

Illinois

UNIFORM APPLICATION

FY 2020/2021 Community Mental Health Services Block Grant Plan

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 08/30/2019 5.13.32 PM)

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

State Information

State Information

Plan Year

Start Year 2020

End Year 2021

State DUNS Number

Number 067919071

Expiration Date 3/18/2020

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

Agency Name Illinois Department of Human Services

Organizational Unit Division of Mental Health

Mailing Address 600 East Ash St Bldg 500, Floor 3

City Springfield

Zip Code 62703

II. Contact Person for the Grantee of the Block Grant

First Name Diana

Last Name Knaebe

Agency Name Illinois Dept. of Human Services/Division of Mental Health

Mailing Address 600 East Ash Street Bldg 500, Floor 3

City Springfield

Zip Code 62703

Telephone (217)782-5700

Fax (217)785-3066

Email Address Diana.Knaebe@Illinois.Gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? Yes No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

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

From

To

V. Date Submitted

Submission Date 8/30/2019 5:12:46 PM

Revision Date

VI. Contact Person Responsible for Application Submission

First Name Lee Ann

Last Name Reinert

Telephone 217-782-0059

Fax

Email Address lee.reinert@illinois.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2020

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Community Mental Health Services Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
 - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
 - b. Collecting a certification statement similar to paragraph (a)
 - c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee¹: _____

Title: _____

Date Signed: _____

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

I. State Information

Chief Executive Officer's Funding Agreements, Assurances Non-
Construction Programs and Certifications (Form 3)
Fiscal Year 2020/21

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements as required by Substance Abuse Prevention and Treatment
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Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act

Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Section 1935	Core Data Set	42 USC § 300x-35

Title XIX, Part B, Subpart III of the Public Health Service Act

Section	Title	Chapter
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
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State: Illinois

Name of Chief Executive Officer (CEO) or Designee: Diana Knaebe

Signature of CEO or Designee¹: Diana Knaebe

Title: Director, IDHS/DMH Date Signed: 08/29/19
mm/dd/yyyy

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15. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
16. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
17. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

18. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
19. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

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



OFFICE OF THE GOVERNOR

207 STATE HOUSE
SPRINGFIELD, ILLINOIS 62706

JB PRITZKER
GOVERNOR

August 22, 2019

Monique S. Browning
Lead Public Health Advisor/Project Officer
Department of Health and Human Services (HHS)
Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Mental Health Services (CMHS)
Division of State and Community Systems Development (DSCSD)
5600 Fishers Lane 14E 65C
Rockville, MD 20852

Dear Ms. Browning:

As the Governor of the State of Illinois, for the duration of my tenure, I delegate authority to the current Director of the Illinois Department of Human Services/Division of Mental Health, or anyone officially acting in this role in the instance of a vacancy, for all transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant (MHBG).

Sincerely,

A handwritten signature in black ink, appearing to read "JB Pritzker".

JB Pritzker
Governor

State Information

Disclosure of Lobbying Activities

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

[Standard Form LLL \(click here\)](#)

Name

Title

Organization

Signature:

Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

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.

- **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.)

Planning Steps

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

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

A data-driven process must support the state's priorities and goals. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data sets including, but not limited to, the [National Survey on Drug Use and Health](#) (NSDUH), the [Treatment Episode Data Set](#) (TEDS), the [National Facilities Surveys on Drug Abuse and Mental Health Services](#), and the [Uniform Reporting System](#) (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

In addition to in-state data, SAMHSA has identified several [other data sets](#) that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)¹⁶ HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

¹⁶ <http://www.healthypeople.gov/2020/default.aspx>

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

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 IL Mental Health Planning and Advisory Council Members:

The following recommendations were developed, and in some cases, excerpted from member’s 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.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1
Priority Area: Continue to develop and improve the array of clinical and support services available for adults and children
Priority Type: MHS
Population(s): SMI, SED

Goal of the priority area:

Address the statewide availability and comprehensiveness of community-based mental health services available for adults and youth in the public mental health service system.

Objective:

Identify gaps in the delivery of community-based services based on the service array provided and geographic location.

Strategies to attain the objective:

- Through ongoing certification processes that include periodic review, monitoring, and certifications of Certified Community Specialty Providers and Certified Community Mental Health Centers, identify and evaluate service shortfalls.
- Design and implement a database to process the components and data of the evaluation.
- Analyze the resulting data to: (a) identify areas where access needs to be improved; (b) inform the publicly funded community service system; and (c) facilitate decision making and planning.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	The State will utilize data to inform the development of and ongoing support for the publicly funded mental health system.
Baseline Measurement:	Baseline: FY19 No system in place to do comprehensive analysis
First-year target/outcome measurement:	FY2020 the State will develop a comprehensive data collection platform.
Second-year target/outcome measurement:	FY2021 the State will utilize the comprehensive data platform to identify potential gaps in the service areas
Data Source:	Information provided by entities seeking certification.
Description of Data:	Geographic area by zip code; Service types provided; Ages served.
Data issues/caveats that affect outcome measures::	We must first develop the system to collect the data, which will be dependent on work with agencies outside the Division.

Priority #: 2
Priority Area: Continue work on accomplishing the integration of behavioral health and primary health treatment to expand and improve the array of health and support services available for adults and children within community settings.
Priority Type:
Population(s): SMI, SED, ESMI

Goal of the priority area:

Assure the integration of physical health care with behavioral health services to adults having a serious mental illness and children with serious emotional disturbance to promote wellness, encourage prevention and support early intervention to address the current disparities in health outcomes experienced by individuals with SMI and SED.

Objective:

Pilot the implementation of selected evidence-based, best practices aimed at achieving results that yield positive and lasting outcomes through the integration of primary health care with behavioral health treatment that also addresses wellness and prevention activities such as smoking cessation, nutrition/exercise, and other wellness interventions along with a range of traditional mental health services.

Strategies to attain the objective:

- Develop a partnership/full collaboration between three established community mental health centers and their respective Federally Qualified Health Centers to 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
- Support the improvement of integrated care treatment 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);
- 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.
- Use lessons learned throughout the five-year implementation project to support statewide planning and implementation of integrated health homes.
- By the end of five years (FY2024) identify experienced experts to provide support to all other Illinois providers who are interested in exploring and implementing PIPBHC-IL.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number of clients receiving integrated treatment and support during the fiscal year.
Baseline Measurement: 70 clients in initial nine month period
First-year target/outcome measurement: 220 clients
Second-year target/outcome measurement: 295 clients (Aggregate total served to end of FY2021= 515)

Data Source:

Provider Quarterly Reports

Description of Data:

Providers' reports of number served.

Data issues/caveats that affect outcome measures::

None

Indicator #: 2
Indicator: Number of staff persons trained and participating in the program each fiscal year.
Baseline Measurement: N/A
First-year target/outcome measurement: 40 staff
Second-year target/outcome measurement: TBD based on FY2020 data

Data Source:

Quarterly report from each provider citing number of staff trained and carrying out PIPBHC-IL programming.

Description of Data:

Data issues/caveats that affect outcome measures::

None

Indicator #: 3

Indicator: Number of collaborative meetings convened by DMH to review and discuss progress and issues in service integration and delivery, program evaluation, and client impact.

Baseline Measurement: 3

First-year target/outcome measurement: 5 on-site meetings

Second-year target/outcome measurement: 10 including fidelity reviews

Data Source:

Records and minutes maintained by DMH Principal Investigators

Description of Data:

See Above

Data issues/caveats that affect outcome measures::

None

Indicator #: 4

Indicator: An annual written report will identify the most successful practices, achievements, and lessons learned during each year.

Baseline Measurement: Not Applicable

First-year target/outcome measurement: FY2020 Annual Report completed, reviewed, submitted to SAMHSA, and filed.

Second-year target/outcome measurement: FY2021 Annual Report completed, reviewed, submitted to SAMHSA, and filed.

Data Source:

Providers' Quarterly Written reports submitted by the three partnering agencies and compiled into an Annual Report by DMH

Description of Data:

See Above

Data issues/caveats that affect outcome measures::

None

Priority #: 3

Priority Area: Integrated Care- Work collaboratively with IL Dept. of HealthCare and Family Services (DHFS), the State Medicaid Agency, to develop policies, procedures and models for Integrated Health Homes to be sustained with Medicaid Funding.

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Develop models of care coordination utilizing the strengths of community mental health service agencies to ensure that persons with serious mental illness and their families can receive fully integrated and seamless services in their community.

Objective:

Establish criteria for an Illinois Integrated Health Home model through collaborative work with DHFS.

Strategies to attain the objective:

Provide consultation and technical assistance to DHFS in the planning and the implementation of the Illinois Integrated Health Homes model.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of consultations provided to DHFS by DMH administrative staff.

Baseline Measurement: One meeting

First-year target/outcome measurement: 12 Meetings

Second-year target/outcome measurement: TBD based on FY2020 progress and outcome

Data Source:

Agendas , Minutes and Notes collected and maintained by DMH administrative staff.

Description of Data:

See Above.

Data issues/caveats that affect outcome measures::

Priority #: 4

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

Priority Type: MHS

Population(s): SMI, SED, ESMI, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Military Families, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Sustain and expand the infrastructure for evidence-based clinical programs for persons with ESMI.

Objective:

Sustain 15 Coordinated Specialty Care teams currently in the State.

Strategies to attain the objective:

Provide education, training, and ongoing consultation to staff involved in FEP programs that includes:

- 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
- Case Management/Recovery Support Specialists
- 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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: (a) Number of sites in the State with funded ESMI Programs. (b) The total FEP Set-Aside expenditures by the State for each site.

Baseline Measurement: 15 funded sites at the end of SFY2018.

First-year target/outcome measurement: 15 Funded sites

Second-year target/outcome measurement: 15 Funded sites

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 FIRST.IL sites on an ongoing basis by statewide coordinators of the program using the Enrollee Outcomes Form. Outcomes in terms of number of referrals and number of clients enrolled at each participating site are counted.

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.

Data issues/caveats that affect outcome measures::

The full potential of the First.IL Program may be affected by federal restrictions on eligible diagnosis.

Indicator #: 2
Indicator: Number of training events held each year to increase clinical competence and expertise in the delivery of ESMI services in FIRST.IL sites.
Baseline Measurement: 12 key training events
First-year target/outcome measurement: 13
Second-year target/outcome measurement: 13

Data Source:

Records of teleconference calls and attendance are maintained by statewide coordinators.

Description of Data:

See Above

Data issues/caveats that affect outcome measures::

Indicator #: 3
Indicator: Number of clients meeting criteria for FIRST.IL enrolled in team services statewide.
Baseline Measurement: 251
First-year target/outcome measurement: 300
Second-year target/outcome measurement: 350

Data Source:

Enrollment data from each participating site aggregated by statewide coordinator retrieved from Enrollee Outcome Form at Baseline and every 6 months.

Description of Data:

Number of persons meeting eligibility criteria for FEP program enrolled at each site.

Data issues/caveats that affect outcome measures::

The full potential of the FIRST.IL Program may be affected by the federal restrictions on eligible diagnosis.

Priority #: 5
Priority Area: Promote Provision of Evidence Based and Evidence-Informed Practices -Individual Placement Services/Supported Employment
Priority Type:
Population(s): SMI, SED

Goal of the priority area:

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.

Objective:

During FY2020 and FY2021, maintain and support the statewide implementation of Evidence Based Supportive Employment.

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 350 consumers acquiring competitive employment in their local communities.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of consumers receiving supported employment in FY2020 and FY2021. (National Outcome Measure)
Baseline Measurement:	3,413 individuals were served in SFY2018.
First-year target/outcome measurement:	3,354
Second-year target/outcome measurement:	3,514

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.

Description of Data:

As always, DMH has developed specifications for reporting that DMH funded providers must use when submitting data.

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.

Priority #: 6

Priority Area: Promote Provision of Evidence Based and Evidence-Informed Practices-Assertive Community Treatment (ACT)

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

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.

Objective:

Continue to reach expected outcomes for individuals in need through provision of Assertive Community Treatment (ACT).

Strategies to attain the objective:

Reach full capacity by reducing the 25% current vacancy rate by serving individuals transitioning to the community from long-term care under Williams/Colbert consent decree

Annual Performance Indicators to measure goal success

Indicator #:	1
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Indicator: Number of persons with SMI receiving Assertive Community Treatment in FY2020 and FY2021 (National Outcome Measure).

Baseline Measurement: 1,532

First-year target/outcome measurement: 1,764

Second-year target/outcome measurement: 1,996

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.

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.

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.

Priority #: 7

Priority Area: Expansion of the scope of consumer and family participation through advancement of the recovery vision and family driven care.

Priority Type: MHS

Population(s): SMI, SED, ESMI, Other (Adolescents w/SA and/or MH, Students in College, Rural, Military Families, Criminal/Juvenile Justice, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders)

Goal of the priority area:

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.

Objective:

- #1 Continue work to increase the number of Certified Recovery Support Specialists and to facilitate their deployment statewide.
- #2 Increase the use and efficacy of the WRAP model.
- #3 Continue to inform and empower consumers and families.

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.
- Strategy #2: Enhance competency and encourage WRAP trained and certified facilitators to provide an increasing number of WRAP® classes in the State.
- Strategy #3: Conduct a series of statewide teleconferences designed to disseminate important information to adult consumers and families across the State.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: Nine training events in FY2018; Nine targeted in FY2019. 12 actually completed

First-year target/outcome measurement: 12

Second-year target/outcome measurement: 12

Data Source:

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

Description of Data:

Training agenda and attendance sheets documenting participation for each training event held.

