FY 2020-FY2021
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT APPLICATION

ILLINOIS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH

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State Information

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

__X__ FY 2020-FY2021

STATE NAME: __ILLINOIS_____
DUNS #: ____067919071____Expiration: 3/28/20

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

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

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

FY 2020-21 MENTAL HEALTH BLOCK GRANT APPLICATION
EXECUTIVE SUMMARY

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

During FY2019 and continuing into FY2020-FY2021, the priorities of the DMH include: (1) Facilitation and coordination of an effective array of clinical and support services. (2) The provision of services in the least restrictive manner including screening and crisis services for individuals at risk of hospitalization that contribute to reducing the use of hospitalization and identification of individuals who are experiencing psychosis for the first time as a priority population for community-based services.(3) Advancement of the recovery vision including Wellness Recovery Action Planning, expansion of the scope and quality of consumer and family participation, and promotion of the utilization of the Certified Recovery Support Specialist (CRSS) credential. (4) Continuing development of System of Care concept and infrastructure for children, adolescents and their families in Illinois. (5) Enhancement of capacity for community living consistent with the Olmstead Decision, as stipulated in Implementation Plan of the Williams vs. Pritzker Consent Decree. (6) Partnership with state agencies and statewide organizations in initiatives which respond to ongoing consumer needs such as the criminal justice system, alcoholism and substance abuse services, vocational and employment services, housing opportunity, and services for military personnel. (7) Bi-directional Integration of Primary Health Care and Behavioral Health Care and the maximization of benefits to adults with SMI and children with SED through Affordable Care. (8) Continuing consultation and partnering with the state Medicaid agency, DHFS, the IDHS Community Health and Prevention Division (CHP) and the Illinois Children's Mental Health Partnership to address the behavioral health needs of women in pregnancy, single mothers with young children, and early childhood interventions. (9) Enhancement of collaborative efforts with state and local

partners to address the mental health needs of adults involved with the criminal justice system and youth in the juvenile justice system. (10) Advancements in the use of data to inform and guide decision-making. The FY2020-21 Plan has been organized to comply with the priorities and format established by the SAMHSA.

PLANNING STEP I

Framework for Planning-Assessment of the Mental Health Service System

Description/Overview of the State's Mental Health System

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

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

DMH contracts with approximately 204 community mental health agencies to provide community-based services. These contracted organizations provide mental health services funded principally under the Medicaid Rehabilitation Option, including psychiatry, psychotherapy, medications, psychosocial rehabilitation, and case management to individuals eligible for Medicaid. Some services are also funded through a capacity grant mechanism. DMH also operates seven state mental health hospitals and one treatment detention facility. In addition, DMH supports services provided through long term care facilities and in residential settings.

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

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

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

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

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

The Community-Based Mental Health Service System

Community services are considered the cornerstone of the mental health delivery system. Services provided and purchased by the DMH are geographically based. The DMH is geographically organized into five service regions. Through these regions, the DMH operates seven state hospitals and contracts with 204 community-based outpatient/rehabilitation provider agencies across the state. These Service Regions are responsible for planning, coordination and general oversight of mental health services,

assisting in developing the capacity and expertise of providers, and increasing the quality and the quantity of participation from persons who receive mental health services. Two regions are in the Chicago Metropolitan area and surrounding suburbs, and three regions cover the central, southern and metro-east southern (East St. Louis region) areas of the State.

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

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

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

Mental health services are purchased or delivered by many other state agencies and local mental health authorities in some areas of the state (including 708 boards, the City of

Chicago and other municipalities, and Cook County). Over the years, DMH has worked actively to establish and maintain relationships across these systems with the goal of integrating mental health services under its purview with the services provided or purchased by other agencies.

Description and Overview of Child and Adolescent Services

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

The Growth of Community-Based Services

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

The Illinois Mental Health Collaborative for Access and Choice

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

- Operating and Maintaining a Consumer Warm Line and a Consumer Family Care Line.
- Collaborating with DMH on the development and maintenance of an integrated Management Information System (MIS).

- Completion, dissemination, and posting of a variety of mental health reports, manuals, and handbooks, a consumer and family handbook, and a study guide for the CRSS credential.

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

Community Integration from Long Term Care

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

Collaborative Planning in Mental Health and Substance Abuse Prevention and Treatment

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

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

Strengths and Needs in the Service System

The consistent vision for mental health services in Illinois is a well-resourced and transformed mental health system that is person centered and community driven; that provides a continuum of culturally inclusive programs which are integrated and effective; a range of direct and support services (including prevention, early intervention, treatment and supports) that support healthy lifelong development through equal access and promote recovery and resilience**.** The fundamental belief (credo) is that:

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

-The expectation is recovery

-The individual is central

Accordingly, all children with a diagnosis of, or at risk for developing, an emotional disorder will have access to a family-driven, youth-guided, trauma-informed, culturally and linguistically competent, strengths-based system of care that supports optimal physical and mental health and social and emotional wellbeing. All adults with a diagnosis of, or at risk for developing, a mental illness will have access to a coordinated, integrated, well-funded mental health system that promotes recovery and social inclusion through timely access to prevention, treatment, and recovery support services. Illinois has a strong foundation on which to create a behavioral health system grounded in recovery and built on the premise that *mental health is essential to health*. With support at the highest levels, DMH and its partners in state government, communities, and the private sector engage in collaborative problem-solving to address identified gaps and emerging needs. In Child and Adolescent services, the emphasis is on resilience and evidence informed practice as components in the systemic transformation process. Specific system strengths and gaps are noted below.

SYSTEM STRENGTHS

A person-centered, recovery focus

Illinois emphasizes the concept of recovery for all individuals suffering with mental illnesses. The State has shown a commitment to a recovery-oriented system of care by developing and supporting positions within state leadership, in the regions, and at the direct service level for Certified Recovery Support Specialists (CRSS). CRSS staff, who have lived experience with mental illness, have a voice in directing policy, monitoring quality, and providing services to their peers.

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

Evidence-based practices are interventions for which there is consistent scientific evidence showing that, when implemented with fidelity to the model, individual outcomes improve. Evidence-informed practices refer to those practices determined by children, their families, and practitioners to be appropriate to the needs of the child and family, reflective of available research, and measurable with respect to meaningful outcomes.

Illinois has devoted resources to support the implementation and use of evidence-based practices for adults with mental illnesses in such areas as outreach, engagement and treatment (Assertive Community Treatment), housing (Permanent Supportive Housing), employment (Individual Placement Services), and recovery (Wellness Recovery Action

Planning). Dollars also have been allocated to support the implementation and measurement of evidence-informed practices with child-serving agencies.

A pledge to work together

Collaborative efforts across state agencies that support adults and/or children with mental health conditions abound. Examples include a collaborative effort between IDCFS, DMH, and IDHFS to provide crisis services to youth with serious emotional disturbances and the Jail Data Link program, which was developed by DMH to identify and coordinate services between county jails and mental health agencies for individuals with mental health needs. The behavioral health and law enforcement systems work together in problem-solving courts and on law enforcement Crisis Intervention Teams. Support for Illinois service members, veterans, and their families comes from a broad range of community, faith-based, and fraternal organizations, as well as elected officials and the general public. The Illinois Joining Forces Foundation has established nineteen Veterans Support Communities across the State for the purpose of local resource utilization that spans physical and behavioral healthcare, as well as broader social determinants of health for service members, veterans, and their families.

Transition to Managed Care

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

Coordination of Care

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

A focus on technology

Technology is increasingly being used to help drive both service provision and data collection and analysis. Telepsychiatry, e-prescribing, and other mobile and video tools are currently being used in limited capacities to make services accessible to Illinois residents with mental health needs who otherwise might not be served. Although Illinois behavioral health providers have exceeded the national average of 10 percent for implementation of EHRs, there is still much work to be done. (See the discussion of "gaps" below.)

SYSTEM WEAKNESSES

Fragmentation of Services

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

Insufficient resources

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

Workforce Challenges

Ultimately, behavioral health care is only as good as the workforce that provides it. Overall, the health care workforce in America is aging and insufficiently sized and trained to meet the growing demand for integrated physical and behavioral health care. Illinois has made strides in addressing the education of future behavioral health care workers through collaboration with some key universities on graduate and training programs in psychology and social work. The state also has advocated and developed employment for peers, family members, and veterans as service providers. However, there is an overall lack in Illinois, as elsewhere, of such specialists as child and adolescent psychiatrists, advanced practice nurses, physician assistants, and other behavioral health care workers. Workforce members need to be trained to provide trauma-informed, culturally competent services, especially to youth involved in the justice system and returning veterans. Recruitment and retention of a sufficient number of culturally competent/sensitive staff and those with the language proficiencies to meet the needs of the ethnic populations served is also an issue.

Assessing Needs in the Service System

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

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

- 14.2% of children in Illinois ages 3-17 years have received treatment and counseling from a mental health professional. An additional 2.1% were estimated to need to see a mental health professional but did not.

