of community partners in system design and implementation.

The Division maintains working partnerships with many state agencies that support mental health services and offer specialized interventions. **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 Substance Use Prevention and Recovery (DSUPR)** 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. DMH is working toward an adaptation of the trauma informed credential that has been developed by DCFS

Interagency Partnering and Collaboration

DMH works regularly with the following state 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. Illinois Public Act 096-1501 (Medicaid Reform) required that a minimum of 50 percent of Medicaid clients be enrolled in coordinated care by 2015. IDHFS has implemented a Care Coordination Project known as Innovations which was the vehicle by which this goal was 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.
- IDHS Division of Substance Use Prevention and Recovery (DSUPR) to address services for individuals with co-occurring mental and substance use disorders.
- 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 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.
- 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.
- Illinois Department of Corrections (IDOC) and IDJJ to address the needs of adults and juveniles involved with the justice system. It has been estimated by IDOC healthcare staff that 16% of 48,000 in the total DOC population have a mental health disorder. Fourteen percent of the detainees in reporting Illinois county jails have mental illnesses. IDJJ has reported that 17 percent of the youth under their purview were identified as having moderate mental health needs and 50 percent were identified as having mild mental health needs. All of them, representing 67 percent of the population, received some form of 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 have included 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 to facilitate the integration of community mental health providers in schools to address prevention and early intervention and provide for the social, emotional, and behavior supports for students, teachers and families.

22. The Illinois Behavioral Health Planning and Advisory Council and Input on the Mental Health Block Grant Application (Required)

Description of Role and Activities

The Illinois Mental Health Planning and Advisory Council (IMHPAC) advises the DMH on mental health issues. The Advisory Council currently is a body of 52 members, which includes consumers and representatives from public and private organizations that plan, operate, and advocate for mental health and support services for persons with serious mental illness. Established in 1992, the Advisory Council's participation in the analysis of Illinois' mental health system has yielded a significant public/private partnership that focused on restructuring public mental health services in Illinois and guided the development of a strategic plan for consumer-responsive, community-based, and cost-effective service delivery. The Council approved a set of By Laws at the end of FY2002 and has revised them periodically as needed.

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

The Advisory Council currently has several sub-committees including an Executive Committee, a Council Development Committee, and Substantive Committees. The Substantive Committees include: Adult Inpatient, Child and Adolescent Services, Justice and Adult Community Services. Other committees may be appointed as needed. The Council as a whole meets six times a year to review new developments, monitor the progress of initiatives, and discuss problematic issues in the mental health service system.

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

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

In April 2016, concern was raised that the Council was not compliant with requirements of the Illinois Open Meetings Act. Clarification as to whether the Council is subject to these legal requirements was requested from the Attorney General of Illinois. To avoid penalties prescribed in the Act, the Council temporarily suspended its business with the expectation that a response would be forthcoming. In June 2017, the Attorney General advised the Council to proceed under the guidelines of the Open Meetings Act and assured that there will be no repercussions. Although the Attorney General has not yet issued a precise legal opinion regarding the applicability of the Open Meetings Act to the functions and responsibilities of the Illinois Mental Health Planning and Advisory Council, the Council has been meeting regularly since June 2017 and is following the guidelines of the Illinois Open Meetings Act.

23. Public Comment on the State Plan (Required) Illinois Mental Health Block Grant Application:

The development of the state mental health block grant plan is made available for public comment in multiple ways. (1) The Illinois Mental Health Planning and Advisory Council (MHPAC) includes consumers of mental health services and family members who also participate in a range of advocacy groups such as the Mental Health Summit, the Mental Health Association, and NAMI-Illinois (National Alliance for the Mentally Ill-Illinois). Council members regularly consult with their respective advocacy groups during the development of the state plan. (2) All Council meetings are open to the public. Council meeting dates are set up a year in advance to facilitate participation. Persons with an interest in the state plan may attend meetings at which the plan is discussed and provide feedback and comments. Unfortunately, this year the Illinois Mental Health Planning Advisory Council (MHPAC) suspended its business temporarily due to concerns about violations of the Illinois Public Meetings Act (See Section C-22 above for

information). It reconvened in early July and moved immediately into reviewing the FY2018-FY2019 Block Grant Plan. (3) The final state block grant application and proposed plan will be posted on the web site for the Division of Mental Health (www.dhs.state.il.us). The public can access this DHS DMH Internet site. Interested parties have been instructed to contact Lee Ann Reinert, DMH Deputy Director of Policy, Planning, and Innovation to provide comment. Contact information will be provided on the website. Comments from the public submitted after the final draft of the plan is posted will be reviewed by the IMHPAC Executive committee and discussed with Council membership in upcoming meetings. As always, DMH will be receptive to constructive comments and will move, with notification to SAMHSA, to modify the plan as needed.

DRAFT