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: (a) Number of WRAP Refresher trainings offered statewide each year. (b) Number of WRAP participants each year

Baseline Measurement: 20

First-year target/outcome measurement: 20

Second-year target/outcome measurement: 20

Data Source:

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

Description of Data:

Training agenda and attendance sheets documenting participation for each training event held.

Data issues/caveats that affect outcome measures::

Indicator #: 3

Indicator: Number of statewide teleconferences held each year. Number of participants per teleconference.

Baseline Measurement: Ten (10) statewide teleconferences in SFY2018 and 10 targeted for FY2019.

First-year target/outcome measurement: 10

Second-year target/outcome measurement: 10

Data Source:

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

Description of Data:

Teleconference agendas

Data issues/caveats that affect outcome measures::

None

Priority #: 8

Priority Area: Use of Data for Planning-Consumer Satisfaction Survey

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Use Quantitative and qualitative data to assess access to care and perception of treatment outcomes to provide data for decision support.

Objective:

Continue to improve and maintain quality data collection and reporting.

Strategies to attain the objective:

(a) Conduct an annual consumer satisfaction survey that includes national outcome measures (NOMs) and report results. (b) Assess access to care through the Consumer Satisfaction Survey. (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).

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percent of Adult Consumers and Parents/Caregivers surveyed who report positively about the services they received in response to the MHSIP Adult Consumer and MHSIP Youth Services Survey for Families perception of care surveys.

Baseline Measurement: FY2018 Surveys: Adult Survey 83% reported positively about their satisfaction with services and on the Youth survey-68% of parents -caregivers reported positively on their overall satisfaction with services.es and on the Youth survey-68% of parents -caregivers reported positively on their overall satisfaction with services.

First-year target/outcome measurement: Adults = 85% Youth = 70%

Second-year target/outcome measurement: Adults =85% Youth= 75%

Data Source:

Survey responses to Satisfaction questions on the Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Survey and the MHSIP Youth Services Survey for Families.

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 9

Priority Area: Maintain effective systems to serve the forensic needs of justice-involved consumers of services.

Priority Type: MHS

Population(s): SMI, SED, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Maintain a system of care to address the mental health needs of consumers with criminal justice involvement.

Objective:

Provide an alternative to incarceration for youth with SED and link them to community-based services that addresses their unique needs and strengths.

Strategies to attain the objective:

Maintain the Mental Health Juvenile Justice Initiative

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of youth served by the MHJJ Program statewide.

Baseline Measurement: In FY2019 789 youth were referred to the program and 618 were linked to agencies for ongoing service

First-year target/outcome measurement: 500

Second-year target/outcome measurement: 500

Data Source:

MHJJ Program Data Base maintained internally by DMH oversight staff.

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.

Data issues/caveats that affect outcome measures::

None

Priority #: 10

Priority Area: Advancement of Community Integration

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Complete the successful transition of residents of long-term nursing homes with diagnosed SMI from this level of care to the less restrictive settings, ideally, independent living in the communities with appropriate and necessary support services.

Objective:

Transition up to 400 additional Williams Class Members annually before the sunset of the Consent Decree.

Strategies to attain the objective:

Through FY2020, and perhaps beyond, through the provision of open market units rent subsidies, implement the transition of residents (Williams and Colbert Class Members) from 23 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.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of consumers who transition from long term institutional settings who access appropriate permanent supportive housing or other housing options. (National Outcome Measure)

Baseline Measurement: 315 Class Members were transitioned by the end of SFY2018. 400 Class members were projected by the end of FY2019.

First-year target/outcome measurement: 400

Second-year target/outcome measurement: To Be Determined- (The Williams vs. Pritzker 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.)

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.

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.

Data issues/caveats that affect outcome measures::

Continuation after the FY2020 fiscal year will be dependent on negotiations between parties and the court decision.

Priority #: 11
Priority Area: Coordination and facilitation of mental health services for Illinois Servicemembers, Veterans, and their Families (SMVF).
Priority Type: MHS
Population(s): Other (Military Families)

Goal of the priority area:

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

Objective:

1. Sustain a coordinated system of care
2. Improve quality of community mental health services to service members, veterans, and their families.

Strategies to attain the objective:

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. Develop an inventory of existing behavioral health system providers and services to provide a referral system.. Provide DMH expertise in the promotion and provision of education and training for community mental health providers in military and veteran clinical and cultural competence.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: The number of collaborative meetings attended by DMH staff representatives that have agendas aimed at identifying and accomplishing strategies for coordination of services.
Baseline Measurement: 12 collaborative meetings in FY2019.
First-year target/outcome measurement: 12
Second-year target/outcome measurement: 12

Data Source:

Meeting Minutes and records of DMH staff members assigned to this collaborative task.

Description of Data:

See Above

Data issues/caveats that affect outcome measures::

None

Indicator #: 2
Indicator: The provision of Military and Veteran 101 Clinical Cultural Competency Workshops. the number completed during the fiscal year, and the number of participants each year.
Baseline Measurement: Not Applicable-New Objective in FY2020
First-year target/outcome measurement: Four (4) Workshops
Second-year target/outcome measurement: Four (4) Workshops

Data Source:

Calendar dates of these events and attendance records of each.

Description of Data:

See Above

Data issues/caveats that affect outcome measures::

None

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
a. Substance Abuse Primary Prevention							
b. Mental Health Primary Prevention [†]		\$0	\$0	\$0	\$0	\$0	\$0
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG) ^{**}		\$4,892,464	\$0	\$0	\$0	\$0	\$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			\$0	\$0	\$508,812,000	\$0	\$0
7. Other 24 Hour Care		\$42,110,216	\$0	\$0	\$69,611,548	\$0	\$0
8. Ambulatory/Community Non-24 Hour Care		\$0	\$477,011,430	\$12,810,078	\$189,995,088	\$0	\$0
9. Administration (Excluding Program and Provider Level) ^{***}		\$1,921,956	\$0	\$0	\$9,405,644	\$0	\$0
10. Total	\$0	\$48,924,636	\$477,011,430	\$12,810,078	\$777,824,280	\$0	\$0

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

*** Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.

Footnotes:

Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

MHBG Planning Period Start Date: 07/01/2019 MHBG Planning Period End Date: 06/30/2021

Activity	FFY 2020 Block Grant
1. Information Systems	
2. Infrastructure Support	
3. Partnerships, community outreach, and needs assessment	
4. Planning Council Activities (MHBG required, SABG optional)	\$8,900
5. Quality Assurance and Improvement	
6. Research and Evaluation	
7. Training and Education	
8. Total	\$8,900

0930-0168 Approved: 06/07/2017 Expires: 06/30/2020

Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²² Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.²³ It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.²⁴

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.²⁵ SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.²⁶ For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.²⁷

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.²⁸

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.²⁹ The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.³⁰ Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes³¹ and ACOs³² may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.³³ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.³⁴

One key population of concern is persons who are dually eligible for Medicare and Medicaid.³⁵ Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.³⁶ SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.³⁷ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.³⁸ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration. SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.³⁹ Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs. SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.⁴⁰

SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.⁴¹ However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

²² BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013; 91:102-123 <http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 52-77

²³ Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts, <https://www.samhsa.gov/wellness-initiative>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <https://www.samhsa.gov/health-care-health-systems-integration>; Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

²⁴ Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses> Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014; 71 (3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <http://www.samhsa.gov/co-occurring/>

²⁵ Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <https://www.cdc.gov/nchstp/socialdeterminants/index.html>

²⁶ <http://www.samhsa.gov/health-disparities/strategic-initiatives>

²⁷ <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

²⁸ Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, <https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf>; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. <http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

²⁹ Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

³⁰ Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, <https://www.integration.samhsa.gov/operations-administration/telebehavioral-health>; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/home>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>;

³¹ Health Homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

³² New financing models, <https://www.integration.samhsa.gov/financing>

³³ Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf>

³⁴ What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

³⁵ Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>

³⁶ Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>

³⁷ BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

³⁸ TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

³⁹ Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORk/PEP13-RTC-BHWORk.pdf>; Creating jobs by addressing primary care workforce needs, <https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n>

⁴⁰ About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>; National Behavioral Health Quality Framework, Draft, August 2013, <http://samhsa.gov/data/NBHQF>

⁴¹ Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA/>

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

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.

HealthChoice Illinois: Integration of Behavioral Health and Primary Health Care

In the past four years Medicaid Managed Care has been increasingly implemented in Illinois. In February 2017, when the Governor announced a reboot of the Illinois managed care system which had been initiated 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 and also intended to shift managed care in Illinois to a more value-based system with less managed care companies participating. At that time, Medicaid managed care expenditures were expected to total an estimated \$10.8 billion in state and federal dollars. Subsequent to discussions with the Illinois Medicaid Authority (IL Department of Healthcare and Family Services – HFS) the Division of Mental Health expects that the contracts for the new Illinois managed care companies will permit more data mining, as currently it can be difficult to extract from managed care companies various statistical measures that would be very useful for behavioral health policymaking in Illinois.

The Illinois Department of HealthCare and Family Services is responsible for and oversees Medicaid Managed Care through the HealthChoice Illinois program which has consisted of seven major Managed Care Organizations (MCOs) serving the State. HealthChoice Illinois offers a complete range of health services within the standards and criteria of Illinois' Medicaid program. These health plans are available in every county in the state. As of May 2019, 2,098,310 persons were enrolled in HealthChoice Illinois and 53,073 in the Medicare-Medicaid Alignment Initiative that funds care to persons with both Medicaid and Medicare benefits -seniors and those with disabilities - in fourteen counties. All of the MCOs are required to fund Behavioral Health Services through community-based provider panels who are certified. Care Coordination between MCOs and Behavioral Health providers has been of paramount importance for the past 5years. Meetings were held between the Health Plan organizations and community providers in September and October 2014 which ironed out the requirements and procedures for coverage of Medicaid clients. The MCOs performance is evaluated annually in the Illinois Plan Report Card. The HealthChoice Illinois Plan covers a range of services in Women's Health, Chronic Illnesses eg: Kidney Disease, Diabetes, Behavioral Health, Keeping Kids Healthy, Medical Services by Primary Care Physicians and a full range of Medical Specialties. In Behavioral Health, specific performance measurements are reported for:

Follow-Up Care after a Hospital Visit Due to Mental Illness

Start of Addiction Treatment
Start and continuation of Addiction Treatment

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.

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. DMH continues to support this work by providing subject matter expertise consultation to both the Department of Insurance and the Department of Healthcare and Family Services. DMH collects 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.

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. Subsequent to the new administration following the 2018 election cycle, the State has reevaluated the previous strategies, and is currently in the process of developing a new plan to implement integrated health homes. This plan will include the Medicaid managed care programs in the implementation. 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.

In August, 2018, the Department of Healthcare and Family Services (HFS) introduced the service of Integrated Assessment and Treatment Planning (IATP) into the community behavioral health service array. IATP is an integrated service that ensures an individual's assessment of needs and strengths are clearly documented and lead to specific treatment recommendations. Providers must minimally review and update clients' IATPs every 180 days. Providers must utilize an HFS-approved instrument in order to be reimbursed for IATP services.

HFS has designated the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) as the approved IATP instrument. HFS has partnered with the University of Illinois at Urbana-Champaign's School of Social Work (UIUC-SSW) to provide training and technical assistance to providers delivering IATP services. Staff must attend a one-day, in-person training and complete annual certification in order to utilize the IM+CANS.

The IM+CANS serves as the foundation of Illinois' efforts to transform its publicly funded behavioral health service delivery system. It was developed as the result of a collaborative effort between the Illinois Departments of Healthcare and Family Services (HFS), Human Services-Division of Mental Health (DHS-DMH), and Children and Family Services (DCFS). The comprehensive IM+CANS assessment provides a standardized, modular framework for assessing the global needs and strengths of individuals who require mental health treatment in Illinois. Today, the IM+CANS incorporates:

A complete set of core and modular CANS items, addressing domains such as Risk Behaviors, Trauma Exposure/Adverse Childhood Experiences, Behavioral/Emotional Needs, Life Functioning, Substance Use, Developmental Disabilities, and Cultural Factors;

A fully integrated assessment and treatment plan;

A physical Health Risk Assessment (HRA); and,

A population-specific addendum for youth involved with the child welfare system.

At the core of the IM+CANS is the Child and Adolescent Needs and Strengths (CANS) and the Adult Needs and Strengths Assessment (ANSA); communitric tools containing a set of core and modular items that identify a client's strengths and needs using a '0' to '3' scale. These items support care planning and level of care decision-making, facilitate quality improvement initiatives, and monitor the outcomes of services. Additional data fields were added to the CANS items to support a fully Integrated Assessment and Treatment Plan (IATP), placing mental health treatment in Illinois on a new pathway built around a client-centered, data-driven approach.

The IM+CANS also includes a Health Risk Assessment (HRA), developed to support a holistic, wellness approach to assessment and treatment planning by integrating physical health and behavioral health in the assessment process. The HRA is a series of physical health questions for the individual that is designed to: 1) assess general health; 2) identify any modifiable health risks that can be addressed with a primary health care provider; 3) facilitate appropriate health care referrals, as needed; and 4) ensure the incorporation of both physical and behavioral health needs directly into care planning.