- Of those who received or needed mental health care, the Survey reported that 36% had a problem getting it, including 11.5% that "had a big problem getting it" (an estimated 41,314 children).
- In response to: "How often does this child's health insurance offer benefits or cover services that meet this child's mental health or behavioral needs, age 3-17years" the estimates are: 37.7% - Always, 24.8% - Usually, and 37.5%- Sometimes or Never.
- The Survey focuses ADD/ADHD as a Child Health issue and reports that 6.1% of Illinois children were estimated to have the condition in 2017 based on survey responses; 3.3% were rated as Mild by their parents and 2.8% as Moderate or Severe; 4.3% have the condition and are taking medication and 1.8% have the condition but are not taking medication for it. 3.2% of Illinois children (Pop. Est.=75,578) received behavioral treatment for ADD/ADHD.
- The Survey, under Family Health and Activities, reports the mental health status of 4% of fathers and 4.2% of mothers in Illinois as either Fair or Poor.

The 2017 SAMHSA Behavioral Health Barometer

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

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

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

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

past year serious thoughts of suicide was similar to the corresponding national annual average percentage.

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

Mental Health and Service Use-Mental Health Service Use Among Adults with Any Mental Illness (AMI):
In Illinois, an annual average of about 679,000 adults aged 18 or older with AMI (45.3% of all adults with AMI) from 2011 to 2015 received mental health services in the past year. From 2011 to 2015, Illinois's annual average of past year mental health service use among adults aged 18 or older with any mental illness (AMI) was similar to the corresponding national annual average percentage (42.9%).

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

Homeless Persons with Mental Illness
In reference to homeless persons in the State, the HUD Continuum of Care Homeless Assistance Programs Point -In Time Count completed on January 25, 2018 identified 2,352 persons as being Severely Mentally Ill. Of these, 1,225 were domiciled in Emergency Shelters, 547 were in Transitional Housing, and 580 were Unsheltered.

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

Comments by Council Members and Stakeholders:

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

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

FY 2020-FY2021 PLANNING TABLES

Plan Table 1-1 Design of Public Mental Health Services

1. Priority Area: **Continue to develop and improve the array of clinical and support services available for adults and children.**	2. Priority Type MENTAL HEALTH SERVICES
3. Population(s) SMI, SED	
4. 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.*	
5. Objective: Identify gaps in the delivery of community-based services based on the service array provided and geographic location.	
6. Strategies to attain the objective: • Through ongoing certification processes that include periodic review, monitoring, and recertifications 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.	
7. Annual Performance Indicators to measure goal success: **Indicator:** The State will utilize data to inform the development of and ongoing support for the publicly funded mental health system	
a) Baseline measurement (Initial data collected prior to and during SFY2020): FY2019 No system in place to do comprehensive analysis.	
b) First-year target/outcome measurement (Progress to end of SFY 2020): In FY2020 the State will develop a comprehensive data collection platform.	
c) Second-year target/outcome measurement (Final to end of SFY 2021): FY2021 the State will utilize the comprehensive data platform to identify potential gaps in the service areas.	
d) **Data source:** Information provided by entities seeking certification.	
e) **Description of data:** Geographic area by zip code; Service types provided; Ages served.	
f) **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.	

Plan Table 1-2 Integrated Care- PIPBHC Project (Promoting Integration of Primary and Behavioral Health Care in Illinois (PIPBHC-IL)

1. Priority Area #1: **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.**	2. Priority Type: MENTAL HEALTH SERVICES

3. Population(s) SMI, SED, Other
4. 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.*
5. 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.
6. 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.
7. Annual Performance Indicators to measure goal success: **Indicator: Number of clients receiving integrated treatment and support during the fiscal year.**

a) Baseline measurement (Initial data collected prior to and during SFY2020): **70 clients in initial 9-month period.**
b) First-year target/outcome measurement (Progress to end of SFY 2020): **220**
c) Second-year target/outcome measurement (Final to end of SFY 2021): **295** clients (Aggregate total served to end of FY2021= 515)
d) **Data source:** Provider Quarterly Reports
e) **Description of data:** Providers' reports of numbers served.
f) **Data issues/caveats that affect outcome measures**: None

7. Annual Performance Indicators to measure goal success: **(7-2) Number of staff persons trained and participating in the program each fiscal year.**
a) Baseline measurement (Initial data collected prior to and during SFY2020): N/A
b) First-year target/outcome measurement (Progress to end of SFY 2020): **40 staff**
c) Second-year target/outcome measurement (Final to end of SFY 2021): **TBD based on FY2020 data**
d) **Data source:** Quarterly report from each provider citing number of staff trained and carrying out PIPBHC-IL programming.
e) **Description of data:**
f) **Data issues/caveats that affect outcome measures**: None

7. Annual Performance Indicators to measure goal success: **(7-3) Number of collaborative meetings convened by DMH to review and discuss progress and issues in service integration and delivery, program evaluation, and client impact.**
a) Baseline measurement (Initial data collected prior to and during SFY2020): **3**
b) First-year target/outcome measurement (Progress to end of SFY 2020): **5 on-site meetings per year**
c) Second-year target/outcome measurement (Final to end of SFY 2021): **10 including fidelity reviews**
d) **Data source:** Records and minutes maintained by DMH Principal Investigators
e) **Description of data:** See Above
f) **Data issues/caveats that affect outcome measures**: None

7. Annual Performance Indicator to measure goal success: **(7-4) An annual written report will identify the most successful practices, achievements, and lessons learned during each year.**
a) Baseline measurement (Initial data collected prior to and during SFY2020): N/A
b) First-year target/outcome measurement (Progress to end of SFY 2020): **Annual Report completed, reviewed, submitted to SAMHSA, and filed.**
c) Second-year target/outcome measurement (Final to end of SFY 2021): **Annual Report completed, reviewed, submitted to SAMHSA, and filed.**
d) **Data source:** Providers' Quarterly Written reports submitted by the three partnering agencies and compiled into an Annual Report by DMH
e) **Description of data:** See Above
f) **Data issues/caveats that affect outcome measures**: None

Plan Table 1-3 Integrated Care: Integrated Health Home Model

1. Priority Area #2: **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.**	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s)-SMI, SED,	
4. Goal: *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.*	
5. Objective: Establish criteria for an Illinois Integrated Health Home model through collaborative work with DHFS	
6. Strategy: Provide consultation and technical assistance to DHFS in the planning and the implementation of the Illinois Integrated Health Homes model.	
7. Annual Performance Indicators to measure goal success: **Indicator: Number of consultations provided to DHFS by DMH administrative staff.**	
a) Baseline measurement (Initial data collected prior to and during SFY 2020): 1 Meeting	
b) First-year target/outcome measurement (Progress to end of SFY 2020): 12 Meetings	
c) Second-year target/outcome measurement (Final to end of SFY 2021): TBD	
d) Data source: Agendas, minutes, and notes collected and maintained by DMH administrative staff	
e) Description of data: See Above	
f) Data issues/caveats that affect outcome measures:	

Plan Table 1-4: FIRST.IL/MHBG FEP SET-ASIDE

1. Priority Area: **FEP Set-Aside: Implementation of FIRST IL Specialized Programming and Evidence – Based Services for persons experiencing First Episode Psychosis/Early Serious Mental Illness**	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s) SMI, SED, OTHER:	
4. Goal of the priority area: ***Sustain and expand the infrastructure for evidence-based clinical programs for persons with ESMI.***	
5. **Objective: Sustain 15 Coordinated Specialty Care teams currently in the State.**	
6. 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

7. Annual Performance Indicators to measure goal success:
Indicator #1: (a) Number of sites in the State with funded ESMI Programs.
(b) The total FEP Set-Aside expenditures by the State for each site

a) Baseline measurement (Initial data collected prior to and during SFY 2019): **15 funded sites at the end of SFY2018.**

b) First-year target/outcome measurement (Progress to end of SFY 2020) **15 Funded sites**

c) Second-year target/outcome measurement (Final to end of SFY 2021): **_15 Funded Sites**

d) Data source: The DMH contractual process for this initiative included specified goals, performance measures and performance standards for each participating provider. Data is collected from participating 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.

e) Description of data: The Enrollee Outcome Form lists all active sites in the State. Records of contracts and funding awards for each agency are maintained by the DMH Fiscal Office. Quarterly Report Performance Forms track Training, Module Advancement, and Employment and IPS/Supported Ed Involvement. Quarterly Expenditure Reports are also completed by our FEP Set-Aside agencies and provided to DMH.

f) Data issues/caveats that affect outcome measures: The full potential of the First.IL Program may be affected by federal restrictions on eligible diagnosis.

5. Objective #2: Improve and maintain quality of clinical services received by FIRST.IL clients

6. Strategies to obtain objective; (1) Continue training in key clinical approaches including CBT-p, Family Psychosocial Education (FPE), Case Management/Recovery Support Specialists, and ongoing technical assistance. (2) Provide advanced CBT-p training for experienced provider staff and team leaders to develop mentoring expertise and peer consultation. (3) Provide training events in Fidelity to the CSC model with follow-up consultation and supportive collaboration.

7. Indicators: Number of training events held each year to increase clinical competence and expertise in the delivery of ESMI services in FIRST.IL sites.

a) Baseline measurement (Initial data collected prior to and during SFY 2019): **12 key training events**

b) First-year target/outcome measurement (Progress to end of SFY 2020): 13

c) Second-year target/outcome measurement (Final to end of SFY 2021): 13

d) Data source: **Records of teleconference calls and attendance are maintained by statewide coordinators.**

e) Description of data: See Above
f) Data issues/caveats that affect outcome measures:

Objective #3 Increase number of FIRST.IL enrollees statewide.
Strategies to obtain the objective: • Expand outreach efforts and provide public information about FIRST.II. • Each FIRST.IL Site to achieve five Marketing and Outreach events per month • Each FIRST.IL Site will achieve a minimum of five new Enrollees per Fiscal Year.
Indicator #3: Number of clients meeting criteria for FIRST.IL enrolled in team services statewide.
a) Baseline measurement (Initial data collected prior to and during SFY 2019): **251**
b) First-year target/outcome measurement (Progress to end of SFY 2020): **300**
c) Second-year target/outcome measurement (Final to end of SFY 2021): **350**
d) Data source: **Enrollment data from each participating site aggregated by statewide coordinator retrieved from Enrollee Outcome Form at Baseline and every 6 months.**
e) Description of data: Number of persons meeting eligibility criteria for FEP program enrolled at each site. Minimum of 5 additional FEP Enrollees per Site Per year
f) Data issues/caveats that affect outcome measures: The full potential of the FIRST.IL Program may be affected by the federal restrictions on eligible diagnosis.

Plan Table 1-5: Evidence Based Practices-Individual Placement and Support (IPS)

1. Priority Area #2: **Promote Provision of Evidence Based and Evidence-Informed Practices**	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s) SMI, SED	
4. Goal of the priority area: ***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.***	
5. Objective: During FY2020 and FY2021, maintain and support the statewide implementation of Evidence Based Supportive Employment.	
6. Strategies to attain the objective: (1) During FY2020 and FY2021, continue the development of the state infrastructure required to support implementation and sustainability of IPS Evidence Based Supported Employment. (2) During FY2020 and FY2021, continue to develop the integration of physical and behavioral health with employment supports and peer support statewide. (3) By the end of FY 2021, through the provision of additional funding resources, continue the implementation of IPS Evidence Based Supportive Employment which targets an additional 350 consumers acquiring competitive employment in their local communities.	
7. Annual Performance Indicators to measure goal success: **Indicator: Number of consumers receiving supported employment in FY2020 and FY2021. (National Outcome Measure)**	
a) Baseline measurement (Initial data collected prior to and during SFY 2019): **3,413 individuals were served in SFY2018. Estimated for SFY2019= 3,194**	
b) First-year target/outcome measurement (Progress to end of SFY 2020): **3354**	
c) Second-year target/outcome measurement (Final to end of SFY 2021): **3514**	

Data source: Data for this indicator are generated through a special web-based database created specifically for the DMH SE initiative. Fidelity and outcomes data are submitted to the DMH SE coordinator.
e) **Description of data:** As always, DMH has developed specifications for reporting that DMH funded providers must use when submitting data.
f) **Data issues/caveats that affect outcome measures:** DMH only reports data for teams that have been found to exhibit fidelity to the evidenced based practice model. DMH is working to promote fidelity in all IPS agencies and thereby expand the database.

Plan Table 1-6: Evidence Based Practices: Assertive Community Treatment (ACT)

1. Priority Area #2: **Promote Provision of Evidence Based and Evidence-Informed Practices-Assertive Community Treatment (ACT)**	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s) SMI	
4. 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.*	
5. Objective 1: Continue to reach expected outcomes for individuals in need through provision of Assertive Community Treatment (ACT).	
6. Strategy to attain the objective: **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 decrees.**	
7. Annual Performance Indicators to measure goal success: **Indicator**: **Number of persons with SMI receiving Assertive Community Treatment in FY2020 and FY2021 (National Outcome Measure).**	
a) Baseline measurement (Initial data collected prior to and during SFY2019): **1,532**	
b) First-year target/outcome measurement (Progress to end of SFY 2020): **1,764**	
c) Second-year target/outcome measurement (Final to end of SFY 2021): **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.	
e) **Description of data:** Providers of ACT services submit monthly reports of team capacity to DMH, which is monitored for system sufficiency. This information is used as a basis for developing reports, analytic purposes, and is the basis for reporting the data used to populate the URS tables.	
f) **Data issues/caveats that affect outcome measures:** Most ACT Teams currently operate within areas where individuals are served through Managed Care Contracts. The claims data related to MCO funded care is currently not available to the State Mental Health Authority, and thus individual outcomes from ACT cannot be accurately measured at this time. Through the State's work on the HHS transformation, plans are underway to improve the interoperability of the data systems and it is believed that DMH will in the future be able to track outcomes of individuals.	

Plan Table 1-7 Recovery/Consumer Services

1. Priority Area: **Expansion of the scope of consumer and family participation through advancement of the recovery vision and family driven care.**	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s) SMI, SED OTHER:	
4. Goal of the priority area: *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.*	
5. Objective #1: Continue work to increase the number of Certified Recovery Support Specialists and to facilitate their deployment statewide.	
6. Strategies to attain the objective: **Strategy #1:** Support the role of Certified Recovery Support Specialists and their deployment statewide by hosting training for consumers and providers to help increase agencies' understanding of the role, value, function, and advantages of hiring CRSS professionals and by providing competency training events for individuals interested in the CRSS credential.	
7. Annual Performance Indicators to measure goal success: **Indicator #1:** **Number of training events held each year to increase stakeholder understanding of the CRSS credential and to increase competency in CRSS domains.**	
a) Baseline measurement (Initial data collected prior to and during SFY 2020: **Nine training events in FY2018; Nine targeted in FY2019. 12 actually completed.**	
b) First-year target/outcome measurement (Progress to end of SFY 2020): **12**	
c) Second-year target/outcome measurement (Final to end of SFY 2021): **12**	
d) Data source: **Document each training event and aggregate by year for comparison across years.**	
e) Description of data: Training agenda and attendance sheets documenting participation for each training event held.	
f) Data issues/caveats that affect outcome measures:	

5. **Objective #2: Increase the use and efficacy of the WRAP model**
6. **Strategy #2:** Enhance competency and encourage WRAP trained and certified facilitators to provide an increasing number of WRAP® classes in the State.
7. Annual Performance Indicators to measure goal success: **Indicator #2:** **(a) Number of WRAP Refresher trainings offered statewide each year** **(b) Number of WRAP participants each year**
a) Baseline measurement (Initial data collected prior to and during SFY2020: **20**
b) First-year target/outcome measurement (Progress to end of SFY2020): **20**
c) Second-year target/outcome measurement (Final to end of SFY 2021): **20**
d) Data source: Document each training event and aggregate by year for comparison across years.
e) Description of data: Training agenda and attendance sheets documenting participation for each training event held.
f) Data issues/caveats that affect outcome measures: None

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

Plan Table 1-8 Access Data/ Consumer Satisfaction Survey

1. Priority Area: **Use of Data for Planning-Consumer Satisfaction Surveys**	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s)-SMI, SED,	
4. Goal: ***Use Quantitative and qualitative data to assess access to care and perception of treatment outcomes to provide data for decision support***.	
5. Objective: Continue to improve and maintain quality data collection and reporting.	
6. Strategies: (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).	
7. Annual Performance Indicators to measure goal success: **Indicator #1:** **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**	
a) Baseline measurement (Initial data collected prior to and during SFY 2020): MHSIP Surveys were resumed in FY2018. On the adult Consumer Survey 83% of respondents reported positively about their satisfaction with services received and on the Youth Survey, 68% of parents-caregivers reported positively on their overall satisfaction with services.	
b) First-year target/outcome measurement (Progress to end of SFY 2020): **For Adults- 85% reporting positively. For Youth-70% of respondents reporting positively**.	
c) Second-year target/outcome measurement (Final to end of SFY 2021): **For Adults- 85% reporting positively. For Youth-70% of respondents reporting positively**	
d) 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.	
e) Description of data:	
f) Data issues/caveats that affect outcome measures:	

Plan Table 1-9 Justice

Priority Area: Maintain effective systems to serve the forensic needs of justice–involved consumers of services.	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s) SMI, SED, OTHER:	
4. Goal of the priority area: ***Maintain a system of care to address the mental health needs of consumers with criminal justice involvement.***	
5. Objective; Provide an alternative to incarceration for youth with SED and link them to community-based services that addresses their unique needs and strengths.	
6. Strategies to attain the objective: Maintain the Mental Health Juvenile Justice Initiative.	
7. Annual Performance Indicators to measure goal success: Indicator: **Number of youth served by the MHJJ Program statewide.**	
a) Baseline measurement (Initial data collected prior to and during SFY 2020): **In FY2019 789 youth were referred to the program and 618 were successfully linked to an agency for service.**	
b) First-year target/outcome measurement (Progress to end of SFY 2020): **500 youth linked**	
c) Second-year target/outcome measurement (Final to end of SFY 2021): **500 youth linked**	
d) Data source: MHJJ Program Data Base maintained internally by DMH oversight staff	
e) Description of data: Aggregate the number of youth receiving services from the Mental Health Juvenile Justice program across the year that will be compared to data from subsequent years.	
f) Data issues/caveats that affect outcome measures: None	