The Illinois Medicaid - Crisis Assessment Tool (IM-CAT) is a decision support and communication tool to allow for the rapid and

consistent communication of the needs of individuals experiencing a crisis that threatens their safety or well-being or the safety of the community. It is intended to be completed by those who are directly involved with the individual. The form serves as both a decision support tool and as documentation of the identified needs of the individual served along with the decisions made with regard to treatment and placement at the time of the crisis.

The IM-CAT is composed of a crisis subset of items from the IM+CANS assessment.

The IM-CAT and the IM+CANS together comprise a broader toolkit of linked assessments that are designed to meet the unique needs of multiple public payer systems, while also breaking down barriers to accessing behavioral health treatment. This suite of assessments is designed to reduce the duplicate collection of administrative and clinical data points needed to appropriately assess a client's needs and strengths while establishing a commonality of language between clients, families, providers, and payer systems.

Providers delivering Mobile Crisis Response (MCR) services are required to utilize the IM-CAT as a component of service delivery. In order to utilize the IM-CAT, staff must be certified annually in either the IM-CAT or the IM+CANS. Training and technical assistance for the IM-CAT is also coordinated with the UIUC-SSW.

Promoting Integration of Primary and Behavioral Health Care in Illinois (PIPBHC-IL)

The DMH is currently investigating best practices in the integration of Primary Health Care with Behavioral Health Care through a five year SAMHSA grant funded initiative. 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.

2. Describe how the state provide 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.

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.

3. a) Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? Yes No

b) and Medicaid? Yes No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

The Illinois Department of Healthcare and Family Services is the State's Medicaid Agency and oversees Medicaid Managed Care. The IL Department of Insurance oversees Qualified Health Plans.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? Yes No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education Yes No

b) Health risks such as

ii) heart disease Yes No

iii) hypertension Yes No

iv) high cholesterol Yes No

v) diabetes Yes No

c) Recovery supports Yes No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? Yes No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? Yes No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions? Rights are individual. Individuals must complain. Education of behavioral health consumers and families as to their rights and complaint/appeal processes continues to be an urgent need.

10. Does the state have any activities related to this section that you would like to highlight?
The IL Department of HealthCare and Family Services is currently working with its MCO's on the implementation of risk-based contracting.

The Director of DMH is actively working with HFS and the Department of Insurance in reviewing parity issues, complaints, and developing recommendations for policy changes.

Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁴², [Healthy People, 2020](#)⁴³, [National Stakeholder Strategy for Achieving Health Equity](#)⁴⁴, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for [Culturally and Linguistically Appropriate Services in Health and Health Care](#) (CLAS)⁴⁵.

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."⁴⁶

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status⁴⁷. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations⁴⁸. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

⁴² http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁴³ <http://www.healthypeople.gov/2020/default.aspx>

⁴⁴ https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf

⁴⁵ <http://www.ThinkCulturalHealth.hhs.gov>

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?
 - a) Race Yes No
 - b) Ethnicity Yes No
 - c) Gender Yes No
 - d) Sexual orientation Yes No
 - e) Gender identity Yes No
 - f) Age Yes No
2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? Yes No
3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? Yes No
4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? Yes No
5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards? Yes No
6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? Yes No
7. Does the state have any activities related to this section that you would like to highlight?
None at this time.
Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

$$\text{Health Care Value} = \text{Quality} \div \text{Cost}, (\mathbf{V} = \mathbf{Q} \div \mathbf{C})$$

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,⁴⁹ The New Freedom Commission on Mental Health,⁵⁰ the IOM,⁵¹ NQF, and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).⁵² The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."⁵³ SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series (**TIPS**)⁵⁴ are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (**KIT**)⁵⁵ was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

⁴⁹ United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

⁵⁰ The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

⁵¹ Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

⁵² National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

⁵³ <http://psychiatryonline.org/>

⁵⁴ <http://store.samhsa.gov>

⁵⁵ <http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf>

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? Yes No

2. Which value based purchasing strategies do you use in your state (check all that apply):
 - a) Leadership support, including investment of human and financial resources.
 - b) Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
 - c) Use of financial and non-financial incentives for providers or consumers.
 - d) Provider involvement in planning value-based purchasing.
 - e) Use of accurate and reliable measures of quality in payment arrangements.
 - f) Quality measures focus on consumer outcomes rather than care processes.
 - g) Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
 - h) The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode ([RAISE](#)) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? Yes No
2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI? Yes No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

Coordinated Specialty Care (CSC)

Cognitive Behavioral Therapy for Psychosis (CBT-p)-p,

Individual Placement Services-Supported Employment/Supported Education

Illinois is providing an early intervention Program for the treatment of persons experiencing their first psychotic break. The majority of individuals served are in the young adult age range. This intensive new, Coordinated Specialty Care Program is an evidence-based practice, that includes 5 specialists as a Treatment Team, namely: the Prescriber/Psychiatrist, the Team Leader who also provides Family Psychoeducation, the Individual Resiliency Training (IRT) Clinician, The Case manager/Recovery Support Specialist, the Supported Employment/Supported Education staff person (also Known as Individual Placement & Support or IPS). This Treatment Team provides intensive services to individuals ages 14- 40 who have experienced their first psychotic episode within the last 18 months. This exciting new Program is a true early intervention Program that has as its goal, to assist individuals having their first psychotic episode in the recent past with multiple intervention services so as to allow for Recovery and resumption of work and or school for persons served, and to

reduce number of hospitalizations for such persons, divert persons from needing to go on Social Security Disability and ideally, to possibly reduce the need for medications over time.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?
- The 15 CSC Teams in the State do active marketing and outreach educating health providers in their communities and coordinate the services received by ESMI clients.
Recovery support is also provided by Recovery Support Specialists and peer support staff across all 15 teams.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI? Yes No

5. Does the state collect data specifically related to ESMI? Yes No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? Yes No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

We have growing expertise in CBT-p to the extent that we are undertaking advanced training for staff who have experience in using this practice to prepare them as experts and mentors to incoming staff who are at the beginning level. We are also initiating training in fidelity to the CSC model based on a fidelity scale developed for CSC.

8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state's ESMI programs including psychosis?

Continuation of initiatives undertaken during FY2018 and FY2019. Additionally, the initiation of advanced training in CBT-p to accommodate those who are more experienced in this best practice and to develop available expertise to mentor team members who are joining at a beginning level. Increasing in-person training and consultation in Family Psychoeducation. Six training events in Fidelity to the Coordinated Specialty Care model are being planned. These sessions will be attended by members of all 15 teams in the State.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

A special web-based data system has been developed and established for the program with data definitions and criteria for provider reporting provided through an accompanying data manual. Agencies are now entering and bringing their data up to date. A complete set of data for FY2019 should be available by the end of October.

10. Please list the diagnostic categories identified for your state's ESMI programs.

Schizophrenia Spectrum Disorders,
Major Depression with Psychotic Features
Bi-Polar Disorder with Psychotic Features
Post-Traumatic Stress Disorder with Dissociative Symptoms

In 2018, we expanded to 15 Sites, 9 being downstate, and SAMHSA allowed for the expansion of persons served to include additional persons with Early Serious Mental Illness, namely persons with Bipolar Disorder with Psychotic Features, Major Depression Disorder with Psychotic Features and PTSD with Dissociative Symptoms. The latter diagnosis allowed for the inclusion of many persons in their teenage years who did not have a diagnosis related to the Schizophrenia Spectrum disorders. Currently we are serving 251 enrollees at our 15 FIRST.IL sites with 20% of persons served being with the newer allowed diagnosis.

Please indicate areas of technical assistance needed related to this section.

FIRST.IL staff have been attending Webinars that are relevant to clinical issues being encountered. Consultation on advanced training in CBT-p and on training in Fidelity to the CSC model would be appreciated.

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5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning? Yes No
2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.
3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

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. They are the dynamic core of Person-Centered Planning linking individuals and families with a comprehensive and supportive array of mental health services.

In the Illinois Administrative Rule 132 (59 Ill Admin. Code 132) Certified Comprehensive Community Mental Health Centers are defined as "specialty service providers embedded in the community with knowledge and expertise in providing services to adults with or at risk of serious mental illnesses (SMI) and/or children and youth with or at risk of serious emotional disturbances (SED). CMHCs respond to the unique mental health needs of the community with a continuum of services ranging from prevention/promotion through treatment and recovery. CMHCs collaborate with other social service and health care providers to deliver integrated care to individuals in the identified geographic service area. CMHCs must be nonprofit or local government entities."

CMHCs are required to:

Operate within a system of care that provides treatment, habilitation and support services.

Provide a comprehensive strengths-based array of mental health services within an identified geographic service area.

Provide care to individuals with or at risk for SMI/SED by using a person-centered approach to care performed by an interdisciplinary team.

Serve individuals who have complex needs as a result of child welfare, justice or multisystem involvement, medical co-morbidity, homelessness, dual disorders, etc.

Ensure the connectability of services in the service area for individuals across the life span.

Provide services in the client's natural settings.
Provide a safety net for individuals with SMI/SED who are indigent.
Provide evidence-based and evidence-informed developmentally appropriate practices in a proficient manner.
Provide for a screening prior to a referral to a more intensive level of care.
Provide education and resources to the public on mental health issues, including suicide prevention and wellness.
Prioritize principles of recovery, system of care, trauma informed care, and culturally relevant practices.
Provide access or linkage to psychiatric services and other health and social services.

Person Centered Planning is the cornerstone of the General Requirements for CCMHCs (Section 132.75):

Establish and maintain policies and procedures to be used by all CMHC staff in the administration of CMHC programs and the delivery of services from any CMHC site or location including:

Policies detailing the organization's clear commitment to person-centered recovery and resilience principles and the empowerment of families and individuals served. Programs and services should promote personal choice, self-help measures, the strengthening of natural supports, the use of education and interventions in natural settings, and the reduction of the utilization of institutional levels of care.

Policies detailing how clients will actively participate in the development, planning and oversight of programs and services.

Policies and procedures to ensure co-morbid physical healthcare needs are addressed for clients as needed. A CMHC that is not licensed to provide Level 1 and Level 2 Substance Use services and enrolled to participate in the Illinois medical assistance Program shall develop policies and procedures to ensure that clients receive referrals for services as needed.

Policies and procedures to ensure SAMHSA's principles of trauma informed approaches are embedded into the organizational structure and clinical practices of the CMHC.

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.

Ensure the availability of and/or linkage to a psychiatric resource for the purpose of consultation, evaluation, prescription and management of medication as needed by clients served by the CMHC. This may be secured through various arrangements, including but not limited to employment, contractual relationship or mutual agreement.

Identify a specific geographic service area in which the CMHC will operate and organize the delivery of services and programs and provide interventions to clients.

In CMHCs Person Centered Planning occurs in the context of Individual Treatment Planning and Plans (ITPs) which are the center of ongoing clinical work with clients. In the Medicaid system it is an integral component of Integrated Assessment and Treatment Planning (IATP). DHFS has designated the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) as the approved IATP instrument. It is noteworthy that the IM+CANS also includes a Health Risk Assessment (HRA), developed to support a holistic, wellness approach to assessment and treatment planning by integrating physical health and behavioral health in the assessment process. The HRA is a series of physical health questions for the individual that is designed to: 1) assess general health; 2) identify any modifiable health risks that can be addressed with a primary health care provider; 3) facilitate appropriate health care referrals, as needed; and 4) ensure the incorporation of both physical and behavioral health needs directly into care planning.

Additionally, 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. DMH conducts an annual consumer and caregiver survey using the MHSIP Adult Consumer and MHSIP Youth Services Survey for Families perception of care surveys.

4. Describe the person-centered planning process in your state.

In CMHCs Person Centered Planning occurs in the context of Individual Treatment Planning and Plans (ITPs) which are the center of ongoing clinical work with clients. In the Medicaid system it is an integral component of Integrated Assessment and Treatment Planning (IATP). DHFS has designated the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) as the approved IATP instrument. It is noteworthy that the IM+CANS also includes a Health Risk Assessment (HRA), developed to support a holistic, wellness approach to assessment and treatment planning by integrating physical health and behavioral health in the assessment process. The HRA is a series of physical health questions for the individual that is designed to: 1) assess general health; 2) identify any modifiable health risks that can be addressed with a primary health care provider; 3) facilitate appropriate health care referrals, as needed; and 4) ensure the incorporation of both physical and behavioral health needs directly into care planning.

Additionally, 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. DMH conducts an annual consumer and caregiver survey using the MHSIP Adult Consumer and MHSIP Youth Services Survey for Families perception of care surveys.

Please indicate areas of technical assistance needed related to this section.

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6. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: <http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf>. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? Yes No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? Yes No
3. Does the state have any activities related to this section that you would like to highlight?

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 certifies Specialty Programs and Comprehensive Community Mental Health Centers in accordance with the requirements and processes cited in Administrative Rule 132. Certification activities are ongoing.

Please indicate areas of technical assistance needed related to this section

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7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)⁵⁶ to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

⁵⁶ <https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf>

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized 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.
2. What specific concerns were raised during the consultation session(s) noted above?
3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The State funds community mental health centers for the provision of community-based treatment and rehabilitation services for individuals with mental illnesses as well as individuals with co-occurring disorders.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?
- a) Physical Health Yes No
 - b) Mental Health Yes No
 - c) Rehabilitation services Yes No
 - d) Employment services Yes No
 - e) Housing services Yes No
 - f) Educational Services Yes No
 - g) Substance misuse prevention and SUD treatment services Yes No
 - h) Medical and dental services Yes No
 - i) Support services Yes No
 - j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA) Yes No
 - k) Services for persons with co-occurring M/SUDs Yes No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

As above, The State funds community mental health centers for the provision of community-based treatment and rehabilitation services for individuals with mental illnesses as well as individuals with co-occurring disorders.

3. Describe your state's case management services
- Case management is provided as a set of Medicaid Rehabilitation Option services to individuals in need of services across the system of care, who require assistance in accessing those services and/or obtaining referral to such services.
4. Describe activities intended to reduce hospitalizations and hospital stays.
- The State Plan provides for multi-disciplinary team services available to individuals with a history of or at risk for multiple hospitalizations. In addition, the State has sponsored the piloting of programs aimed at reducing hospital stays. 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.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1. Adults with SMI	534,861 (5.4%)	396,320
2. Children with SED	104,727 (7.0%)	59,844

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

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 FY2019 there were 534,861 adults with serious mental illnesses residing in Illinois.

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). Based on this formula, there were 104,727 youth in Illinois with Serious Emotional Disturbance.

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

- a) Social Services Yes No
- b) Educational services, including services provided under IDE Yes No
- c) Juvenile justice services Yes No
- d) Substance misuse prevention and SUD treatment services Yes No
- e) Health and mental health services Yes No
- f) Establishes defined geographic area for the provision of services of such system Yes No

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

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population.

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 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.

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.

b. Describe your state's targeted services to the homeless population.

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 FY2019 Illinois was awarded \$2,705,121 and recently submitted an application for FY2020 for \$2,705,569. Illinois currently has 13 agencies and 16 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. In FY2020 we anticipate serving about 5,000 individuals.

PATH program services in the state are:

Outreach and engagement, including:

- Two (2) Mobile Assessment Units, one of which is the Chicago Transit Authority Outreach Team
- 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.

c. Describe your state's targeted services to the older adult population.

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.

WRAP For Seniors

A grant that began on July 1, 2018, for \$838,425 over three years was awarded to the Center on Mental health services Research and Policy at the University of Illinois at Chicago. The purposes of the grant are: (1) to significantly increase the number of older adults and adults with disabilities who participate in evidence-based self-management education and support programs to improve their confidence in managing their chronic condition(s) and to implement innovative funding arrangements to support the proposed programs, while embedding the programs into an integrated sustainable program network. DMH is one of nine active partners with UIC CMHSRP in working towards achieving the goals of the grant which are to create a trained workforce of 120 WRAP facilitators across the State. The others are the IL Dept on Aging, Copeland Center for wellness and Recovery, 13 Area Agencies on Aging, the IL WRAP Steering committee, IL Pathways to Health, IL Coalition of Mental Health and Aging, IL Mental health Collaborative for Access and Choice, and the IL Community Health & Aging collaborative. DMH WRAP Facilitators are now actively learning how to provide WRAP to seniors. The majority of seniors qualifying for services through this grant-funded program have mental illnesses which frequently go undiagnosed. Clients in the Illinois Department of Aging's Community Care Program as well as older adults served at the state's 13 Area Agencies on Aging are targeted for WRAP services. The partners are seeking to serve 1,000 seniors in Illinois over the three-year period of the grant (1% penetration rate of the estimated 102,994 seniors in Illinois with untreated mental illness) and want to effectively engage 900 participant ages 60+ and achieve a 90% completion rate. They are aiming to develop new funding sources, including a fee-for-service contract. It is anticipated that work on the grant will produce a culturally adapted version of WRAP tailored for seniors in English and Spanish. An important benefit of the grant is the expansion of employment opportunities for persons with lived experience and seniors who attain WRAP Facilitation skills and can provide peer support.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

The Division of Mental Health provides support to community mental health centers for training and develops resources which are made available through the DMH website for use with staff in a variety of subjects related to evidence based practices. The state utilizes technology whenever possible to reduce the cost of participation for providers. This includes sponsoring learning collaboratives and communities that meet using resources such as WebEx to discuss various treatment approaches for specific populations. The Division has a staff person assigned to work on a weekly basis on an initiative with police around CIT training. The Division also utilizes its Regionally based staff to provide training and technical assistance in a geographically based way to reduce burden on providers with travel by locating these meetings closer to the providers' service region. This also allows for personalization/modifications based on the needs of the Region.

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019? Yes No

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma⁵⁷ is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma⁵⁸ paper.

⁵⁷ Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

⁵⁸ Ibid

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? Yes No
2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? Yes No
3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? Yes No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? Yes No
5. Does the state have any activities related to this section that you would like to highlight.

Please indicate areas of technical assistance needed related to this section.

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Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.⁵⁹

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.⁶⁰

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

⁵⁹ Journal of Research in Crime and Delinquency: : *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNeil, Dale E., and Ren?e L. Binder. [OJJDP Model Programs Guide](#)

⁶⁰ <http://csgjusticecenter.org/mental-health/>

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? Yes No
2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? Yes No
3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? Yes No
4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? Yes No
5. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

15. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.⁶¹ SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427)⁶²,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

⁶¹<http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

⁶²Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- a) Wellness Recovery Action Plan (WRAP) Crisis Planning
- b) Psychiatric Advance Directives
- c) Family Engagement
- d) Safety Planning
- e) Peer-Operated Warm Lines
- f) Peer-Run Crisis Respite Programs
- g) Suicide Prevention

2. Crisis Intervention/Stabilization

- a) Assessment/Triage (Living Room Model)
- b) Open Dialogue
- c) Crisis Residential/Respite
- d) Crisis Intervention Team/Law Enforcement
- e) Mobile Crisis Outreach
- f) Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- a) Peer Support/Peer Bridgers
- b) Follow-up Outreach and Support
- c) Family-to-Family Engagement
- d) Connection to care coordination and follow-up clinical care for individuals in crisis
- e) Follow-up crisis engagement with families and involved community members

f) Recovery community coaches/peer recovery coaches

g) Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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Environmental Factors and Plan

16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

- a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? Yes No
- b) Required peer accreditation or certification? Yes No
- c) Block grant funding of recovery support services. Yes No
- d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? Yes No
2. Does the state measure the impact of your consumer and recovery community outreach activity? Yes No
3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

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.

A variety of Recovery Support initiatives are available to all individuals receiving services:

- 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 tenth year, the Warm Line assures the accessibility of a human connection at a time when it is needed.
- 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 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.

o 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:

- o 100 hours of training/education
- o 2,000 hours on-the-job experience
- o 100 hours of supervision
- o 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

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

The DHS Division of Substance Use Prevention and Recovery will respond.

5. Does the state have any activities that it would like to highlight?

Two new activities in Recovery Support Services for FY2020-2021 are:

1. Introduction of CRSS Fundamental Training for newly certified CRSS Specialists and those who are interested in obtaining the CRSS credential. This training series will answer questions and concerns CRSS specialists encounter at the beginning level and serve as an orientation for persons who are interested in joining the meetings who are considering or currently pursuing completing the requirements for certification.
2. To educate consumers about CRSS, A Webinar has been produced that will be connected to the Recovery Services Website and will be available to anyone interested in learning more about recovery and the CRSS credential.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights ([OCR](#)) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

- Does the state's Olmstead plan include :
 - Housing services provided. Yes No
 - Home and community based services. Yes No
 - Peer support services. Yes No
 - Employment services. Yes No
- Does the state have a plan to transition individuals from hospital to community settings? Yes No
- What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.⁶³ Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.⁶⁴ For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.⁶⁵

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.⁶⁶ Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.⁶⁷

According to data from the 2015 Report to Congress⁶⁸ on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

⁶³Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

⁶⁴Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

⁶⁵Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

⁶⁶The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁶⁷Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM>

⁶⁸http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

Please respond to the following items:

- Does the state utilize a system of care approach to support:
 - The recovery and resilience of children and youth with SED? Yes No
 - The recovery and resilience of children and youth with SUD? Yes No
- Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:
 - Child welfare? Yes No
 - Juvenile justice? Yes No
 - Education? Yes No
- Does the state monitor its progress and effectiveness, around:
 - Service utilization? Yes No
 - Costs? Yes No
 - Outcomes for children and youth services? Yes No
- Does the state provide training in evidence-based:
 - Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? Yes No
 - Mental health treatment and recovery services for children/adolescents and their families? Yes No
- Does the state have plans for transitioning children and youth receiving services:
 - to the adult M/SUD system? Yes No
 - for youth in foster care? Yes No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

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, the establishment of an online data system to monitor treatment progress and individual child and adolescent outcomes, and the integration of primary health care and behavioral health services. 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. The following are examples of successful planning and collaborative activities:

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. New legislation, the Children and Young Adult Mental Health Crisis Act (HB2154)

requires the Department of Healthcare and Family Services to restructure the Family Support Program (SFSP) to enable early treatment of youth, emerging adults, and transition-age adults with a serious mental illness or serious emotional disturbance. Contains provisions on the new hallmarks of the Program including federal Medicaid matching dollars and a group or individual policy of accident and health insurance, or managed care plan that will be renewed after December 31, 2020 for the purpose of early treatment of a serious mental illness in a child or young adult under age 26 to provide coverage for: (i) coordinated specialty care for first episode psychosis treatment and (ii) assertive community treatment and community support team treatment. For further information about the SFSP Program see the website at: <https://www.illinois.gov/hfs/MedicalProviders/behavioral/sass/Pages/sfsp.aspx>

DMH C&A is currently implementing recent legislation, HB907, that requires the Department of Human Services to create and maintain an online database and resource page on its website. The website will contain mental health resources specifically geared toward school counselors, parents, and teachers with the goal of connecting those people with mental health resources related to bullying and school shootings and encouraging information sharing among educational administrators, school security personnel, and school resource officers. It is also being geared toward school social workers and school support personnel.

Since FY2016 when 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, efforts to address this problem have continued. This action was in support of Public Act 098-0808, and consistent with the unique population of focus that Illinois had identified in 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 HIPAA, but also FERPA and the Illinois Mental Health Confidentiality requirements.

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- Division of Mental Health (DMH), 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.

In August, 2018, the Department of Healthcare and Family Services (HFS) introduced the service of Integrated Assessment and Treatment Planning (IATP) into the community behavioral health service array and designated the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) as the approved IATP instrument. HFS has partnered with the University of Illinois at Urbana-Champaign's School of Social Work (UIUC-SSW) to provide training and technical assistance to providers delivering IATP services. Staff must attend a one-day, in-person training and complete annual certification in order to utilize the IM+CANS.

The comprehensive IM+CANS assessment provides a standardized, modular framework for assessing the global needs and strengths of individuals who require mental health treatment in Illinois. Today, the IM+CANS incorporates:
A complete set of core and modular CANS items, addressing domains such as Risk Behaviors, Trauma Exposure/Adverse Childhood Experiences, Behavioral/Emotional Needs, Life Functioning, Substance Use, Developmental Disabilities, and Cultural Factors;
A fully integrated assessment and treatment plan;
A physical Health Risk Assessment (HRA); and,
A population-specific addendum for youth involved with the child welfare system.

7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? Yes No

2. Describe activities intended to reduce incidents of suicide in your state.

The SAMHSA Behavioral Health Barometer for Illinois, Volume 5, reports that during 2013-2017, the annual average prevalence of past year serious thoughts of suicide in Illinois was 3.6% (or 349,000), lower than the Midwest regional average(4.2%) but similar to the national average (4.1%). The percentage did not change significantly between 2008-2012 and 2013-2017. 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. 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 advocate for increased funding, develop training opportunities, increase public and professional awareness of state and local suicide prevention resources in Illinois, and increase opportunities for linkages. Several significant bills to increase resources to address suicide have been introduced in the General Assembly but are still pending.

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 at the time of admission and prior to 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 in community-based settings.

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 Illinois 2018-2021 Suicide Prevention Strategic Plan with Updated Goals and Objectives is attached.

3. Have you incorporated any strategies supportive of Zero Suicide? Yes No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? Yes No

5. Have you begun any targeted or statewide initiatives since the FFY 2018-FFY 2019 plan was submitted? Yes No

If so, please describe the population targeted.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:



Illinois Suicide Prevention Strategic Plan

Updated Goals and Objectives

2018-2021

January 2019



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The Illinois Department of Public Health and the Illinois Suicide Prevention Alliance want all Illinois residents, especially those at risk of suicidal behaviors, to live to their full potential.

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

The Illinois Suicide Prevention Strategic Plan is a required activity of the Suicide Prevention, Education and Treatment Act (Public Act 095-0109.)

Overview

What is the Illinois Suicide Prevention Strategic Plan?

This document serves as an update to the *Illinois Suicide Prevention Strategic Plan*, which was published in 2008, and offers recommended action steps for the upcoming years. The previous plan outlined the problem of suicide and identified strategies around the goals and objectives necessary to prevent suicides. It extended the continued national efforts encouraging states to coordinate across government agencies and involve the private sector to develop, implement and evaluate a comprehensive prevention plan.

With guidance from public and private partners, the Illinois Department of Public Health and the Illinois Suicide Prevention Alliance devoted several meetings to revising the plan. Members took steps, to review the first strategic plan, reflect on accomplishments, modify the objectives, and identify recommended action steps. Where appropriate, this plan identifies potential strategies and potential audiences for individual objectives.

Similar to the first strategic plan, this plan is comprehensive, complex, and ambitious. The updated plan challenges communities, public health professionals, and health care providers to educate, inform, and motivate the public to maximize resources to reduce the burden of suicide. By doing so, there can be an improved environment and better outcomes for individuals with depression and other mental illnesses, and for those whose life situations have brought seemingly unbearable pain.