Table 1-10 Community Integration

1. Priority Area: **Advancement of Community Integration**	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s) SMI, SED, OTHER:	
4. Goal of the priority area: ***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.***	
-5. Objective: Transition up to 400 additional Williams Class Members annually before the sunset of the Consent Decree.	
6. Strategies to attain the objective: Through FY2020, and perhaps beyond, through the provision of open market rental units, and 24 hour supervised residential settings/Community Integrated Living Arrangements (CILA)implement transition of residents (Williams Class Members) from designated Specialized Mental Health Rehabilitation Facilities (SMHRFs) (statewide) 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.	
7. Annual Performance Indicators to measure goal success: **Indicator: Number of consumers who transition from long term institutional settings who access appropriate permanent supportive housing or other housing options. (National Outcome Measure)**	

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

Plan Table 1-11 Mental Health and the Military

1. Priority Area: **Coordination and facilitation of mental health services for Illinois Servicemembers, Veterans, and their Families (SMVF).**	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s) OTHER Service Members, Veterans, and their Families (SMVF) requiring mental health services:	
4. Goal of the priority area: ***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.***	
5. Objective #1: Sustain a coordinated system of care	
6. Strategies to attain the objective: a). Develop and maintain partnerships with the Department of Veterans Administration, the Illinois Departments of Veterans' Affairs (IDVA), and Military Affairs (IDMA), and other agencies and organizations meeting regularly to develop, establish and maintain a coordinated system of care. b). Develop an inventory of existing behavioral health system providers and services to provide a referral system. c). Build a coordinated crisis service intervention system between the VA and community providers, with special emphasis on suicide prevention.	
7. Annual Performance Indicators to measure goal success: **Indicator #1: The number of collaborative meetings attended by DMH staff representatives that have agendas aimed at identifying and accomplishing strategies for coordination of services.**	
a) Baseline measurement (Initial data collected prior to and during SFY2019): **By the end of FY2018, twelve collaborative meetings had been attended by DMH representatives that had agendas aimed at completing the behavioral health inventory and coordination of services.**	

Twelve (12) meetings were again attended in FY2019.
b) First-year target/outcome measurement (Progress to end of SFY 2020): **12**
c) Second-year target/outcome measurement (Final to end of SFY 2021): **12**
d) Data source: Meeting Minutes and records of DMH staff members assigned to this collaborative task.
e) Description of data: See Above.
f) Data issues/caveats that affect outcome measures: None.

Objective #2: Improve quality of community mental health services to servicemembers, veterans, and their families Improve quality of community mental health services to servicemembers, veterans, and their families
Strategy to obtain the objective: 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.
Indicator #2. **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.**
a) Baseline measurement (Initial data collected prior to and during SFY 2020): **N/A**
b) First-year target/outcome measurement (Progress to end of SFY 2020): **Four (4) Workshops**
c) Second-year target/outcome measurement (Final to end of SFY 2021): **Four (4) Workshops**
d) Data source: Calendar dates of these events and attendance records of each.
e) Description of data: See Above.
f) Data issues/caveats that affect outcome measures: None.

C. ENVIRONMENTAL FACTORS AND PLAN

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

Only Responses to Questions 1 and 2 below are Required

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

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

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. Currently it is difficult at times to extract information from managed care companies about 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); communimetric 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.

DMH/DSUPR Collaborative Efforts

Over the years, the SMHA, DHS/DMH and the SSA, DHS/DSUPR have co-located their Central Offices in both Chicago and Springfield, affording closer collaboration across the two divisions in policy and planning work. DHS/DMH requires a team member specializing in substance use services on every multi-disciplinary Assertive Community Treatment team and requires screening for substance use issues upon intake across its funded providers. DHS/DMH and DHS/DSUPR created a specialized crisis residential model for individuals with co-occurring mental illness and substance use disorders who

experienced a crisis that required 24-hour supervision and created a braided funding model to support this approach. Treatment funded by DHS/DSUPR in Illinois emphasizes services that are consumer-oriented, geographically accessible, comprehensive, bridging continuing care responsibilities between all levels of an integrated system of care.

Mental Health Parity in Illinois

In August 2011, the Governor signed the Illinois Behavioral Health Parity Law that brought state law into line with the federal MHPAEA requiring mental health coverage to be comparable with other physical health coverage. This law added addiction health care and autism health care to the definition of behavioral health care and is applicable to any plan of a small employer (with 2-50 employees) as well as larger employers required by federal law.

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

The Illinois Behavioral Health Parity Law:

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

In FY2017, DSUPR and DMH, participated extensively with the IL Dept of Insurance, DHFS, and others in the promotion of policies that will provide equity in behavioral health coverage.

Three pieces of legislation introduced early in CY2019 reflect continuing concerns about behavioral health parity and efforts to improve upon currently perceived inequities:

Senate Bill 1449 has passed and is awaiting the Governor's signature. It requires that the Department of Insurance form a task force to review the plans and policies for individual and group short-term and long-term disability income insurance issued and offered to individuals and employers to examine the use of such insurance for behavioral health conditions. The task force is to be comprised of experts in the disability income insurance industry, experts in the behavioral health conditions and treatment industry, members of the general public, and members of the General Assembly. The task force is required to submit findings and recommendations to the Governor and the General Assembly by December 31, 2020.

HB3473/SB35 is pending and requires that a group or individual policy of accident and health insurance or managed care plan shall provide coverage for the treatment of serious mental illnesses and serious emotional disturbances and that coverage shall include, but not be limited to, certain evidence-based and evidence-informed bundled treatment approaches. Payment for services performed under a treatment model shall be based on all the components of the treatment model combined, rather than for each separate service.

HB1462 proposes the creation of the Children's Mental Health Ombudsman Program Act for the purposes of advocating on behalf of children with mental health disorders, identifying barriers to effective mental health treatment and proposed solutions; monitoring and ensuring compliance with relevant statutes, regulations, rules, and policies pertaining to children's behavioral health services. It is still pending.

Additional questions in this section for which responses are requested but not required:

Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs	**YES**
and Medicaid	**YES**

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

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

At the request of DHFS, DMH is participating in collaborative efforts and provides subject expertise in the coordination of clinical services to persons with SMI and youth with SED.

6. Do the M/SUD providers screen and refer for: (Through the IMCANS)
Prevention and wellness education YES

a) Health risks such as:

ii) heart disease, - Yes
iii) hypertension- Yes
iv) high cholesterol - Yes
v) diabetes -Yes

b) Recovery supports- Yes

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? Yes

The IL Department of HealthCare and Family Services is currently working with its MCO's on the implementation of risk-based contracting.

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? YES

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.

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? See #7 and #8 above.

2. Health Disparities - REQUESTED

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

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

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

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

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, LGBT, and age?
a) Race Yes
b) Ethnicity Yes
c) Gender Yes
d) Sexual orientation No
e) Gender identity, No
f) Age? Yes

2) Does the state have a data-driven plan to address and reduce disparities in access, service use, and outcomes for the above subpopulation? No

3) Does the state have a plan to identify, address, and monitor linguistic disparities/language barriers? Yes

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? No

5) If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards? Yes (Attachment B of Contract Boilerplate)

6) Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? No

7) Does the state have any activities related to this section that you would like to highlight? None

3. Innovation in Purchasing Decisions - REQUESTED

Evidence Based Practices are emphasized in purchasing and policy decisions. DMH regional staff work closely with provider agencies and are responsible for tracking and disseminating information about Evidence Based Practices (EBPs). The provision of evidence-based supportive employment through the Individual Placement Services (IPS) model, Assertive Community Treatment (ACT), and Permanent Supportive Housing (PSH) are consistently tracked. DMH policy requires adherence to national fidelity standards for EBPs and purchasing decisions are largely made in reference to local needs and the capacity of provider agencies to provide services at the level of fidelity required. DMH has used information about EBPs and fidelity standards educationally in working with partner agencies, such as IDHFS, the State Medicaid agency, in revising the Illinois Medicaid Rule accordingly. Services are purchased either directly or indirectly to maintain the EBP or to build provider capacity to meet fidelity standards and increase service delivery. This year DMH is providing training events in fidelity to the Coordinated Specialty Care (CSC) model for FIRST.IL staff. This model has proven effective in treating persons with First Episode Psychosis and other ESMI conditions. State coordinators and consultants will provide follow-up consultations and set up ongoing supportive collaboration among staff to carry out fidelity reviews as a central strategy aimed at improving and maintaining the quality of clinical services received by FIRST.IL clients.

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

- Leadership support, including investment of human and financial resources.
- Use of available and credible data to identify better quality and monitor the impact of quality improvement interventions.
- Provider involvement in planning value-based purchasing.
- Gaining consensus on the use of accurate and reliable measures of quality.
- Quality measures focused on consumer outcomes and also on process issues and care
- Statewide teleconferences to educate consumers and empower them to select quality services
- Emphasis on quality as a priority across the entire state infrastructure.
- Ongoing assessment of the impact of purchasing decisions.

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (Required for MHBG)

The FIRST-IL Program (The 10% Set-Aside)

Planning and Initial Implementation

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

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

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

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

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

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

Agency	**Number of Referrals As of 6/27/2019**	**Number of Clients Enrolled As of 6/27/2019**
Advocate Illinois Masonic Behavioral Health Services, Chicago	58	34
Bridgeway MHC,	46	15
Centerstone	49	26
Chestnut Granite City	61	15
Chestnut Bloomington	11	4
Grand Prairie	88	21
Human Resources Development Institute	61	11
LifeLinks	35	2
Memorial Behavioral Health	65	12
Robert Young Mental Health Center	57	19
Trilogy	141	23
Thresholds – Chicago	88	25
Thresholds – Westmont	68	15
Transitions of Western Ill	13	8
Human Service Center of Peoria	29	13
TOTAL	**870**	**243**

Use of Set-Aside Funding

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

Set-Aside dollars are paid for:

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

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

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

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

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

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

- Working with participating providers to modify the treatment paradigm from a singular focus on agency services for persons with serious and continuous mental

illness to include the engagement of persons in acute distress and encountering mental illness for the first time in their lives.

- Assuring the financial support required for agencies to be able to sustain their programs and to serve those individuals who should be served but lack the resources to pay for their services.
- The three newest FIRST.IL Sites in Illinois have had very little experience in conducting the outreach and engagement activities that are required in the ESMI program. Adaptation and the development of skill in these areas takes significant time and slows down the implementation process. In the past year, these agencies have shown growth through active marketing and outreach and their enrollment numbers have increased.
- Coverage for CSC programming by private insurance has been problematic and only some ESMI services are being paid. In Illinois, current legislation is being considered aimed at improving and streamlining coverage by private insurance.

SAMHSA FY2020-2021 Questions:

1. **Does the state have policies for addressing early serious mental illness (ESMI)? Yes**

2. **Has the state implemented any evidence-based practices (EBPs) for those with ESMI? Yes**

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 (CSC) 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 –**

   CSC Team Leaders coordinate treatment and recovery supports

5. **Does the state collect data specifically related to ESMI? Yes**

6. **Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? Yes**

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 now 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 FFY2020 and FFY2021 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 area of technical assistance needed related to this section.

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

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

1. Does your state have policies related to person centered planning? Yes

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 resulting from 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 I 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.

6. Program Integrity-Required

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

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

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

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

DMH 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 respond to the following:

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**

2. **Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? Yes**

3. **Does the state have any activities related to this section that you would like to highlight? None**

7. Consultation with Tribes - Requested

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

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

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

AIHSC has identified three primary goals of service:

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

8. Primary Prevention-Required for Substance Abuse Only

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

9. Statutory Criteria for MHBG Required

Criterion I: The Comprehensive Community Based Mental Health System:

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

living with their children 18 years old or younger and relatives who are caring for children in place of their parents.

1. **Describe available services and resources 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.

Does your state provide the following services under comprehensive community-based mental health service systems?

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

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

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.

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.

Significant decreases of admissions in state hospitals are the result of attention to the issue of local area utilization of state hospital resources and continuity of care. A variety of strategies have resulted in a significant reduction in civil admissions to state hospitals. The reduction in admissions has allowed a reduction in the size of all facilities and closure of several with the concomitant increase in the provision of services in the community to persons who would otherwise have been hospitalized in state hospitals. To parallel the downsizing of state hospitals and fostering transition to the community, Illinois has developed a network of community mental health agencies covering all geographic areas of the State. These providers share the goal of providing the necessary basic services to maintain persons with serious mental illness in the least restrictive setting possible.

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

Criterion 2: Mental Health System Data Epidemiology

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

The "Prevalence and Access" Gap

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

<u>Adults</u>

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 532,236 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.

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 103,275 youth in Illinois with Serious Emotional Disturbance.

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

Target Population (A)	Statewide Prevalence (B)	Statewide Incidence (C)
Adults with SMI	**532,236**	**396,320**
Children with SED	**103,275**	**59,844**

Column B of the table is based on the most recent SAMHSA prevalence estimate received from SAMHSA on 9-11-2019 (after the Web-based submission).

Column C (as required) is the state's expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system

Criterion 3: Children's Services

- ✓ Collaboration with IDHS Divisions and state agencies to ensure continuity of care and service integration is a multifold strength of the DMH service delivery system for children and adolescents.
- ✓ The on-going collaboration with the Children's' Mental Health Partnership has been fruitful in providing the resources needed to advance several vitally needed initiatives including services to youth in transition, early intervention, and the promotion of Evidence Informed Practices.
- ✓ The statewide Mental Health Juvenile Justice (MHJJ) program brings services to youth in county detention centers across the State in collaboration with juvenile justice.

- ✓ Long-standing collaborations are in place with the DCFS, the ISBE and the DASA. The DMH has partnered with these agencies to implement the wraparound approach to the delivery of children's services as well as to provide or coordinate delivery of mental health services.

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

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

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.

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.

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, 994seniors 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

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 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.

10. Substance Use Disorder Treatment (SABG Only)

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

11. Quality Improvement Plan-Requested

The DMH Quality Improvement Mission and Vision has been described in previous applications. A description of the Division's Quality Improvement Mission and Vision as well as the mechanisms employed to assure quality is again described below.

Quality Improvement Mission and Vision
The core values and concepts of continuous quality improvement include continuous assessment of key activities with an eye toward improving processes and outcomes, consumer service and focus, decisions based on facts, data and analysis, employee involvement/empowerment and teamwork.

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

- Certification Reviews: Performed by the DHS Bureau of Accreditation, Licensure, and Certification (BALC). These reviews verify that the sites and services of providers are meeting standards for Medicaid certification. These reviews are performed at least every 3 years, more often if significant findings are discovered in an earlier review.

- Fidelity Reviews: A review by DHS/DMH providing feedback to providers on fidelity to specific service definitions, with the goal of ensuring that providers are maintaining fidelity and identifying areas that need improvement.

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

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

The Division has developed a number of state specific indicators and measures that are regularly monitored and reviewed. The National Outcome Measures have been incorporated into this process. Many of these indicators and measures are described in the priorities, goals and indicators section of this application.

12. Trauma-Requested

Currently DMH encourages providers to seek out education and training in the treatment of post-traumatic stress disorders, to provide trauma–informed care, and to develop appropriate screening tools and referral mechanisms. The Division values the trauma-informed care approach and takes every available opportunity to focus on it with community-based providers and staff in State Hospitals.

Trauma Initiatives

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

Service Members, Veterans, and their Families

Post -Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury(TBI) of returning veterans who have served under combat conditions has been a continuing concern in Illinois. DMH collaborates with the Illinois Departments of Veterans Affairs' and Military Affairs (National Guard and Air Guard), to coordinate and improve services for service members, veterans, and their families throughout the state. *Military personnel returning from the wars in Iraq and Afghanistan are at increased risk of traumatic brain injury, post-traumatic stress disorder, depression, anxiety and other mental health symptoms as well as new-onset heavy drinking, binge drinking and other alcohol-related problems. Anxiety, depression and engagement in high risk behaviors, such as substance use, are more likely among adolescents in families with a deployed parent than among similar adolescents in non-deployed families (Chandra et al., 2009) Given the increasing recovery needs among returning military personnel and their families, DMH and DSUPR have partnered with the Illinois National Guard and Illinois Department of Veterans Affairs in order to improve access to mental health services, alcohol and other drug treatment, and recovery support services among military personnel returning from deployment and their families.*

DMH has worked to establish and maintain veteran contacts to facilitate coordination of SMVF services and to continue Illinois relationships with the SAMHSA Service Members, Veterans, and their Families Technical Assistance Center. A Veterans' Care Management

Referral System and a Veterans' Warm Line have been created to help ensure veteran referrals are properly accommodated.

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

During FY2018-FY2019, efforts to build and maintain an effective system of care to meet the needs of service men and women, veterans, and their families has been ongoing. DMH continues to participate in collaborative meetings that have agendas aimed at maintaining partnerships with the Department of Veterans Administration, the Illinois Departments of Veterans' Affairs (IDVA), and Military Affairs (IDMA), and other agencies and organizations; completing the behavioral health inventory of existing providers; monitoring the ongoing coordination of services; and facilitating a coordinated system of care. Emphasis has been placed upon coordination of a crisis intervention system with a focus on suicide prevention. There is an ever-growing network of community providers in a collaborative system of care.

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

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

DMH has actively participated in the formation and implementation of the Illinois Joining Forces Initiative and was active in the legislative process that created the Illinois Joining Forces Foundation. Public Act 098-0986, which became effective on August18, 2014, created the Illinois Joining Forces Foundation, a not-for-profit foundation. Provisions in the law for incorporation, the appointment of a Board of Directors, and the collection of funds ensures the long-term sustainability of Illinois Joining Forces, now considered to be critically important for the support of the state's military and veteran communities.

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

Building Veteran Support Communities (VSC) throughout the state that can ensure access to Behavioral Health Services is a continuing process. So far 19 Veterans Support Communities have been initiated in the state and are at various stages of development. Illinois Joining Forces is the lead in addressing this initiative. DMH has been limited to providing subject expertise and support. Illinois Joining Forces, IDVA, IDHS/DMH and other community partners are working to get the VSC's up and running but the process has been slower than anticipated, especially in Greater Illinois.

At a minimum, VSC partners must have the capacity to service veterans in at least these six core functions:
Housing,
Employment
Financial Assistance
Education
Integrated Primary and Behavioral Healthcare
Women Veterans.

13. Criminal and Juvenile Justice-Requested

DMH Forensic Services oversees and coordinates the inpatient and outpatient placement of adults remanded by Illinois County Courts to the Department of Human Services under the Statutes finding them Unfit to Stand Trial (UST) (725 ILCS, 104 -16) and Not Guilty by Reason of Insanity (NGRI) (730 ILCS, 5/5-2-4). Inpatient services are provided at 5 state hospitals with secure forensic Units. In regards to non-mandated justice involved individuals with behavioral health needs, DMH has also been centrally involved in several key programs and initiatives that have impacted large numbers of justice involved individuals including the Jail Data Link Program, the Cook County Community Reintegration Initiative (CRC), the Veterans Reintegration Initiative (VRI), the Transformation Transfer Initiative, and the Illinois Mental Health Courts. DMH continues toward a more comprehensive and effective system of care and treatment that stresses best practices, recovery, diversion, and appropriate use of inpatient and community resources.

Individuals involved in the criminal and juvenile justice systems who qualify are currently being enrolled in Medicaid by both the Illinois Department of Corrections and the Illinois

Department of Juvenile Justice. Coordination with the criminal and juvenile justice system is ongoing and includes planning around diversion issues, support for mental health services in correctional facilities, and addressing the needs of individuals re-entering their communities.

Mental Health Courts: A key component of this mission is enhancement and development of Problem-Solving Courts through technical assistance, consultation, training, and information dissemination. The State of Illinois has 102 counties and, as of 2017, there were 60 counties with drug courts, 23 counties with mental health courts, and 15 counties with Veterans courts. Several counties have multiple courts or have multiple counties participating in one problem-solving court. In 2017, the State of Illinois had 106 problem solving courts including 63 drug courts, 26 mental health courts and 17 Veterans courts. Five counties were discussing the possibility of starting a veterans court and have received training and technical assistance from Illinois Center of Excellence for Behavioral Health and Justice on how to start a veterans court. The Center of Excellence lost its grant early in FY2019 which has resulted in the loss of tracking and training in the implementation of Problem-Solving courts.

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

Cook County has a network of seven courts are post adjudicatory probation mental health court programs which target felony non-violent offenses, many of which are felonies resulting from repetitive criminal activity. These courts facilitate compulsory medical, psychiatric and substance abuse treatment through a sentence of Mental Health Court Probation (usually 2 years) as an alternative to incarceration in the Illinois Department of Corrections. The probationer is required to comply with the recommendations by the Mental Health Treatment Court team which include participation in specified evaluations and treatment programs, compliance with medication prescriptions, reporting to probation

(weekly decreasing to monthly as ordered), appearing in Court as ordered, and participating in any vocational, educational or job training program as directed. These courts and other diversion initiatives are the results of effective partnerships and collaborations that includes consumers, family members of consumers, treatment providers, law enforcement and correction professionals, legal personnel and members of the judiciary. Working together, they help to integrate the effective elements of the mental health, substance use systems and criminal justice systems.

Interest in diverting persons with mental illness from the criminal justice system is continuing to grow but has been significantly hampered by the lack of funding and barriers to full cross-system collaboration. DMH has participated collaboratively in the development of the Misdemeanor Diversion Pilot Project in Cook County. Persons with mental illness arrested on misdemeanor charges are referred and linked to mental health services with court supervision and oversight. This pilot has been limited to one court in Cook County and several mental health treatment resources in the Chicago Area. It has been moderately successful in meeting the needs of approximately 20 individuals in the course of the past year and intervening in the path of their extended involvement in the criminal justice system. Three other counties in Illinois: McLean, Winnebago, and Champaign, were interested in developing a diversion system but only Mclean County has had the available resources and infrastructure to successfully carry out diversion activity. DMH is looking forward to the passage of Senate Bill 1188, submitted in the past year which will provide support and encouragement to counties to plan and implement diversion. The bill has garnered interest and is being actively considered in the Illinois General Assembly.

Mental Health Juvenile Justice (MHJJ) is a DHS funded initiative to help identify community services for minors who have severe mentally illnesses and are being released from juvenile detention centers. This project is overseen through the DHS/DMH Forensic Services Program. Whenever any court personnel (Judge, attorney, probation officer, detention center staff) refers a minor who is in detention, a liaison (a masters level clinician from a community agency), with parental consent, will assess that child. Should that child have a major mental illness (with psychotic or affective disorders), the liaison will work with the family to identify appropriate community services (using a wraparound model that includes mental health, medication, substance abuse, special education and public health services). Next, the liaison identifies funding sources. MHJJ is funded from the state general revenue funds. DHS provides funding to the community agencies, with most agencies receiving funding for one liaison. MHJJ began at seven pilot sites in 2000 and has expanded to all Juvenile Detention Centers in Illinois. Since FY2007, DHS has been funding liaisons in 21 community agencies servicing 34 counties. In addition MHJJ also funds juvenile justice mental health re-entry liaisons that provide linkage and case management for youths exiting Illinois Youth Centers in the Department of Juvenile Justice. Similar to the MHJJ model, the IYC liaison links youth to appropriate services in their home communities and provides ongoing monitoring for a period of six months. MHJJ is a simple model that can be expanded to these and other juvenile justice populations and is applicable in multiple settings (urban, suburban and rural) as it makes use of existing community services at no cost to the courts.

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

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

MHJJ continues to emphasize targeted outreach to, and education of, referral sources of minority youth with serious mental illnesses. As research has shown that an estimated 75% of children in the juvenile justice system have experienced traumatic victimization, the MHJJ program continues to guide agencies to be considerate of trauma informed practices in interacting with youth and in linking youth to trauma informed services.

14. Medication Assisted Treatment – Requested (SABG Only)

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

15. Crisis Services - Requested

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

reported in another section of the application, DMH staff collaborate constructively with DPH on the annual Illinois Suicide Plan.

Regarding crisis stabilization, several DMH funded providers have implemented living room models, and DMH also purchases crisis residential beds for those individuals requiring these services. DMH has also been a leader in terms of working with law enforcement entities around CIT and working with individuals with mental illnesses. NAMI Illinois has put into place family to family programs and has supported these activities over the years.

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

16. *Recovery-Required*

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.

However, a variety of initiatives that 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.

  - CRSS is the professional credential for individuals providing peer recovery support services in Illinois. It is a competency-based credential, managed by the Illinois Certification Board. In order to obtain the CRSS, individuals must complete:

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

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

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

As of the end of FY2019, 242 individuals with CRSS certification were active in the State, an increase of 9 more individuals since June 2018, and all were in good standing with the Illinois Certification Board (ICB). An additional 22 individuals were in the application process. This reflects a 39.9% increase in the number of CRSS certified individuals since July 2015 when 173 individuals with CRSS certification were reported active in the state. Information regarding this credential can be found at http://www.iaodapca.org/forms/crss/CRSS_Model.pdf

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

1. Introduction of CRSS Fundamentalist 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.

The link to the Recovery Support Services website is:

http://www.dhs.state.il.us/page.aspx?item=36696roduction

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
b) Required peer accreditation or certification? Yes
c) Block grant funding of recovery support services. 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

2.Does the state measure the impact of your consumer and recovery community outreach activity? No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state. Above

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

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 Fundamentalist 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.

17. Community Living and the Implementation of Olmstead - Requested

The Illinois Department of Human Services has been responsible for two Olmstead related consent decrees, Williams and Ligas, and currently has assumed responsibility for a third consent decree, Colbert, which was just transferred from the Illinois Department on Aging. These three consent decrees have comprised much of the focus and activity of Olmstead implementation in the State.

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

The *Williams vs. Rauner* Class Action lawsuit was filed in 2005 and settled in 2010. The suit targeted 4,500 residents of nursing facilities designated as Institutes for Mental Disease (IMD) in which more than 50% of the residents had a diagnosed mental illness. The suit contended that the State violated the rights of residents by not affording them opportunities to move from these settings to the community, specifically to their own leased held apartments. The Williams Implementation Plan may be accessed at: http://www.dhs.state.il.us/page.aspx?item=56446.

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

Colbert

On December 20, 2011, the State of Illinois entered into a Consent Decree, settling the Colbert vs. Rauner class action Lawsuit, first filed in 2007. Plaintiffs alleged that members of the class were unnecessarily segregated and institutionalized in nursing facilities, and that they were denied opportunity to live in appropriate community integrated settings where they could lead more independent and productive lives. The Colbert Consent Decree requires the State to provide Class Members with the necessary supports and services to allow them to live in the most integrated settings appropriate to their needs in community-based settings. Eligible Class Members must currently live in a nursing home located in Cook County, Illinois, and must be receiving or be eligible to receive Medicaid.

Ligas

On June 15, 2011, the State entered into a Consent Decree settling the Ligas v. Norwood lawsuit, filed on July 28, 2005 on behalf of individuals who were residing in private, state-funded facilities (Intermediate Care Facilities for Persons with Developmental Disabilities or ICFs/DD) of nine or more persons or who were at risk of being placed in such facilities. Plaintiffs sought placement in Community-Based Settings and receipt of Community-Based Services. The Consent Decree identifies two groups of of Class Members:

- Adult individuals in Illinois with developmental disabilities who qualify for Medicaid Waiver services, who reside in ICFs/DD with nine or more residents, who affirmatively request to receive Community-Based Services or placement in a Community-Based Setting.

- Adult individuals in Illinois with developmental disabilities who qualify for Medicaid Waiver services, who reside in a Family Home, who are in need of Community-Based Services or placement in a Community-Based Setting, who affirmatively request Community-Based Services or placement in a Community-Based Setting.

Housing

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

Permanent Supported Housing is provided in a manner consistent with the national standards for this evidence-based practice. The DMH Bridge Subsidy model provides

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

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

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

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

In FY2019, $32,908,200 in General Revenue funds were dedicated and spent to expand home and community-based services and other transitional costs associated with the implementation of the Consent Decree.

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

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

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

18. C&A Behavioral Health Services - Required

C&A SERVICES

The DMH Bureau of Child and Adolescent Services facilitates the delivery of the array of services for youth with SED and their families through the dissemination of knowledge, research, information, evidence-based practices, and data analytics. It has especially been active in the advancement of family driven care, the promotion of evidence informed practices, 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 HIPPAA, 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.

Does the State have any activities related to this section that you would like to highlight?

DMH C&A has developed Learning Collaboratives with provider agencies interested in applying for Federal Funding Opportunities when they are posted to prepare them with the tools for submitting successful applications. In FY2019, The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), was accepting applications for fiscal year (FY) 2019 Healthy Transitions: Improving Life Trajectories for Youth and Young Adults with Serious Mental Disorders Program grants (Short Title: Healthy Transitions). The purpose of this program is to: improve access to treatment and support services for youth and young adults, ages 16-25, who have a serious emotional disturbance (SED) or a serious mental illness (SMI). The expected outcome is improvement of emotional and behavioral health functioning so that this population of youth and young adults can maximize their potential to assume adult roles and responsibilities and lead full and productive lives. Upon learning the providers did not provide what was needed to write a competitive response DMH C&A decided to offer the interested entities the opportunity to participate in a Learning Collaborative to prepare them before the funding opportunity posted again, To determine content of the individual learning community sessions, a survey monkey was used to prioritize the

needs of the participants. and in the first sessions, topics would be based on the interest of the participants. DMH staff research the topics and prepare presentations that include pertinent resources.

To date, four Learning Collaborative sessions for providers have been held:
Session 1 was held on 5/14/19. The topic was Introductions and orientation to the Healthy Transitions Grant.
Session 2 was held on 6/11/19. The topic was Partnerships. Guidelines for School Community Partnerships, developed by IDHS/DMH, in collaboration with the Illinois Children's Mental Health Partnership, a tool kit that can be utilized in all types of partnerships, was presented and discussed.
Session 3 was held on 7/9/19. The topic was Developing the Role of the Youth Coordinator. "Language in the Youth Movement," was presented
Session 4 was held on 8/13/19. covering the Role of DMH in a Federal Grant, and discussion of the use of the grant funding and that the funding is for providing additional services that they currently do not provide – no "business as usual."
The series will end after five sessions and DMH C&A plans to use the lessons learned from the experience to repeat and expand this type of Learning Collaborative statewide.

Please respond to the following:

1. Does the state utilize a system of care approach to support: a) The recovery and resilience of children and youth with SED? Yes
b) The recovery and resilience of children and youth with SUD? Not Applicable

2. 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
a) Child welfare? Yes
b) Juvenile justice? Yes
c) Education? Yes

3. Does the state monitor its progress and effectiveness, around:
a) Service utilization? Yes
b) Costs? Yes
c) Outcomes for children and youth services? Yes

4. Does the state provide training in evidence-based: a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? Not Applicable
b) Mental health treatment and recovery services for children/adolescents and their families? Yes

5. Does the state have plans for transitioning children and youth receiving services:
a) to the adult M/SUD system? Yes
b) for youth in foster care? Yes

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

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

19. Suicide Prevention -Required

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 2008-2012and 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. As funding has not been available, suicide prevention efforts have largely been voluntary and collaborative.

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.

Please respond to the following:

1. Have you updated your state's suicide prevention plan in the last 2 years? Yes

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

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

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? Yes

5. Have you begun any targeted or statewide initiatives since the FFY 2018 - 2019 plan was submitted? No
If so, please describe the population targeted?

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

20. Support of State Partners (Required)

1. **Has your state added any new partners or partnerships since the last planning period? No**

2. **Has your state identified the need to develop new partnerships that you did not have in place? Yes**

   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. T**he 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 **DHS 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 the **DHS 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. Prizker 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.

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

Description of Role and Activities

The Illinois Mental Health Planning and Advisory Council (IMHPAC) advises the DMH on mental health issues. The Advisory Council currently is a body of 52 members, which includes consumers and representatives from public and private organizations that plan, operate, and advocate for mental health and support services for persons with serious mental illness. Established in 1992, the Advisory Council's participation in the analysis of Illinois' mental health system 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.

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.)
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-FY2021Application 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.

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.

Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? No
Although Substance Use, Prevention and Recovery have occasionally been raised and discussed by Council members in meetings, the Council has not yet successfully integrated substance use issues into its work.

Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? Yes

State Mental Health Planning Council Membership List
As of the IMHPAC Meeting on May 2, 2019
(Updated 9-26-19)

Table 11: List of Planning Council Members

Name	**Type of Membership**	**Agency /Organization Represented**	**Address, Phone, Fax & E-Mail**
Aranowski, Jeffrey	State Employees	Illinois State Board of Education	100 W. Randolph St. Suite 14-300 Chicago, IL 60601 (312) 814-2734 jaranows@isbe.net
Backstein, Cindy	Family Members of Children with SED.		26 Amberley Road Springfield, IL 62712 217-498-8774 backstein@mchsi.com
Brien, John	Family Member of Individual in Recovery		9726 S. Seeley Ave. Chicago, IL 60643 773-756-7789 Johnbrien312@att.net
Broughton, Geogianne	Provider	Community Resource Center	101 South Locust Centralia, IL 62801 618-533-1391 618-533-0012 (fax) gbroughton@crconline.info
Carmichael, Terry	Others (not state employees or providers)	Community Behavioral Health Association (CBHA)	3085 Stevenson Drive Springfield, IL 62703 217-585-1600 tcarmichael@cbha.net
Connor, Ray	Family Member of Individual in Recovery		1218 N. Grove Ave Oak Park, IL 60302 847-426-3692 847-649-8915(Fax) rayconnor@comcast.net
Cooke, Andrea	Individual in Recovery		11353 S. St. Lawrence Ave. Chicago, IL 60628 708-381-9088

Cooley, Tanya	Family Member of Individual in Recovery	Sojourn Shelter	amrcooke@gmail.com 837 Louisa St. Iliopolis, IL 62539 (217) 414-2548 TCooley1982@hotmail.com
Cunningham, Kelly	State Employee	Deputy Administrator, Division of Medical Programs IL Dept. of Healthcare and Family Services	201 S. Grand Avenue East Springfield, IL 62763 Office: 217-782-2570 Kelly.cunningham@illinois.gov
Davis, Shirley J.	Individual in Recovery		502 West Park Plaza Mattoon, IL (217) 246-1034 Sdavis8966@hotmail.com
Daxenbichler, Cindy	Family Members of Children with SED.		114 Daddono Circle Bloomington, IL 61701 309-642-1080 Taurus463@gmail.com cindy.daxenbichler.15xl@statefarm.com
Diodonet, Yasmin	Provider	Association House of Chicago	2822 W. Dickens Ave Flr 1 Chicago, Il 60647 773-510-4599 y.diodonet@yahoo.com
Dykstra, Thane A Council Secretary	Provider	Chief Executive Officer Trinity Services, Inc.	301 Veterans Parkway New Lenox, IL 60451 Office: 815/485-6197 tdykstra@trinityservices.org
Emrich, Cara	Individual in Recovery		402 N. Ward Street Benton, IL 62812 618-513-9762 c.emrich.tigerlily@gmail.com
Fallon, John	Other	Senior Program Manager Corporation for Supportive Housing	205 W. Randolph, 23rd Fl Chicago, IL 60606 Office:312-332-6690 ext 2821 Cell: 773-719-4601 john.fallon@csh.org
Frank, Stephanie	State Employee	Deputy Director of Planning, Performance Assessment, and Federal Projects DHS Div. of Substance Use Prevention and Recovery (SUPR)	401. S. Clinton, 2nd Floor Chicago, IL 60607 312-814-6401 Stephanie.Frank@illinois.gov
Frazier, Sondra	Family Members of Children with SED.		6957 South Jeffery Blvd. Chicago, IL 60649-1521 773-324-6644 Slfrazier6@aol.com

French, A.J	Individual in Recovery	Gift of Voice	2735 E. Broadway, Suite B Alton, IL 62002 618-792-2049 Aj.french@giftofvoice.com
Frial-Lopez, Norwil	Provider	Chief Clinical Officer Turning Point Behavioral Health Care Center	8324 Skokie Blvd. Skokie, IL 60077 O 847-933-0051 ext.461 F 847-933-0057 nfrial@tpoint.org
Friedman, Fred	Individual in Recovery		2442 N. Kilbourn Ave. 1st Floor Chicago, IL 60639 773-661-6705 Fredfriedman1954@gmail.com
Furnas, Joanne	Provider	Association for Individual Dev.	1630 Plum Street Aurora, IL 60506 630-966-4884 jfurnas@aidcares.org
Gunning, Belinda	Provider	Behavioral Health Alternatives	20792 Rothe Road Jerseyville, IL 62052 618-372-8432 bgunning@bha-inc.org
Hopkins, Dennis PsyD,	Provider	Iroquois Mental Health Center	323 West Mulberry Street Watseka, IL 60970 815-432-5241 dhopkins@imhc.net
Hopkins, Tracy Council Treasurer	Individual in Recovery		1820 53rd street Moline, IL 61265 309-779-3051 tracyyhopkins@yahoo.com or Tracy.Hopkins@unitypoint.org
Johnstone, Patricia	Family Member of Individual in Recovery	NAMI DuPage	1302 Kingsbury Dr., Unit D, Hanover Park, IL 630-479-1307 p.johnstone@namidupage.org
Jones, Kathleen (Katie)	Family Members of Children with SED.		6831 N. Fox Point Drive Peoria, IL 61614 309-339-9211 Katiejoneslcsw@gmail.com
Kellermann, James	Provider	Call For Help, Inc.	208 North Cherry Hoffman, IL 62250 618-292-9683 9400 Lebanon Road E. St Louis, IL 62203 618-397-0968 jkellermann@callforhelpinc.org

Kieft, Alice R.	Individual in Recovery		771 St. Andrews Cir Rantoul, Il 61866 309-714-3252 arkieft@gmail.com
Larson, Nanette	State Employees	Director of Consumer Services Development Division of Mental Health	200 S. 2nd St., Suite 20 Pekin, IL. 61554 309-346-2094 Ext. 407 Nanette.Larson@illinois.gov
Lewis, Meg	Others (Not State Employees or Providers)	Representative Labor Relations AFSCME	205 N. Michigan Av. Rm 2100 Chicago, IL 60601 312-641-6060 ext.4763 312-346-1016 (Fax) Mlewis@afscme31.org
Lodge, Joan	Provider	Administrator Adult Mental Health Services Rosecrance Ware Center	2704 North Main Street Rockford, IL 61103 815-520-9423 815-720-5029 (cell) jlodge@rosecrance.org
Madlock, Pearl	State Employees (Housing)	IL Housing Development Authority Office of Housing Coordination Services	401 North Michigan Avenue, Suite 900 Chicago, IL 60611 312-836-5354 312-832-2191 (Fax) pmadlock@ihda.org
Mahoney, Kate	Others (not state employees or providers)	Chicago School of Professional Psychology	2538 Gross Point Road Evanston, IL 60201 847-702-4126 (C) kmahoney@thechicagoschool.edu
Martin, Janet L	Family Member of Individual in Recovery		104 Woodland Drive Georgetown, IL 61846 217-799-8324 martinjanetbob@gmail.com robert.martin5709@att.net
McGinnis, Robin Dawn	Provider	CEO Infant Welfare Society of Chicago	3600 W. Fullerton Ave. Chicago, IL 60647 773-782-5018 mcginnisr@infantwelfare.org robindawnmcginnis@gmail.com
McGowan-Tomke, Jennifer	Others (not state employees or providers)	Associate Director, NAMI Chicago	1801 W. Warner Ave. Ste.202 Chicago, IL 60613 jen@namichicago.org
Melka, Ronald R. MPA	Others (not state employees or providers)	Lyons Township Mental Health Commission	6404 Joliet Road, Suite 204 Countryside, IL 60525 708-352-2992 708-354-7212 (FAX)

			rmelka@lyonsts.com 6956 N. Ashland Blvd. #407 Chicago, IL 60626 (763)793-8669 Juliusmercer6doc@gmail.com
Mercer, Julius	Individual in Recovery		
Morrison, Orson	Provider	Executive Director, DePaul Family & Community Service	2219 N. Kenmore St. Chicago, IL 60614 773-325-7787 omorriso@depaul.edu
Noble, Scott	Individual in Recovery		5465 S. Everett St. Chicago, IL 60615 (312) 772-7984 Scottnoble88@gmail.com
O'Neill, Irene	Individual in Recovery		303 E. National St West Chicago, IL 60185 630-606-8732 ioneill@dupagehealth.org or info@awakeningsproject.org
Oulvey, Gene	State Employees	Office of Rehabilitation Services (Vocational Rehabilitation)	618 E. Washington, 3rd Fl Springfield, IL 62794 217-720-9378 217-524-7549 (Fax) Gene.Oulvey@illinois.gov
Perry, Matthew Council Co-Chair	Individual in Recovery		1434 W Summerdale Ave Chicago, IL, 60640 847-910-2556 mperry374@gmail.com
Reinert, Lee Ann	State Employees	Deputy Director, Policy, Planning, and Innovation Division of Mental Health	600 E. Ash, Bldg 500, 3rd Fl S Springfield, IL 62703 O: 217-782-0059 FAX: 217-785-3066 Lee.Reinert@illinois.gov
Roethlisberger, Margo Council Co-Chair	Provider	Ada S. Mckinley Community Services	98 Chelsea Avenue Sugar Grove, IL 60554 (630) 466-5086 mroethlisberger@adasmckinley.org
Schroeder, Susan	Provider	Executive Director, Stepping Stones of Rockford,Inc.	706 N. Main Street Rockford, IL, 61103 815-963-0683 815-963-6018 (fax) 815-509-7645 (cell) sschroeder@ssrinc.org

Shustitzky, John	Other		675 Rockefeller Road Lake Forest, IL 60045 (708) 302-6920 (cell) (847) 482-1638 (home) jwshust@gmail.com
Starin, Amy	Family Member of Individual in Recovery		537 Gunderson Oak Park, IL 60304 (773) 296-2625 astarin@sbcglobal.net
Vacancy	State Employees	Illinois Department of Corrections	Criminal Justice Representative
Walker, Christine	Family Member of Child with SED.		399 Ridge Avenue Winnetka, IL 60093 847-446-6436 (Home) 847-338-1505 (Cell) critique@sbcglobal.net
Wathen, Michael	Individual in Recovery		3500 Blandford Ave New Lenox, IL 60451 309-287-5270 mbwathen@gmail.com
Weissman, Sydney H., MD	Provider	Clinical Professor of Psychiatry Feinberg School of Medicine Northwestern University	625 North Michigan Avenue Suite 1910 Chicago, IL 60611 312-751 1144 s-weissman2@northwestern.edu
Wiemeyer, Sarah	Provider	Sertoma Center, Inc.	4331 Lincoln Hwy Matteson, IL 60443 708-748-1951 ext. 420 swiemeyer@sertomacentre.org

Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP (As of 8/30/19)	**53***	
Individuals in Recovery (to include adults with SMI who are receiving or have received, mental health services)	**12**	
Family Members of Individuals in Recovery	**6**	
Parents of Children with SED	**5**	
Vacancies (Individuals & family members)	**0**	
Others (Advocates who are not state employees or providers)	**7**	
TOTAL Individuals in Recovery, Family Members & Others	**30**	**56.60%**
State Employees	**7**	
Providers	**15**	
Leading State Experts		
Federally Recognized Tribe Representatives		
Vacancies	**1**	
TOTAL State Employees & Providers	**23**	**43.40%**

22. Public Comment on the State Plan (Required)

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.

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? No
b) Posting of the plan on the web for public comment? Yes
Other? if yes, provide URL http://www.dhs.state.il.us/page.aspx?item=43686
c) Other (e.g. public service announcements, print media) No

ATTACHMENT A

SECTION C- 19:
Illinois Suicide Prevention Strategic Plan
Updated Goals and Objectives
2018-2021

Illinois Department of Public Health
January 2019