The intent of the plan is to guide suicide prevention efforts within the following areas:

- Education and Training
 - Goal 1 - Knowledge is Power; Ask About Suicide - *Increase awareness, knowledge, and competency in suicide prevention, assessment, and treatment for first responders and health care workers, social service workers, clergy, law enforcement, and school personnel.*
 - Goal 2 - Ensure Safety to Live and Love - *Promote utilization of suicide prevention services for victims of harassment and violence.*
- Community Awareness
 - Goal 3 - Treatment Works - *Advocate for a comprehensive continuum of care for those at highest risk for suicide.*
 - Goal 4 - Suicide is Everyone's Business; It Only Takes One - *Increase the public's awareness of the burden of suicide and how individuals and communities can be part of prevention efforts.*
- Data
 - Goal 5 - Data Counts - *Improve suicide-related data collection.*

- Sustainability
 - Goal 6 - Bank on Saving Lives - *Develop sustainable funding sources for implementing suicide prevention intervention and crisis response/aftercare programs in Illinois and for evaluation of the results in order to save more lives.*

Who is the Plan for?

The *Illinois Suicide Prevention Strategic Plan* (Plan) is for any person, community, agency, institution, or organization that has the means to and interest in helping to implement recommendations outlined in the plan. This plan also can be useful for policy and decision makers to gauge Illinois suicide prevention efforts and what still needs to be done.

How to Use this Plan?

This Plan is meant to guide the suicide prevention efforts in Illinois. This Plan is not a substitute for individualized work or action plans developed by organizations or persons interested in preventing suicide. Rather, the Plan should be viewed as a compass shared by all suicide prevention stakeholders that will give a unifying direction to all their programs. The goals, objectives, and strategies can be pursued by individual stakeholders. Collaboration is encouraged among stakeholders to increase the effectiveness of their individual efforts.

Goal 1: Knowledge is Power; Ask About Suicide

Increase awareness, knowledge, and competency in suicide prevention, assessment, and treatment for first responders, health care workers, social service workers, clergy, law enforcement, and school personnel.

Bystander intervention programs (e.g. gatekeeper training)

Objective 1.1 By 2021, bystander intervention programs will be implemented in settings where first responders are likely to be found.

Potential strategy:

- Implement gatekeeper trainings for community members and professionals in a position to have first contact with persons at risk for suicide (gatekeeper) in order to recognize a person at risk of suicide and to connect them with help.
 - *Potential audiences* – all school personnel, correctional workers, faith community leaders, first responders, judges and court staff, juvenile justice/detention personnel, law enforcement professionals, primary care providers, public health officials, service members, veterans and their families, and students

Best practices, evidence-based practices, and evidence-informed practices

Objective 1.2 By 2021, best practices, evidence-based practices, and evidence-informed practices will be instituted in settings where first responders are likely to be found.

Potential strategies:

- Best practices, evidence-based practices, and evidence-informed practices curriculum/modules will be developed and offered to professional preparation programs.
 - *Potential audiences* - mental health workers, social service workers, clergy, law enforcement, and school personnel
- Best practices, evidence-based practices, and evidence-informed practices curriculum/modules will be promoted through professional development and continuing education opportunities, social marketing, and networking.

Objective 1.3 By 2021, statewide associations will collaborate to promote evidence-based and evidence-informed practices for reducing suicide risk.

- *Potential audiences* – associations representing various disciplines, such as children’s mental health, chronic illness, coroners, disability, domestic violence survivors, faith-based, family violence, firefighters, hospitals, law enforcement,

maternal and child health, nurses, psychiatry, psychology, public health, rehabilitation, school health, school health centers, service members, veterans and their families, sexual assault survivors, support groups, and trauma survivors

Professional programs

Objective 1.4 By 2021, incorporate course objectives with regards to the assessment and management of suicide risk, and identification and promotion of protective factors within curriculums for health care professionals.

- *Potential audiences* - providers of nursing care, physician assistant education programs, medical residency programs, clinical social work counseling, and psychology graduate programs

Objective 1.5 By 2021, increase the number of licensing programs or recertification in relevant professions that require or promote competencies in depression assessment and management and suicide prevention strategies.

- *Potential audiences* – physician specialties (psychiatry, family practice, pediatrics, and emergency medicine), substance abuse counselors, employee assistance professionals, employee health services, and behavioral health services (psychology, social work, psychiatric nursing, counseling, and marriage and family therapy personnel)

Objective 1.6 By 2021, efforts to implement screening and assessment for suicide will be implemented in professional preparation programs (e.g. first responders, health care professionals, curriculums, etc.).

Potential strategies:

- Curriculum will be developed and offered to professional preparation programs.
 - *Potential audiences* – clergy, law enforcement, local municipalities, mental health workers, nursing programs, and school and social services personnel
- The concept of screening and assessment for suicide will be promoted and advocated for through meetings, professional development and continuing education, social marketing, and other means.
- Provide education programs to family members and others in close relationship with those at risk of suicide.
- Include a module/component on suicide prevention within academic curriculum (e.g., nursing programs, social work).
- Include a module/component on suicide prevention within new employee orientation.

-
- Assist health care facilities in preventing suicides, which is a sentinel event identified by the Joint Commission.

-
- Objective 1.7 By 2021, increase the number of relevant professionals who receive training on identifying and responding to persons at risk of suicide.
- *Potential audiences* – clergy, education faculty and staff, correctional workers, divorce and family law attorneys, and criminal defense attorneys

Technical assistance

-
- Objective 1.8 By 2020, collaborate with schools to work toward compliance with the Illinois State of Education’s suicide prevention requirement in the School Code that certain school personnel be trained to identify the warning signs of suicidal behavior in adolescents and teens and be taught appropriate intervention and referral techniques.

-
- Objective 1.9 By 2021, offer information with regards to free suicide prevention screening, prevention, intervention, and crisis response.
- *Potential audience* – health care workers

-
- Objective 1.10 By 2021, establish informal and formal approaches to provide technical assistance, networking, and communications to assist communities in their suicide prevention efforts.
- Potential strategies:
- Offer a series of training and technical assistance conferences, in order to help communities identify existing, or build new, public health-oriented partnerships to advance suicide prevention.
 - Provide training on core public health competencies, including strategic planning, to community members.
 - Gather and share success stories from across the state.

-
- Objective 1.11 By 2021, increase the number of conferences and meetings devoted to suicide prevention.
- Potential strategy:
- Host conferences and symposia at state, regional, and local levels to draw on knowledge and expertise within the suicide prevention community and provide a venue to share best practices and research findings.

Goal 2: Ensure Safety to Live and Love

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

Age groups at-risk

Objective 2.1 By 2021, educate professionals, who work with at-risk individuals, about the age groups that are at higher risk of suicidal behavior.

Potential strategies:

- Middle age – educate professionals that middle-aged men die by suicide at twice the baseline rate of other Americans and most of these men are employed.
 - *Potential audience* – staff of employee assistance programs, especially since the workplace is a prime spot for early intervention
- Older adults – educate professionals that older adults have become a focus in suicide prevention due to the extremely high rates among one segment of that population: older white men. Educate professionals that suicide rates increase with age. Elderly people who die by suicide are often divorced or widowed and suffering from a physical illness.
 - *Potential audiences* – employees of area agencies on aging, long-term care, and older adult day services
- Youth – educate professionals that suicide is the third leading cause of death among Americans between the ages of 15-24 and the second leading cause of death among those between the ages of 25-34.
 - *Potential audiences include:*
 - College campuses – educate professionals on using the multi-disciplinary approach to advancing suicide prevention and mental health.
 - Juvenile justice – educate professionals about the suicide risk of clients of the juvenile justice system, and review the recommendations offered by researchers to prevent suicides in juvenile facilities.
 - Gay, lesbian, bisexual, and transgender youth - increase awareness that family connectedness and support from other adults are protective factors against suicidal behaviors.

Service members, veterans and their families

Objective 2.2 By 2021, educate professionals, who work with at-risk individuals, on the risk of suicidal behavioral among service members, veterans, and their families.

Potential strategies:

- Increase awareness of the rising numbers of suicides among service members and veterans.
- Promote collaboration between public and private partners to engage service member families and veteran’s families in suicide prevention efforts.
- Increase awareness of post-traumatic stress disorder and traumatic brain injury.
- Inform professionals of the importance of providing support and services to members of the National Guard and reservists after they return to their civilian jobs post-deployment.
- Educate professionals about the similar characteristics of veterans who died by suicide, such as they were mid-life or older, not working (not necessarily unemployed but perhaps disabled or retired), and were a gun owner.

Minority and culturally diverse populations

Objective 2.3 By 2021, educate professionals, who work with at-risk individuals, on the various minority and culturally diverse populations at risk of suicidal behavior.

Potential strategies:

- Increase awareness of the way in which different cultures handle mental health, substance abuse, and suicide prevention and intervention issues. Educate professionals on the barriers that slow the progress of suicide prevention among these groups (e.g. cultural norms, religion, and shortage of service providers who understand a particular culture or speak the same language).
- Encourage professionals to embrace culturally-based prevention and treatment practices.
- Native American – educate professionals that American Indian/Alaska Native youth, when compared with other racial and ethnic groups, have more serious problems with mental health disorders related to suicide, such as anxiety, substance abuse, and depression.

Persons with health issues (physical and mental)

Objective 2.4 By 2021, educate professionals, who work with at-risk individuals, with regards to the association between health issues (physical and mental) and risk of suicide.

Potential strategies:

Physical

- Increase awareness of the suicide risk among persons with a chronic disease (e.g. chronic pain, side effects of medicine, and co-occurrence

of depression with medical, psychiatric, and substance abuse disorders).

- Increase awareness of the suicide risk among those with a physical disability.

Mental

- Increase education of professionals that 90 percent of suicides that take place in the U. S. are associated with mental illness, including disorders involving the abuse of alcohol and other drugs.
- Increase education of professionals that 50 percent of those who die by suicide were afflicted with major depression, and the suicide rate of people with major depression is eight times that of the general population.

Survivors (e.g. attempters of suicide, those who lost a loved one to suicide, children of someone who died of suicide)

Objective 2.5 By 2021, educate professionals that survivors of suicide are at risk of suicide.

Potential strategies:

- Recognize a previous suicide attempt is one of the strongest known predictors of suicide. It is one of many aspects to consider during reintegration into homes, schools, workplace, and communities.
- Educate mental health providers and other caregivers in understanding the unique grief and needs of those who lost a loved one to suicide.
 - *Potential audience* – health care providers, hospital staff, and families and friends of those who have completed suicide.

Victims of trauma (e.g. interpersonal violence, polytrauma)

Objective 2.6 By 2020, educate professionals on the relationship between trauma and suicide risk.

Potential strategies:

- Increase awareness about childhood exposure to extreme stress and how it is a leading cause of suicidal behavior in adolescence and adulthood.
- Explain the range of risk and protective factors experienced before, during, and after trauma exposure.
- Increase awareness about victims of interpersonal violence (e.g. child maltreatment, youth violence, community violence, sexual assault, and intimate partner violence) having a higher risk of suicide than non-victims.
- Increase awareness of the association between bullying, including cyber bullying (both as a perpetrator and victim), and suicidal behaviors.

- *Potential audiences* - health department and school and higher education personnel

Goal 3: Treatment Works

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

Access to care

Objective 3.1 By 2020, increase awareness of the National Suicide Prevention Lifeline.

Potential strategies:

- Encourage communities to promote the national lifeline materials.
- Encourage crisis centers to join the national lifeline network.

Evidence-base

Objective 3.2 By 2020, increase the number of entities with evidence-based suicide prevention programs.

- *Potential audiences*– staff of school, colleges, and universities; correctional institutions; jails and detention centers; aging networks; and families, youth, and community service providers

Healthcare providers

Objective 3.3 By 2020, increase the capacity of health care providers to assist patients in maintaining a continuum of care.

Potential strategies:

- Promote national guidelines for assessment of suicidal risk among persons receiving care in the healthcare system.
 - *Potential audiences* – employees in primary health care settings, emergency departments, and specialty mental health and substance abuse treatment centers
- Promote the use of guidelines in developing aftercare treatment programs for individuals exhibiting suicidal behavior.
 - *Potential audiences* – those discharged from inpatient facilities
- Increase the number of professionals who are trained to routinely assess the presence of lethal means (including firearms, drugs, and poisons) in the home and educate about actions to reduce associated risks.
 - *Potential audiences* – primary care clinicians, other health care providers, and health and safety officials

- Increase the proportion of hospital emergency departments that routinely provide immediate post-trauma psychological support and mental health education for trauma victims.
- Incorporate screening for depression, substance abuse, and suicide risk as minimum standard of care for assessment in suicide risk.
 - *Potential audiences* – employees in primary care settings, hospice, and skilled nursing facilities for all health care treatment programs

Integration into other programs

Objective 3.4 By 2020, increase the number of counties with health and/or social services outreach programs for at-risk populations that incorporate mental health services and suicide prevention.

- *Potential audiences* – emergency medical technicians, firefighters, law enforcement officers, funeral directors, and clergy

Objective 3.5 By 2020, develop training or collaborate with an existing training and technical resource center to build capacity for communities to implement and to evaluate suicide prevention programs.

Objective 3.6 By 2021, encourage integration of suicide prevention practices into substance abuse prevention and treatment services.

Objective 3.7 By 2021, identify state programs which could include suicide-related performance measures in their grant programs.

- *Potential audiences* – personnel of aging services, mental health, substance abuse, health care, and labor and education

Patients

Objective 3.8 By 2020, promote models of treatment shown to increase the probability of adherence to treatment.

Potential strategies:

- Encourage best evidence models such, as *Is Your Patient Suicidal: Tools to Help ED Providers When the Answer is Yes*, by the Substance Abuse and Mental Health Services Administration and Suicide Prevention Resource Center.
- Educate hospital emergency department staff on how they can help patients treated for self-destructive behavior pursue the proposed mental health follow-up plan.

-
- Increase the proportion of patients with mood disorders who complete a course of treatment or continue maintenance treatment as recommended.

Schools

Objective 3.9 By 2020, increase the capacity of schools to screen for mental health problems and to link students to services.

Potential strategy:

- Promote national guidelines for mental health, including substance abuse, on appropriate linkages to screening and referral of students in schools and colleges.

Screenings

Objective 3.10 By 2021, offer year-round suicide-risk, depression, and anxiety health screenings.

Potential strategies:

- Provide a link to online and other screening tools through websites, such as the *It Only Takes One* website.
- Identify agencies doing screenings.
- Include information with regards to online screening services on the *It Only Takes One* website.

Survivors of suicide

Objective 3.11 By 2020, increase survivors of suicide's capacity to support those who have lost a loved one to suicide and the professionals who serve them.

Potential strategies:

- Promote national guidelines for providing education to family members and significant others of persons receiving care for treatment of mental health and substance abuse disorders with risk of suicide.
- Train those who provide key services to suicide survivors to address their own exposure to suicide and the unique needs of suicide survivors.
 - *Potential audiences* – employees of general and mental hospitals, mental health clinics, and substance abuse treatment centers

Goal 4: Suicide is Everyone’s Business; It Only Takes One

Increase the awareness of the burden of suicide and how individuals and communities can be part of prevention efforts.

Mental health care as a critical part of health care

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| Objective 4.1 | By 2020, increase awareness about mental health services as a critical part of health care, and promote efforts to reduce the stigma associated with mental health services. |
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| Objective 4.2 | By 2020, implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services. |
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| Objective 4.3 | By 2021, increase the percentage of the public that views consumers of mental health, substance abuse, and suicide prevention services as pursuing fundamental care and treatment for overall health. |
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Partnering with media

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| Objective 4.4 | By 2020, increase the proportion of news reports on suicide that observe consensus reporting recommendations. |
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| Objective 4.5 | By 2021, encourage journalism schools to increase awareness to include guidance on the portrayal and reporting of mental illness, suicide, and suicidal behaviors in their curricula. |
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| Objective 4.6 | By 2021, inform suicide prevention advocates – both individuals and organizations – about the tools to generate media coverage and the skills to act as effective spokespeople.
Potential strategies: <ul style="list-style-type: none">• Promote the <i>Recommendations for Reporting on Suicide</i> developed by the American Foundation for Suicide Prevention.• Encourage communities to work with the media to generate momentum for suicide prevention policies.• Develop effective media outreach programs at the state and local level.• Encourage organizations to position themselves as a leader in suicide prevention. |
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Public awareness campaign and activities

Objective 4.8 By 2020, increase the capacity of health care providers to assist their patients in maintaining a continuum of care for individuals at risk for suicide.

Objective 4.9 By 2020, provide a resource base of suicide prevention information.

Objective 4.10 By 2020, suicide prevention stakeholders will host suicide prevention activities in communities.

Potential activities – conduct public information campaigns, convene forums; disseminate information through the Internet; recruit new groups and institutions to suicide prevention; establish community-level groups to implement the state plan; and conduct suicide prevention week activities, town hall meetings, and/or suicide prevention presentations.

Objective 4.11 By 2020, identify avenues to use public awareness and education campaigns to increase awareness of other suicide prevention activities and interventions.

Objective 4.12 By 2020, develop avenues to communicate and coordinate among entities responsible for suicide prevention.

Objective 4.13 By 2021, sustain public service awareness and collaboration activities in communities to decrease isolation, to increase neighbor-to-neighbor outreach, and to identify at-risk persons.

Objective 4.14 By 2020, develop public awareness messages for specific audience segments and describe the actions they can take to prevent suicidal behaviors.

Potential strategies:

- Develop issue papers for specific audiences.
 - Identify avenues to distribute information to special audience segments.
 - *Potential audiences* – mental health and social services personnel, clergy, law enforcement, school personnel, firefighters, service members, and veterans and their families
-

Objective 4.15 By 2020, ensure communities are aware of national and state activities so efforts are not duplicated.

Objective 4.16 By 2020, encourage entities to include suicide prevention information on their websites.

Reducing isolation

Objective 4.17 By 2020, increase awareness of policies and programs to foster social connectedness, especially those focused on reaching groups that may be the most isolated or marginalized.

Objective 4.18 By 2020, encourage connectedness at the individual, family, and community level to become as a means to decrease isolation

Potential strategies:

- Promote connectedness between individuals.
 - Recognize the importance of received or perceived social support, close and supportive interpersonal relationships, and the benefit of social integration.
- Promote connectedness of individuals and their families to community organizations.
 - Recognize relevant community organizations such as schools, universities, places of employment, community centers, churches or other religious, or spiritual organizations.
 - Address obstacles for persons and families to receive better access to formal healing resources (e.g. availability, accessibility, and quality of prevention and treatment resources).
- Promote connectedness among community organizations and social institutions.
 - Recognize that formal and informal screening strategies of suicide risk should have strong connections with agencies that can provide prevention and treatment service.

Objective 4.19 By 2020, increase the number of relatives, friends, neighbors, and members of the faith community who are trained in suicide prevention (e.g. gatekeeper training).

Objective 4.20 By 2020, host community-based advisory collaboration committees to address isolation and target rural areas.

Restricting access to means

Objective 4.21 By 2020, develop and initiate an advocacy campaign about the risks of suicide and preventing access to means of suicide.

Objective 4.22 By 2021, increase education of avenues to reduce access to lethal means among individuals with identified suicide risks.

Goal 5: Data Counts

Improve suicide-related data collection.

Data activities

Objective 5.1 By 2020, maintain and expand the Illinois Violent Death Reporting System statewide.

Objective 5.2 By 2020, encourage key stakeholders to expand Illinois' participation in the National Violent Death Reporting System.

Objective 5.3 By 2020, develop methodologies for conducting preliminary estimates of suicide rates and rapidly detecting meaningful changes in rates for specific demographic groups.

Objective 5.4 By 2021, develop a system to collect reliable data on suicide deaths occurring in health care settings.

Objective 5.5 By 2021, increase the proportion of hospitals, including emergency departments, that collect uniform and reliable data on suicidal behavior by coding external cause of injuries, utilizing the categories included in the International Classification of Diseases.

Objective 5.6 By 2021, increase the number of surveys that include questions on suicidal behavior.

Goal 6: Bank on Saving Lives

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

Sustainability activities

Objective 6.1 By 2021, identify potential sources of funding for suicide prevention strategies on an ongoing basis and over the long term.

Objective 6.2 By 2021, actively expand stakeholder's participation in suicide prevention advocacy efforts.

Objective 6.3 By 2021, annually assess current suicide prevention mandates and develop recommendations for enhancements as needed.

Sources

Objectives included in the strategic plan were the result of recommendations by alliance members, stakeholders and from the following sources:

- Illinois Department of Public Health (2007). *Illinois Suicide Prevention Strategic Plan*. Available at http://www.idph.state.il.us/about/chronic/Suicide_Prevention_Plan_Jan-08.pdf
- Suicide Prevention Action Network USA and Suicide Prevention Resource Center. *Guide to Engaging the Media in Suicide Prevention*. Available at http://www.sprc.org/library/media_guide.pdf
- Suicide Prevention Resource Center. *Suicide Prevention Basics*. Available at http://www.sprc.org/suicide_prev_basics/about_suicide.asp
- Suicide Prevention Resource Center and SPAN USA. David Litts, editor. *Charting the Future of Suicide Prevention: A 2012 Progress Review of the National Strategy and Recommendations for the Decade Ahead*. 2012. Newton, MA: Education Development Center, Inc. Available at: www.sprc.org
- Suicide Prevention Resource Center and SPAN USA. *Suicide Among American Indians/Alaska Natives*. Available at <http://www.sprc.org/library/ai.an.facts.pdf>.
- U.S. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. *Promoting Individual, Family, and Community Connectedness to Prevent Suicidal Behavior*. Atlanta, GA. Available at http://www.cdc.gov/violenceprevention/pdf/suicide_strategic_direction_full_version-a.pdf
- U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*. Washington, DC: HHS, September 2012.

Sponsored by

Illinois Department of Public Health

In collaboration with

Illinois Suicide Prevention Alliance and numerous suicide prevention stakeholders

Copies of this plan are available at

<http://dph.illinois.gov/topics-services/prevention-wellness/suicide-prevention>

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? Yes No
2. Has your state identified the need to develop new partnerships that you did not have in place? Yes No

If yes, with whom?

Illinois State Police will partner with DHS/DMH in providing school-based violence prevention education and programming.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

Through the leadership of the Governor's Office, the State is experiencing a new level of collaboration across State agencies. 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.

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. These teams have 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. It oversees the Medicaid Managed Care program in the State. Illinois Public Act 096-1501 (Medicaid Reform) required that a minimum of 50 percent of Medicaid clients be enrolled in coordinated care by 2015. Currently more than 85% of Medicaid clients are in Managed Care. This goal is being achieved through contracts with Coordinated Care Entities, Managed Care Community Networks, and Managed Care Organizations.

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.

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).⁶⁹

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

⁶⁹<https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf>

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.
 - a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?
 1. 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. During FY2019, the Council placed the Mental Health Block Grant on its Agenda at several meetings. The discussions included brief presentations by the DMH Block Grant Planning staff to encourage participation in developing the FY2020-FY2021 Application and Plan. These presentations included an orientation to the Block Grant Plan and its content, a focus on Needs Assessment, the determination of Priorities for the next two years, and review of the Preliminary Draft of the Plan. DMH Planners actively solicited input and Council members suggested data bases and studies that would provide information on service and population issues in Illinois, commented on current priorities and suggested others, and commented on the Preliminary Draft of the Plan.
 - a) Not Applicable to MHBG. DHS/DSUPR is responsible for planning, implementation, SUD treatment and recovery.
 - b) Although these topics have occasionally been raised and discussed by the Council members in meetings, the Council has not yet successfully integrated substance use issues into its work.
 - b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? Yes No
2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? Yes No
3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

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 over time 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.

Members of the IMHPAC participate in a variety of 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.

Please indicate areas of technical assistance needed related to this section.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.⁷⁰

⁷⁰There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Illinois Mental Health Planning and Advisory Council Minutes

January 10, 2019

Attendees from Council in Chicago:

Matt Perry, Margo Rothlisberger, Ron Melka, Amy Starin, Fred Friedman, Ray Connor, John Shustitzky, Meg Lewis, Tina Fogarty, Joan Lodge

Attendees from Council by Telephone:

Georgianne Broughton, Terry, Carmichael, Tanya Cooley, Andrea Cooke, Cindy Daxenbichler, Yasmin Diodonet, Thane Dykstra, Norwil Frial-Lopez, Sondra Frazier, AJ French, Joanne Furnas, Dennis Hopkins, Patty Johnstone, James Kellerman, Irwin Kerzner, Pearl Madlock, Janet Martin, Jennifer McGowan – Tomke, Orson Morrison, Irene O’Niell, Judy Rushton, Susan Schroeder, Christine Walker, Michael Wathen, Dr. Sidney Weissman, Sarah Wiemeyer

Attendees from the Council in Springfield:

John Fallon

Resource Personnel: Brock Dunlap, Diana, Knaebe, Lee Ann Reinert, Jennie Melton

Call to Order:

The Meeting was called to order by Margo Roethlisberger at 12:30 p.m. Attendance was recorded.

Approval of Minutes

Amy Starin moved to approve the Meeting Minutes from November 1, 2018, seconded by Ron Melka. Fred Friedman abstained. Two corrections were made, AJ French was present during the September 6, 2018 meeting. Also, during the Adult Inpatient discussion there was strong objections to developing more small group home institutional settings expressed by Council Members John Fallon, Fred Friedman and AJ French. Motion to approve the Meeting Minutes with revisions passed.

Division of Mental Health Report

- Lee Ann Reinert reported that the Council Members received notice that the Block Grant Annual Report has been published. Webcast and PDF versions were posted on the Open Meetings web page. Lee Ann requested questions and feedback from members. There was no feedback from anyone in Chicago. Michael Watson observed that it was difficult to follow without page numbers. Lee Ann stated that she would bring that issue to the appropriate person so that page numbers can be added. Some members had technical difficulty getting into the report. It was noted that members can go back in any time to view the report. Fred Friedman suggested that copies of all information that is sent out via email be available in the meeting room for those that are unable to print or access the internet.

Irwin Kerzner and Lee Ann Reinert met earlier in the day and have a suggestion on how to proceed with the 2020-2021 plan. Irwin suggested a strategy for the block grant that is due in September. At the next meeting they would like to get input from the members regarding some portions of the grant report. In April they will identify needs and in July a draft will be ready for discussion in July. Irwin suggested members go into the posting page where they can review the past year’s plan in the Needs Assessment section to get a reference as to the kinds of things that will be discussed in upcoming meetings with respect to the plan.

- Andrea Cooke asked Brock Dunlap what form to use for reimbursement. Brock explained that members of the council who participate to represent an individual who is not representing an agency have funding available for reimbursement for participation in the meeting and travel. Forms will be sent out via email. The treasurer, Tracy Hopkins will receive the requests, sign them and send them to DMH.

- Amy Starin asked what impact DMH is expecting with the pending changes in the Governor's office. Brock Dunlap stated that DMH has been in conversations with people on JB Pritsker's team and they are attuned to where things are with DMH.

IHFS Report: No Report

Strategic Planning Committee:

- John Shustitzky stated that he had hoped that there would be a draft to distribute today, however that is not the case. He believes the best approach will be to convene one final meeting by conference call adhering to the open meetings act with one agenda purpose. The purpose is to distribute a draft recommended strategic plan to the council for discussion and feedback. Once there is a plan the next step will be to assign tasks to members to put the plan into action. There were no questions.

Committee Reports:

• **Development Committee:**

- Development Committee minutes from 12/03/2018 were approved by the Council.
- Ron Melka held a new member orientation with 23 in attendance. The training covered bylaws, OMA training and Ethics training.
- Ron Melka reviewed the request for Joan Lodge to replace Mary Ann Abate. The request letter and resume were sent to all members. Ron gave a brief description of Ms. Lodge's experience and credentials. Ron strongly encouraged supporting her membership. Ron Melka motioned, seconded by Fred Freidman. Andrea Cooke stated concern that there is not enough representation on the council by consumers and peers. This sparked a long discussion. Andrea Cooke and AJ French would not like to replace Mary Ann Abate's position on the council until more consumers are added. Discussion regarding what defines a consumer and how to find consumers unfolded. It was decided after the debate that the bylaws would be referred to and if able, the roster would be revised to show the preference in identity for those that are consumers as well as providers. During the voting process, John Shustitzky motioned to table the vote. A vote was taken to table whether to vote on Joan's potential membership. 10 opposed and 17 in favor of tabling the vote until the next meeting. The vote is tabled until the next meeting.

• **Adult Inpatient Report:**

- Adult inpatient report was distributed to the council members prior to this meeting. Amy Starin brought up a concern she had about the tone of the first paragraph in the report. She pointed out a lot of generalities and would like to know what data there is supporting the summations. Andrea said the report is referring to reports from various agencies and that this topic will be added to the agenda for Child and Adolescent Committee. Adult inpatient committee meets on the third Monday of even months at 11am.

• **Justice Committee Report:**

- The justice committee met on 12/13/18 to discuss three points.
 1. The committee met to identify volunteers to serve on the Justice Committee. Anyone that would like to join, please contact AJ French.
 2. The committee established consistent committee dates – The meetings will be held on the first Thursday of every other month opposite the Council meetings. Time to be announced.
 3. The committee updated models of evaluations, dispositions and wellness recovery action plans about getting WRAP into the prisons.
- Notes from the meeting will be emailed to the members in the near future. The time of future meetings will be included in the notes that will be sent out. At the next meeting they will discuss the structure of the meetings and what works best.

Mandatory Meetings Reminder :

- Members were reminded to complete the mandatory trainings which include the one time OMA training, Ethics training and Sexual Harassment training once a year. It was noted that for those that have taken the OMA training there is a public list noting those that aren't in compliance with the trainings.

New Business:

- A motion to have a special meeting was made by AJ French, seconded by John Fallon. Too many people had left the meeting to have a vote as it was 2:43 p.m.
- Matt and Margo will do some research and invite the appropriate person from the new Governor's administration to attend the March meeting.

Public Comment: None

Adjournment

Motion to adjourn was made at 2:45 p.m. Motion Carried.

Next Meeting: Scheduled for March 7 – 12:30 p.m.

Respectfully Submitted,

Thane Dykstra
IMHPAC Secretary

Illinois Mental Health Planning and Advisory Council Minutes

March 7, 2019

Attendees from Council in Chicago:

Matt Perry, Margo Rothlisberger, Ron Melka, Amy Starin

Attendees from Council by Telephone:

Ray Connor, Andrea Cooke, Tanya Cooley, Thane Dykstra, John Fallon, Sondra Frazier, Norwil Frial-Lopez, Fred Friedman, Belinda Gunning, Dennis Hopkins, Tracy Hopkins, Patty Johnstone, James Kellerman, Irwin Kersner, Nanette Larson, Pearl Madlock, Janet Martin, Jennifer McGowen-Tomke, Irene O'Neill, Susan Schroeder, Sidney Weissman

Attendees from the Council in Springfield:

Lisa Betz, AJ French, Lee Ann Reinert, Ralph Schubert, Shirley Davis, Joan Lodge

Resource Personnel: Brock Dunlap, Diana, Knaebe,

Call to Order:

The Meeting was called to order by Margo Roethlisberger at 12:30 p.m. Attendance was recorded.

Approval of Minutes

Andrea Cooke asked to revise the January 10, 2019 minutes changing to 'inpatient facilities' rather than 'group home' in the Approval of Minutes section. Ron Melka moved to approve the minutes with the change, seconded by Amy Starin. Minutes have been approved with that change.

Division of Mental Health Report

- Brock Dunlap reported that Governor Pritzker gave his budget address and laid out more details. DMH will receive funding of two million dollars for the Williams program. They announced a discontinuation of the NAMI of Illinois grant. Recommendations were made for adjustments to increase minimum wage and creating changes in how agencies can manage. Members of the council expressed concerns about NAMI being discontinued. Amy Starin asked if there is a role in the council to stop the recommended discontinuation. Concerns were raised about funding for IMHPAC. Brock assured the council that IMHPAC is not in danger of losing funding for reimbursements.
- The Block Grant Report was discussed in particular, the Needs Assessment. Lee Ann talked about the challenge they are facing in attempting to do a Needs Assessment that is broad enough to show the state need for mental health services. Lee Ann pointed out that they are able to contact those already being served, leaving people that are in a broader area not assessed. Health Departments were suggested. Irwin Kerzner and Lee Ann Rienert requested that council members offer feedback as to how they can identify the needs of the state. A reminder email will be sent to members.
- Nanette Larson made people aware of CRSS training – Offering fundamentals training. An announcement went out in January for registration in February. A summer training notice went out today as a save the date. This is a different training than the fundamentals training.
- Lisa Betz spoke about CFPP credentials being reviewed by the Child and Adolescent Committee. Changes were wanted but they were not able to make them. John Fallon mentioned the cost of credentials and suggests that the council review whether they are too high. Scholarships are available. Fred Friedman suggested that a better job can be done with advertising the scholarship.

IHFS Report: No Report

Strategic Planning Committee:

- A draft of the strategic plan will go out by Monday. Thane will resend the strategic plan to all members.

Committee Reports:

• **Development Committee:**

- Ron Melka noted that the council has 46 members with more than 50% being consumers or people with personal experience. There are 9 membership slots left.
- An application for new member Shirley Davis was discussed. Ron Melka motioned and a second is not necessary for a vote. A vote was taken on membership without opposition. The motion carries and Shirley is welcomed into the council.
- Ron Melka recommended Joan Lodge for membership. Aj French inquired about the percentages of consumer/family and provider/other categories currently in the council. AJ requests a special meeting to further discuss how people are identifying themselves. After further discussion which included a review of the guidelines regarding council membership, Ron Melka motioned a vote for Joan Lodge's membership. Motion passed and a vote was taken. One member opposed and one abstained. All other members voted for Joan Lodge to become a member. The motion carries and Joan is welcomed into the council.
- AJ French requested a special meeting be held to discuss the purpose, history and categories of membership that all members will be invited to. A vote to have this special meeting was taken. Motion passed. Ron will send out an email with available dates for the special meeting. Note: The special meeting must be posted two days in advance and must be sent in for posting three days in advance.

• **Adult Inpatient Report:**

- Patty Johnstone presented for this meeting. Those in attendance were Dennis Hopkins, Andrea Cooke and Patty Johnstone.
- The committee discussed 16 bed facilities or smaller and plans such as Living Rooms as alternatives to the emergency room. A new initiative began looking at criteria for being admitted and funding for people to be seen within 48 hours including being seen by a psychiatrist. Diana Knabe stated that CMS allowed changes in IMD status if the person is enrolled in an MCO. The MCO will pay the state for the admission. The group is looking to exploring alternatives. Several options were noted by Diana Knabe.
- Westlake Hospital in Westlake is proposing to close. This will present a loss of 20-30 psych beds by June.

• **Justice Committee Report:**

- DMH applied for the Gain Center out of SAMHSA for tech assistant training for competency training. A two-day webinar training is scheduled for April 20th and May 1st. DMH is working with McClain, Champaign and Winnebago Counties.
- Illinois Department of Corrections reviewed the Women's Recovery Action Plan (WRAP).
- Tracy Hopkins expressed a desire to join the Justice Committee.

New Business:

- CRSS – Why they are selected and costs will be discussed during the next meeting.

Public Comment:

- Ron Melka for informational purpose mentioned ADA fellowships to develop people with disabilities. There will be an informational meeting on April 11th and symposiums in the fall. Ron will send the information on when it comes in.

Adjournment

Motion to adjourn was made at 2:40 p.m. Motion was seconded by AJ French. Motion Carried.

Next Meeting: Scheduled for May 2, 2019 – 12:30 p.m.

Respectfully Submitted,

Thane Dykstra
IMHPAC Secretary

Illinois Mental Health Planning and Advisory Council Minutes

May 2, 2019

Attendees from Council in Chicago:

Ray Connor, Stephanie Frank, Irwin Kerzner, Ron Melka, Matt Perry, Margo Rothlisberger, Amy Starin, Scott Noble, Julius Mercer

Attendees from Council by Telephone:

Lisa Betz, Georgianne Broughton, Terry Carmichael, Andrea Cooke, Thane Dykstra, Sondra Fraizer, Belinda Gunning, Dennis Hopkins, Tracy Hopkins, Patty Johnstone, James Kellerman, Nanette Larson, Pearl Madlock, Katie Mahoney, Jennifer McGowen-Tomke, Irene O'Neill, Susan Schroeder, Sidney Weissman, Sarah Wiemeyer

Attendees from the Council in Springfield:

Shirley Davis, AJ French, Lee Ann Reinert

Resource Personnel: Brock Dunlap, Diana Knaebe

Call to Order:

The Meeting was called to order by Margo Roethlisberger at 12:30 p.m. Attendance was recorded.

Approval of Minutes

Attendance and a correction to the mental health report were noted on the minutes from the meeting on March 7, 2019 while under review. John Fallon moved to accept the minutes with the corrections. Amy Starin seconded. The minutes were approved with corrections.

Division of Mental Health Report

- Brock Dunlap stated that appropriation hearings with the house and senate will occur. We are waiting for a proposal to go out to the governor's office. They are in a holding pattern.
- Concerns about Governor Pritzker to remove money from NAMI were communicated. A member of the council proposed that IMHPAC draft a letter to legislators regarding the loss of money that NAMI will face with the current budget proposal. AJ French would like the letter to remind the legislators that cuts occurring in the past add up to over \$600,000. Shirley Davis seconded the motion. A vote was taken on drafting the letter. No one opposed. Ray Connor, Stephanie Frank, Sarah Wiemeyer, Lee Ann Reinert and Sue Schroeder abstained. Motion carries. The letter will be drafted by AJ French and upon completion she will send it to the council co-chairs.
- Lee Ann Reinert distributed a draft of a portion of the block grant that was based on input from those that responded to the request. She noted that the structure is the same but input was incorporated into the 'Needs of Service' section. Lee Ann thanked members for their input. Any other input that members would like to provide should be sent in writing to Lee Ann and Irwin. The report was sent out last week and will be resent by Lee Ann Reinert.

IHFS Report:

- No Report
- Lee Ann will follow up with someone from HFS to try to facilitate their participation.

Strategic Planning Committee:

- A draft of the strategic plan was sent to members on March 25, 2019. Amy Starin read through the six major points in the plan. After questions were answered Amy Starin made a motion to approve the plan. Ray

Connor seconded the motion. No one opposed or abstained. The motion carries and the Strategic Plan has been finalized.

Committee Reports:

• **Development Committee:**

- Ron Melka addressed the report regarding membership categories. The roster has been adjusted after feedback from members with their choices. Ron pointed out that one year ago the Committee was grossly short of the 45 members required. The committee now has more than 45 members and continues to grow. The ratio of providers and members is within the requirements, currently, with 21 providers and 20 consumers with 3 more candidates identifying as consumers will be brought before the Committee today for approval.
- Applications for new membership were reviewed for Alice Kieft, Scott Noble and Julius Mercer. Alice being in a car accident recently was unable to attend however her membership application was reviewed with her membership taking effect when she is able to attend her first meeting. The Committee voted on Alice's membership. No one opposed. AJ French abstained. Motion carries.
- Scott Noble addressed the group and summarized his experience and qualifications. Ron motioned that Scott's membership be voted on. No one opposed. No one abstained. The motion carries. Scott was welcomed as a member.
- Julius Mercer addressed the group with his experience. Ron moved to vote on Julius' membership. A vote was conducted. No one opposed. No one abstained. The motion carries. Julius was welcomed as a member.
- It was noted that emergency recruitment had to be done because of the low numbers in membership. The bylaws call for a vote on new members every fall. Ron states that since membership is now compliant with the bylaws that any new recruits be recruited in the fall. Ron's and the Development Committee's work was appreciated by the group. AJ and Irwin were thanked for their assistance with recruiting members. The Child and Adolescent Committee is asking if anyone knows of parents that they can reach out to for membership in the committee. Ron will email names to Margo.
- Shirley requested an orientation for new members when they are recruited at off times. Ron will conduct an orientation for new members in addition to the annual orientation.

• **Adult Inpatient Report:**

- Andrea Cooke expressed concerns that the Adult Inpatient Committee reports are not being acted on, for instance, 16 bed inpatient facilities. The committee previously recommended that consideration be given to the creation of diversion centers with no response as of yet. There is a national movement recommending that we move away from crisis centers and alternatives to emergency rooms be researched. Andrea encourages members to look at other models.
- Lee Ann will provide a call-in number for members that would like to join the committee but are unable to attend in person. Adult Inpatient Committee meets on Mondays opposite the IMHPAC meetings at 11am. The co-chairs appoint members to the committee. Anyone interested should email Margo Rothlisberger and Matt Perry.
- The committee discussed the Living Room model. Sustainable funding is something that eludes the Living Room model. It was noted that anything within Living Room that is potentially fundable through Medicaid makes the state unable to provide a grant for them.

• **Justice Committee Report:**

- AJ French pointed out that in the last three meetings time is running out before the Justice Committee gets to speak. Marlo stated that the order of the agenda can be altered so that the Justice Committee has the time to speak.
- The Justice Committee is looking forward to interactions with other community entities. Wrap class at no cost to the state was offered but it was declined. This was a concern.
- AJ French expressed appreciation to people that have been helpful with the movement. Particular mention goes to Lee Ann Reinert and Sue Schroeder.

New Business:

- No new business.

Public Comment:

- No public comment.

Adjournment

Motion to adjourn was made at 2:48 p.m by Ray Connor. Motion was seconded by Andrea Cooke. Meeting adjourned.

Next Meeting: Scheduled for July 11, 2019 – 12:30 p.m.

Respectfully Submitted,

Thane Dykstra
IMHPAC Secretary

ILLINOIS MENTAL HEALTH PLANNING AND ADVISORY COUNCIL

**Co-Chairs: Matt Perry
Margo Roethlisberger**

AGENDA

July 11, 2019

Harris Building
100 S. Grand Avenue East
3rd Floor Executive Videoconference Room
Springfield, IL

IL Dept. of Human Services
Clinton Building
401 S. Clinton Street
7th Floor Executive Videoconference Room
Chicago, IL

Call to Order/Introductions	12:30
Approval of the Minutes	12:35
• March 7, 2019	
Division of Mental Health Report	12:40
Block Grant Report	
IHFS Report	1:00
Strategic Planning Committee	1:20
Committee Reports:	
• Development Committee Report	1:30
• Adult Inpatient Report	1:50
• Other Committee Reports	2:00
New Business	2:20
Public Comment	2:25
Adjournment	2:30

The call in number/access code/password for individuals unable to participate in person is:
Call in: 1-888-494-4032; Passcode: 156 317 4311

PLEASE NOTE: TIMES LISTED ARE APPROXIMATE. THE ORDER OF THE AGENDA ITEMS MAY CHANGE, AND THE MEETING MAY ADJOURN EARLIER THAN 2:30 PM IF ALL BUSINESS HAS BEEN CONDUCTED.

Revised 7/2/2019

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
 State Vocational Rehabilitation Agency
 State Criminal Justice Agency
 State Housing Agency
 State Social Services Agency
 State Health (MH) Agency.

Start Year: 2020 End Year: 2021

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Jeffrey Aranowski	State Employees	Illinois State Board of Education	100 W. Randolph St. Chicago IL, 60601 PH: 312-814-2734	jaranows@isbe.net
Cindy Backstein	Parents of children with SED/SUD		26 Amberley Road Springfield IL, 62712 PH: 217-498-8774	backstein@mchsi.com
John Brien	Family Members of Individuals in Recovery (to include family members of adults with SMI)		9726 S. Seeley Ave. Chicago IL, 60643 PH: 773-756-7789	johnbrien312@att.net
Georgianne Broughton	Providers	Community Resource Center	101 South Locust Centralia IL, 62801 PH: 618-533-1391 FX: 618-533-0012	gbroughton@crconline.info
Terry Carmichael	Others (Advocates who are not State employees or providers)	Community Behavioral Health Association (CBHA)	3085 Stevenson Drive Springfield IL, 62703 PH: 217-585-1600	tcarmichael@cbha.net
Ray Connor	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1218 N. Grove Oak Park IL, 60302 PH: 847-426-3692 FX: 847-649-8915	rayconnor@comcast.net
Andrea Cooke	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		11353 S.St. Lawrence Ave. Chicago IL, 60628 PH: 708-381-9088	amrcooke@gmail.com
Tanya Cooley	Family Members of Individuals in Recovery (to include family members of adults with SMI)		837 Louisa Street Iliopolis IL, 62539 PH: 217-414-2548	Tcooley1982@hotmail.com
Kelly Cunningham	State Employees	IL Department of Health & Family Services	201 S. Grand Avenue East Springfield IL, 62763 PH: 217-782-2570	kelly.cunningham@illinois.gov
Shirley J. Davis	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		502 West Park Plaza Mattoon IL, PH: 217-246-1034	Sdavis8966@hotmail.com
			114 Daddono Circle	

Cindy Daxenbichler	Parents of children with SED/SUD		Bloomington IL, 61701 PH: 309-642-1080	taurus463@gmail.com
Yasmin Diodonet	Providers	Association House of Chicago	2822 W. Dickens Ave Floor 1 Chicago IL, 60647 PH: 773-510-4599	y.diodonet@yahoo.com
Thane A. Dykstra	Providers	Trinity Services, Inc	301 Veterans Parkway New Lenox IL, 60451 PH: 815-485-6197	tdykstra@trinityservices.org
Cara Emrich	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		402 N. Ward Street Benton IL, 62812 PH: 618-513-9762	c.emrich.tigerlily@gmail.com
John Fallon	Others (Advocates who are not State employees or providers)	NAMI of Lake County	611 Westmoreland St. Waukegan IL, 60085 PH: 773-719-4601	john.fallon@csh.org
Stephanie Frank	State Employees	Division of Substance Use Prevention and Recovery	401 S. Clinton Street, Second Floor Chicago IL, 60607 PH: 312-814-6401	Stephanie.Frank@illinois.gov
Sondra Frazier	Parents of children with SED/SUD		6957 South Jeffery Blvd. Chicago IL, 60649-1521 PH: 773-324-6644	Slfrazier6@aol.com
A.J. French	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Gift of Voice	2735 E. Broadway, Suite B. Alton IL, 62002 PH: 618-792-2049	Aj.french@giftofvoice.com
Norwil Frial-Lopez	Providers	Turning Point Behavioral Health Care	8324 Skokie Blvd Skokie IL, 60077 PH: 847-933-0051 FX: 847-933-0057	nfrial@tpoint.org
Fred Friedman	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2442 N. Kilbourn Ave Chicago IL, 60639 PH: 773-661-6705	Fredfriedman1954@gmail.com
Joanne Furnas	Providers	Association for Individual Development	1630 Plum Street Aurora IL, 60506 PH: 630-844-2065	jfurnas@aidcares.org
Belinda Gunning	Providers	Behavioral Health Alternatives	20792 Rothe Road Jerseyville IL, 62052 PH: 618-372-8432	bgunning@bha-inc.org
Dennis Hopkins	Providers	Iroquois Mental Health Center	323 West Mulberry St. Watseka IL, 60970 PH: 815-432-5241	dhopkins@imhc.net
Tracy Hopkins	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1820 53rd Street Moline IL, 61265 PH: 309-779-3051	tracyhopkins@yahoo.com

Patricia Johnstone	Family Members of Individuals in Recovery (to include family members of adults with SMI)	NAMI DuPage	1302 Kingsbury Drive Hanover Park IL, PH: 630-479-1307	p.johnstone@namidupage.org
Kathleen Jones	Parents of children with SED/SUD		6831 N. Fox Point Drive Peoria IL, 61614 PH: 309-339-9211	Katiejoneslcs@gmail.com
James Kellerman	Providers	Call For Help, Inc.	208 North Cherry Hoffman IL, 62250 PH: 618-397-0968	jkellerman@callforhelpinc.org
Alice R. Kieft	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		771 St. Andrews Circle Rantoul IL, 61866 PH: 309-714-3252	arkieft@gmail.com
Nanette Larson	State Employees	DHS Division of Mental Health	200 S. 2nd Street, Suite 20 Pekin IL, 61554 PH: 309-346-2094	Nanette.Larson@illinois.gov
Meg Lewis	Others (Advocates who are not State employees or providers)	AFSCME	205 N. Michigan Ave, Room 2100 Chicago IL, 60601 PH: 312-641-6060 FX: 312-346-1016	Mlewis@afscme31.org
Joan Lodge	Providers	Rosecrance Ware Center	2704 North Main Street Rockford IL, 61103 PH: 815-520-9423	jlodge@rosecrance.org
Pearl Madlock	State Employees	Illinois Housing Development Authority	401 N. Michigan Avenue Chicago IL, 60611 PH: 312-836-5354 FX: 312-832-2191	pmadlock@ihda.org
Kate Mahoney	Others (Advocates who are not State employees or providers)	Chicago School of Professional Psychology	2538 GrossPoint Road Evanston IL, 60201 PH: 847-702-4126 (Cell)	kmahoney@thechicagoschool.edu
Janet Martin	Family Members of Individuals in Recovery (to include family members of adults with SMI)		104 Woodland Drive Georgetown IL, 61846 PH: 217-799-8324	martinjanetbob@gmail.com
Robin Dawn McGinnis	Providers	Infant Welfare Society of Chicago	3600 W. Fullerton Ave. Chicago IL, 60647 PH: 773-782-5018	mcginnis@infantwelfare.org
Jennifer McGowan -Tomke	Others (Advocates who are not State employees or providers)	NAMI of Chicago	1801 W. Warner Ave. Chicago IL, 60613 PH: 312-563-0445	jen@namichicago.org
Ronald R. Melka	Others (Advocates who are not State employees or providers)	Lyons Township Mental Health Commission	6404 Joliet Road, Suite 204 Countryside IL, 60525 PH: 708-352-2992 FX: 708-354-7212	rmelka@lyonsts.com

Julius Mercer	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		6956 N. Ashland Blvd. Chicago IL, 60626 PH: 763-793-8669	Juliusmercer6doc@gmail.com
Orson Morrison	Providers	DePaul University Family & Community Services	2219 N. Kenmore St. Chicago IL, 60614 PH: 773-325-7787	omorriso@depaul.edu
Scott Noble	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		5465 S. Everett St. Chicago IL, 60615 PH: 312-772-7984	Scottnoble88@gmail.com
Irene O'Neill	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		303 E. National St. West Chicago IL, 60185 PH: 630-606-8732	ioneill@dupagehealth.org
Gene Oulvey	State Employees	DHS Division of Rehabilitation Services	618 E. Washington St. 3rd Floor Springfield IL, 62794 PH: 217-720-9378 FX: 217-524-7549	Gene.Oulvey@illinois.gov
Matthew Perry	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1434 W. Summerdale Ave Chicago IL, 60640 PH: 847-910-2556	mperry374@gmail.com
Lee Ann Reinert	State Employees	DHS Division of Mental Health	600 E. Ash St. Building 500, 3rd Fl. South Springfield IL, 62703 PH: 217-782-0059	Lee.Reinert@illinois.gov
Margo Roethlisberger	Providers	Ada S. Mckinley Community Services	98 Chelsea Avenue Sugar Grove IL, 60554 PH: 630-466-5086	mroethlisberger@adasmckinley.org
Susan Schroeder	Providers	Stepping Stones of Rockford, Inc	706 N. Main Street Rockford IL, 61103 PH: 815-963-0683 FX: 815-963-6018	sschroeder@ssrinc.org
John Shustitsky	Others (Advocates who are not State employees or providers)		675 Rockefeller Road Lake Forest IL, 60045 PH: 847-482-1638	jwshust@gmail.com
Amy Starin	Family Members of Individuals in Recovery (to include family members of adults with SMI)		537 Gunderson Oak Park IL, 60304 PH: 773-296-2625	astarin@sbcglobal.net
Christine Walker	Parents of children with SED/SUD		399 Ridge Avenue Winnetka IL, 60093 PH: 847-446-6436	critique@sbcglobal.net
Michael Wathen	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3500 Blandford Ave New Lenox IL, 60451 PH: 309-287-5270	mbwathen@gmail.com
Sydney H Weissman, MD	Providers	Northwestern University	625 N. Michigan Ave Suite 1910 Chicago IL, 60611 PH: 312-751-1144	s-weissman2@northwestern.edu
			4331 Lincoln Hwy	

Sarah Wiemeyer	Providers	Sertoma Center, Inc.	Matteson IL, 60443 PH: 708-748-1951	swiemeyer@sertomacentre.org
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*Council members should be listed only once by type of membership and Agency/organization represented.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
Total Membership	52	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	12	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	6	
Parents of children with SED/SUD*	5	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	7	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	30	57.69%
State Employees	7	
Providers	15	
Vacancies	0	
Total State Employees & Providers	22	42.31%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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Footnotes:

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

[Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. § 300x-51\)](#) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

- a) Public meetings or hearings? Yes No
- b) Posting of the plan on the web for public comment? Yes No

If yes, provide URL:

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. (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 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.

- c) Other (e.g. public service announcements, print media) Yes No

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Footnotes: