Illinois

UNIFORM APPLICATION
FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 08/31/2017 3.32.14 PM)

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

State Information

State Information

Plan Year

Start Year	2018
End Year	2019

State DUNS Number

Number	067919071
Expiration Date	

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

Agency Name	Illinois Department of Human Services
Organizational Unit	Division of Mental Health
Mailing Address	600 East Ash St Bldg 500, Floor 3
City	Springfield
Zip Code	62703

II. Contact Person for the Grantee of the Block Grant

First Name	Diana
Last Name	Knaebe
Agency Name	Illinois Dept. of Human Services/Division of Mental Health
Mailing Address	600 East Ash Street Bldg 500, Floor 3
City	Springfield
Zip Code	62703
Telephone	(217)782-5700
Fax	(217)785-3066
Email Address	Diana.Knaebe@Illinois.Gov

III. Expenditure Period

State Expenditure Period

From	
To	

IV. Date Submitted

Submission Date	8/31/2017 3:31:28 PM
Revision Date	

V. Contact Person Responsible for Application Submission

First Name	Lee Ann
Last Name	Reinert
Telephone	217-782-0059
Fax	217-785-3066
Email Address	Lee.Reinert@illinois.gov

Footnotes:

State Information

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

Fiscal Year 2018

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

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

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

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

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

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

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

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

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

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

Footnotes:

State Information

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

Fiscal Year 2018

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

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

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse, (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

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

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

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

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

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

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

Signature of CEO or Designee[1]: Diana L. Knaebe

Title: Director, IDHS - DMH

Date Signed: 08/29/2017

mm/dd/yyyy

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

Footnotes:

State Information

Disclosure of Lobbying Activities

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

Name

Title

Organization

Signature:

Date:

Footnotes:

Planning Steps

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

Narrative Question:

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

Footnotes:

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 serious mental illnesses and children/adolescents with 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 of the funding, the services provided in these diverse treatment settings are also supported by a variety of other sources.

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

- **Supportive housing.** Access to supportive housing has been a focus for several years and includes a service model, identified funding sources, and a referral network for those leaving long-term care settings. This investment in supportive housing demonstrates a commitment to helping individuals achieve their independent living goals, with community settings becoming the expected living situation for most adults who are diagnosed with serious mental illnesses.
- **Employment services.** To help individuals access and maintain employment, Illinois has adopted the Individual Placement and Support (IPS) model, an evidence-based practice for which there is robust data indicating success. With the support of both DMH and the IDHS Division of Rehabilitation Services, the IPS model has demonstrated a 63 percent successful

Federal Vocational Rehabilitation Rate (the percentage of people stably employed in a job of their choosing after 90 days), which is above the national average.

• **Recovery supports.** With input from individuals with lived experience in recovery, DMH provides innovative recovery services and supports, including Wellness Recovery Action Planning (WRAP), regional recovery conferences, monthly consumer education calls that discuss a wide range of recovery-oriented topics, three peer support "Living Room" sites, and Recovery Drop-In Centers.

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 five 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 charged with the responsibility for managing care, developing the capacity and expertise of providers, monitoring service provision and increasing the quality and the quantity of participation from persons who receive mental health services. Two regions are located in the Chicago Metropolitan area and surrounding suburbs, and three regions cover the central, southern and metro-east southern (East St. Louis region) areas of the State. Administratively, each Region has an Executive Director, a lead Clinical Director, a lead Recovery Services Development Specialist, and a Coordinator of Forensic Services.

The DMH continually seeks input from consumers, family members, advocates, and representatives of public and private organizations through the framework of the Illinois Mental Health Planning and Advisory Council (IMHPAC) to aid in planning efforts. The DMH uses emerging developments at the local, state and national levels as a basis for strategically setting statewide parameters and goals, with the 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 abuse, 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 co-occurring Mental Illness and Substance Use 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 considered to be unfit to stand trial (UST) or not guilty by reason of insanity (NGRI). Inpatient services are provided at five state hospitals with secure forensic units. DMH also helps lead several programs to address other individuals with behavioral health needs in jails and prisons, including the Jail Data Link Program and other initiatives focused on recovery, diversion, reintegration, best practices, and the appropriate use of inpatient and community resources. Because of budgetary constraints, many community-based mental health services are available only if the individual has health benefits through private insurance, Medicaid, or Supplemental Security Income. These constraints also apply to individuals involved with the criminal justice and juvenile justice systems.

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

Description and Overview of Child and Adolescent Services

DMH's Child and Adolescent Services (C&A) serves children and adolescents with social, emotional, and behavioral disorders who depend on public funding, through a network of 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 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 Department of Public Health, 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. However, the State is currently in the midst of negotiating a the N.B. vs. Norwood lawsuit, which involves the collaboration of multiple child-serving systems, and will drastically reshape the child-serving system within Illinois, as well as expand the service array. The Bureau of Child and Adolescent Services is responsible for contracting activities with 157 child serving agencies which either provide specialized services or are community mental health centers with children's programming. The localized integration of a comprehensive care system including mental health, substance abuse, child welfare, juvenile justice, public health and education is within their purview.

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 illnesses has shifted from institutions to community-based settings. In FY1973, 8% of the DMH's budget was allocated for community services. Until recently, approximately 70% of DMH expenditures have been allocated for community-based services. However, due to continuing budget reductions, the balance between community based and state hospital expenditures has begun to shift. In FY2015, the DMH purchased community based services for 91,083 adults and 34,888 children and provided state hospital services for 5,371 individuals.

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.

Impact of the Economic Recession in Illinois

Illinois is on an annual budget cycle. The vast majority of individuals served in the Illinois public mental health system are unable to pay for their behavioral health care. They are either Medicaid–eligible or their services have been supported through DMH capacity grants. Beginning in FY2009, economic conditions in Illinois significantly deteriorated. Illinois experienced a loss of over $4.6 billion in revenues during FY2009 and FY2010, a steep decline of nearly 16%. In FY2011, with some relief in the economic recession, legislative intervention, and temporarily increased taxation, revenues increased by 21% over the FY2010 level to $29.7 billion but barely surpassed the revenues collected in FY2008. The Illinois Department of Employment Security (IDES) reported that the state's Unemployment Rate (Seasonally Adjusted) peaked in January 2010 at 11.4 (12.1 not seasonally adjusted). Comparatively, by calendar year, the Annual Average percentage of Unemployment rose significantly in CY2009 and CY2010 reflecting an increase in the average number of unemployed persons from 424,600 in CY2008 to 691,900 in CY2010. Since then the average number of unemployed persons has gradually decreased.

Although budget reductions occurred in FY2013, funding levels were maintained in FY2014 and FY2015 but the Governor's budget for FY2016 and FY2017 resulted in further decreases. Service benefit packages for the non-Medicaid eligible population were discontinued. DMH has made every effort to maintain essential mental health services for persons with the most serious mental illnesses through reallocation of existing funds. DMH has strongly encouraged providers to fully support and facilitate applications for individuals who qualify for Medicaid eligibility.

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 Money Follows the Person (MFP) initiative and 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 Alcohol and Substance Abuse (DASA) 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 DASA funded providers to

perform screening and assessment for consumers on-site, and to provide consultation to DMH staff regarding the substance abuse treatment needs of consumers when these services were warranted. This approach resulted in the development of more hospital staff training and expansion of the role of the DASA providers to perform linkage and engagement activities. It may be relevant to note that we still have co-location in some of our hospitals – primarily Madden & Read which consists of DASA-funded agencies being on-site for services such as (varies slightly by hospital):

- Consultation to team clinical staff on addiction illness – related issues pertinent to individuals being treated by a given team
- Evaluation of individuals' conditions and appropriate level of DASA service, if any (inpatient, intensive outpatient, etc…we can refer to the spectrum of DASA services; these services require evaluation by a CADC)
- Referrals and TA Service system consultation to discharge planners
- Targeted motivational interviewing

For people who need addiction treatment immediately, this co-location arrangement can result in timely admissions to residential treatment, when that's the appropriate level of care.

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, DASA 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.

PLANNING STEPS

1. Assessment of 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. In Child and Adolescent services, the emphasis is on resilience and evidence informed practice as components in the systemic transformation process. Many of the activities in which the DMH is engaged are providing the foundation to make this vision a reality even in an era of great fiscal challenge.

VALUES AND PRINCIPLES

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

• Services for individuals of all ages with mental health conditions are person centered, strengths based, trauma informed, and culturally competent. Services are founded on evidence-based, evidence-informed, best, and emerging promising practices.

• Services are flexible, tailored, and provided in the least restrictive setting appropriate to the individual's needs.

• Adults with mental illnesses are provided with the support they need to live in mainstream housing and have real jobs that pay a living wage.

• Children with emotional disorders have access to a broad, flexible array of effective community-based services and supports that are integrated at the system level and individualized to each child's and family's needs.

• The direct involvement of individuals with lived experience of mental illnesses, and of family members of children and adolescents with emotional disorders, guides the planning, provision, and monitoring of mental health services.

- Individuals with mental health conditions are served wherever and whenever they present for care ("no wrong door"). Family members of children and adolescents with behavioral health conditions and of active duty service members and veterans receive the help they request ("no wrong person").
- Services are integrated, to the greatest extent possible, across mental health and primary care settings. Coordination extends to adult- and child-serving systems, and to all systems that serve veterans and individuals currently or previously involved in the criminal or juvenile justice systems. Service members, veterans, and their families receive the help they need from practitioners working in organizations that are competent in military culture, and these individuals are served in the setting where they want to be served.

• Individuals involved with the criminal justice system are diverted to mental health treatment and services as appropriate to their situation and with regard for public safety.

• Outcomes are standardized and measured at the individual, provider, and service system level. Outcome data drive quality improvement efforts.

• The mental health workforce is sufficiently sized, appropriately trained, and properly credentialed.

• Funding for mental health services is appropriate to meet identified needs and priorities within state budgetary constraints. All additional sources of funding (federal, private, insurance, etc.) are maximized.

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

SYSTEM STRENGTHS

A person-centered, recovery focus

Illinois emphasizes the concept that individuals with mental illnesses are expected to recover. The state has shown a commitment to a recovery-oriented system of care by developing and supporting positions within state leadership, in the regions, and at the direct service level for Certified Recovery Support Specialists (CRSS). CRSS staff have a voice in directing policy, monitoring quality, and providing services to their peers. Certified Family Partnership Professionals provide family peer-to-peer support for families whose children have emotional and/or behavioral challenges. Additionally, NAMI-Illinois is a very active education and information resource for consumers and families in the State. NAMI Affiliates conduct Family-to-Family classes across the State, including classes specifically for veterans and their families; Peer to Peer classes, and NAMI Connection Recovery Support Groups. Family to Family is a free 12-week education course for family members and friends of individuals with mental illnesses taught by NAMI family members and covers information about illnesses of the brain and their treatment; coping skills; and advocacy. NAMI Illinois also initiated de Familia a Familia, the Spanish version of Family-to-Family. In Our Own Voice (IOOV) is also a NAMI-IL program in which individuals who have lived the experience of mental illness share their inspirational stories. During FY2015, 52 Family to Family Classes were held, 294 family members graduated, and 31 graduated from de Familia a Familia. There were also 30 In Our Own Voice (IOOV) presentations that reached an audience of 1326 individuals.

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, they improve individual outcomes. 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. Illinois has received several federal System of Care grants. Based on recent collaborative efforts on behalf of children and adolescents, Illinois is poised to create state-of-the-art services for children and families based on System of Care values, principles, and practices.

A pledge to work together

Collaborative efforts that support adults and children with mental health conditions abound. Examples include SASS (Screening, Assessment and Support Services), which is a collaborative effort between IDCFS, DMH, and IDHFS to provide crisis services to youth with serious emotional disturbances; the DMH Jail Data Link program, which was developed by DMH to identify and coordinate services between county jails and mental health agencies for individuals with mental health needs; and the Integrated Care Pilot and Care Coordination Effort projects that span multiple state agencies. The behavioral health and law enforcement systems work together in problem-solving courts and on law enforcement Crisis Intervention Teams. Support for Illinois service members, veterans, and their families comes from a broad range of community, faith-based, and fraternal organizations, as well as elected officials and the general public.

Transition to Managed Care

Managed Care has been implemented in Illinois in recent years and a substantial number of individuals are being served by MCOs outside of the SMHA system. It is anticipated that as the number served by MCOs grows, there will be a concomitant decrease in the numbers served in the SMHA public mental health system as has been the case in SFY2015 and FY2016.

In February 2017, Illinois Governor Bruce Rauner announced a reboot of the Illinois managed care system which began under former Governor Pat Quinn in 2011-12. About two million Illinois residents - nearly two-thirds of Illinois residents on Medicaid - are part of managed care plans. The new plan intends to extend managed care to approximately 85% of all Illinois residents. The managed care reboot also intends to shift managed care in Illinois to a more value based system with less managed care companies participating. Medicaid managed care expenditures are expected to total an estimated $10.8 billion in state and federal dollars between summer 2016 and summer 2017. Bidding under the new managed care RFP has been ongoing. See the RFP Website. (https://www.illinois.gov/hfs/info/MedicaidManagedCareRFP/Pages/default.aspx) Subsequent to discussions with the Illinois Medicaid Authority (IL Department of Healthcare and Family Services – HFS) the Division of Mental Health expects that the contracts for the new Illinois managed care companies will permit more data mining, as currently it can be difficult to extract from managed care companies various statistical measures that would be very useful for behavioral health policymaking in Illinois.

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. With establishment of the statewide Office of Health Information Technology (HIT), housed in the Governor's office, the state understands the need

to embrace the potential for HIT to improve health care quality and reduce costs. Although Illinois behavioral health providers have exceeded the national average of 10 percent for implementation of EHRs, there is still much work to be done. (See the discussion of "gaps" below.) However, under a grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA), the state has begun developing needed infrastructure to promote the exchange of health information among behavioral health and medical care providers.

Planning Steps

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

Narrative Question:

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

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

SAMHSA's Behavioral Health Barometer is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the National Survey of Substance Abuse Treatment Services (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the Behavioral Health Barometers. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the Healthy People Initiative[1] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

---

[1] http://www.healthypeople.gov/2020/default.aspx

Footnotes:

1. Unmet Service Needs

Several sources of data document the mental health services needs of individuals with mental illnesses residing in Illinois.

The SAMHSA Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010 to 2014 found that:

- In Illinois, about 363,000 adults (3.7% of all adults) per year in 2009–2014** had SMI within the year prior to being surveyed. In 2013-2014, Illinois' percentage of SMI among adults was lower than the national percentage of 4.2%.
- In the same period, 2010-2014, about 105,000 adolescents per year aged 12-17 (8.5% of all adolescents in the State) had at least one Major Depressive Episode (MDE) within the year prior to being surveyed. (The percentage increased over this period.) About 35,000 adolescents with MDE (38.2% of all adolescents with MDE) per year in 2010–2014 received treatment for their depression within the year prior to being surveyed.
- The survey also found that 44.6% of all adults with Any Mental Illness (AMI) received mental health treatment or counseling within the year prior to being surveyed. Illinois' percentage of mental health treatment among adults with AMI was similar to the national percentage in 2010–2014.
- Additionally, among adults served in Illinois' public mental health system in 2014, 57.6% of those aged 18–20, 41.8% of those aged 21–64, and 71.7% of those aged 65 or older were not in the labor force. Only 16.1% of all adults served were employed.

Overview of Behavioral Health in Illinois – The Section 1115 Waiver Application submitted to Centers for Medicare and Medicaid Services by the Illinois Department of Healthcare and Family Services on October 5, 2016

Illinois aspires to achieve nation-leading behavioral health outcomes, but today outcomes still vary widely. On some indicators, Illinois performs better than many of its state peers. For example, Illinois ranks 11th among states for rates of youth substance abuse or dependency problems (5.8%) and 14th for drug deaths per 100,000 (11.9). On other measures, the State performs below the national average. Illinois ranks 30th in mental health workforce availability with 844 people per mental health worker compared to the national median of 752 and the 25th percentile of 520. Illinois ranks 32nd and 31st in the nation in pre-term birth and violent crime rates, respectively, both of which have links to behavioral health. Lastly, Illinois ranks 41st in the nation in mental health service coverage for children, with just 45% of children who need services receiving them. Given the State's overall spending on the behavioral health population, these results demonstrate clear room for improvement.

** Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: Illinois, 2015*. HHS Publication No. SMA–15–4895IL. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

The Illinois behavioral health ecosystem is heavily reliant on deep-end, institutional care rather than upstream, community-based care. Approximately 40% of Illinois Medicaid behavioral health spend is dedicated to inpatient or residential care and utilization of state psychiatric hospitals per 1,000 residents is 44% higher than the national average. This stands in sharp contrast to utilization of lower-cost community care facilities, which is less than half the national average. This over-reliance on institutional care has significant implications for behavioral health members, who may experience additional stress due to removal from their communities and treatment in more restrictive institutional settings.

To understand what drives this high spend and poor outcomes, Illinois has conducted quantitative and qualitative analyses and sought extensive stakeholder input through dozens interviews, multiple town halls, and review of more than 200 written recommendations. In addition, to understand the behavioral health system from a member-centric perspective, the State devised 14 representative member archetypes. The archetypes reflect the diversity of Illinois' behavioral health population and illuminate the many clinical and non-clinical factors that can influence behavioral health outcomes. Through the member archetypes, quantitative and qualitative analyses, and stakeholder input, Illinois has identified six primary pain points the State must address to maximize the effectiveness of its behavioral health system:

1. Lack of coordination of behavioral health services
2. Challenges in identifying and accessing those with the greatest needs
3. Insufficient community behavioral health services capacity
4. Limited support services to address "whole-person" needs
5. Duplication and gaps in behavioral health services across agencies raise costs
6. Deficiencies in data, analytics, and transparency

It is believed that this behavioral health strategy, supported by the 1115 waiver, will have substantial impact on the lives of Medicaid members with behavioral health conditions by offering them a more comprehensive suite of services delivered in a way that is tailored more precisely to their needs and will result in a positive financial impact to the state and in federal savings over the life of the waiver. At the moment, however, Illinois' implementation of the system changing 1115 waiver awaits approval from CMS. For more information on the waiver, please see https://www.illinois.gov/hfs/info/1115Waiver/Pages/default.aspx).

An additional source of data that is indicative of the need for mental health services in Illinois is drawn from reports produced by the National Association of State Mental Health Directors Research Institute which uses DMH submitted and other state mental health data abstracted from the SAMHSA CMHS Uniform Reporting System. The 2014 draft multiyear Output Tables generated for Illinois reported the following community utilization rate per 1,000 population for Fiscal Years 2012 to FY 2014: 10.57 in FY 2012, 10.54 in FY2013 and 10.50 in FY2014. This compares to National average utilization rates of 21.67 in FY2012, 22.12 in FY2013 and 22.33 in FY2014. Although there are a number of factors that may account for lower utilization rates in Illinois including state policies, funding and other factors, Illinois overall mental health utilization rates are substantially lower than the National average.

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—is also a key weakness. Individuals and families must 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 come into contact with the criminal justice system for lack of more appropriate alternatives.

Insufficient resources

Reduced funding for behavioral health services also creates significant gaps in service. Between 2009 and 2012, Illinois experienced a large reduction in mental health funding. The reduction in funding was particularly pronounced for Illinois residents not eligible for Medicaid; in fact, the proposed FY2016 budget eliminates much of this funding. Illinois' decision to participate in the expansion of Medicaid under the Affordable Care Act may provide a safety net. However, overall lack of 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.

Lack of Consistent Data and Support for its Use

The inability to collect consistent data and to share this information across agencies affects the state's ability to plan for and provide comprehensive services to adults and children with mental health conditions. Many community-based agencies have neither the capacity nor the resources to implement electronic health records. Also, although state mental health hospitals worked with a national consulting firm several years ago to complete a requirements analysis for an EHR, no resources have been allocated to begin the process of developing or adopting one, an issue that may result in Illinois being out of compliance with federal regulations/requirements. Neither state nor federal funding has been allocated to support the development of electronic health records. Moreover, there is a lack of real-time access to statewide data to support strategic planning or system development efforts. Across agencies, redundancy and some duplication in data collection and lack of uniformity in data definitions inhibit collaboration.

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.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Continue to develop and improve the array of clinical and support services available for adults and children.

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Assure the clinical quality and effectiveness of community based mental health services available to adults and youth and assure the comprehensiveness of the public mental health service system design.

Objective:

Conduct ongoing evaluation of the quality and outcome of community-based services in Illinois.

Strategies to attain the objective:

• Identify, develop and establish outcome measures (indicators) for the evaluation of community services.
• Design a system to process the components and data of the evaluation.
• Implement the system.
• Analyze the resulting data to: (a) inform the publicly funded community service system; (b) facilitate decision making and planning; and (c) improve the quality and effectiveness of services and service delivery

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: a. Number of outcome measures ready for use by the end of each fiscal year. b. Percent of providers that demonstrate capacity to use the outcome measures in reporting.

Baseline Measurement: N/A

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

DMH Information System

Description of Data:

Registration data is submitted directly to the DMH information system which is operated by the DMH's Administrative Services Organization (ASO). Claims data, which is submitted to the state Medicaid agency Healthcare and Family Services (HFS), is returned to the ASO after processing where it is stored with registration information in the DMH data warehouse. This information is used as a basis for developing reports and for analytic purposes, and is the basis for reporting the data used to populate the majority of the URS tables. Data for specific outcome measures will be processed through this system.

Data issues/caveats that affect outcome measures::

None

Priority #: 2

Priority Area: Promote the provision of Evidence-Based and Evidence Informed Practices

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Promote Evidence Based Practices for individuals served in DMH funded agencies and advance the implementation of evidence-informed practices in the child and adolescent service system.

Objective:

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

Strategies to attain the objective:

Development of a set of outcome measures designed to assess the progress of individuals served.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of persons with Serious Mental Illness (SMI) who receive Assertive Community Treatment in FY2018 and FY2019 (national Outcome Measure)

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

DMH Funded providers by contract must submit demographic, clinical information and claims data for all individuals receiving services funded using DMH dollars. DMH provides data specifications to assure consistency of reporting.

Description of Data:

Providers of ACT services submit monthly reports of team capacity to DMH, which is monitored for system sufficiency. This information is used as a basis for developing reports and for analytic purposes, and is the basis for reporting the data used to populate the URS tables.

Data issues/caveats that affect outcome measures::

Most ACT Teams currently operate in areas where individuals are served through Managed Care Contracts. The claims data related to MCO funded care is currently not available to the SMHA, and thus individual outcomes from ACT cannot be accurately measured at this time. Through the State's work on the HHS transformation, plans are underway to improve the interoperability of the data systems and it is believed that DMH will in the future be able to track outcomes of individuals.

Priority #: 3

Priority Area: Promote the provision of Evidence-Based and Evidence Informed Practices - Individual Placement Services

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Promote Evidence-Based Supportive Employment for individuals served in the publicly funded mental health service system.

Objective:

During FY2018 and FY2019, maintain and support the statewide implementation of Evidence Based Supportive Employment.

Strategies to attain the objective:

Continue the development of the state infrastructure required to support implementation and sustainability of IPS Evidence Based Supportive Employment. Continue to develop the integration of physical and behavioral health with employment supports and peer support statewide. By the end of FY2019, contingent upon additional funding resources, target an additional 500 consumers to acquire competitive employment in their local communities.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of consumers receiving supported employment in FY2018 and FY2019 (National

Outcome Measure)

Baseline Measurement: In FY2017, 3003 consumers were served in 56 IPS sites with fidelity to the model and 183 in 6 sites working towards fidelity for a total of 3,275 consumers served.

First-year target/outcome measurement: To serve 3,375 consumers in IPS.

Second-year target/outcome measurement: To serve 3,775 consumers in IPS.

Data Source:

Data for this indicator are generated through a special web-based database created specifically for the DMH SE initiative. Fidelity and outcomes data are submitted to the DMH SE coordinator.

Description of Data:

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

Data issues/caveats that affect outcome measures::

DMH only reports data for teams that have been found to exhibit fidelity to the evidence based practice model. DMH is working to promote fidelity in all IPS agencies and thereby expand the database.

Priority #: 4

Priority Area: Use of the 10% Block Grant Set-Aside to implement specialized programming and Evidence-Based services for persons experiencing First Episode Psychosis.

Priority Type: MHS

Population(s): SMI, SED, ESMI

Goal of the priority area:

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

Objective:

Sustain the 12 FEP teams developed in FY2017 and contingent on available funding, identify a location to develop a new FEP team by the end of FY2019. Improve and maintain the quality of clinical services received by FEP clients. Increase the number of FEP enrollees.

Strategies to attain the objective:

Provide education, training, and ongoing consultation to staff involved in FEP programs that includes:
1. Strategies for outreach and community-based education to attract and retain clients who have recently begun to experience symptoms of psychosis.
2.Assessment and individualized treatment planning in the most supportive and least intrusive manner.
3. Psychiatric and medical treatment
4.Accessing employment through IPS programs, job retention, and smooth transitions in work life.
5. Supportive education.
6.Family and Individual Psycho education.
7. Counseling and Case Management
8. Cognitive Behavioral Therapy for Psychosis
9. Needs analyses of geographic areas to identify the best location for a new program.
Determine a provider's capacity and potential for success using the criteria for provider selection developed by the DMH FEP Workgroup.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of sites in the State with funded FEP programs and total FEP Set-Aside expenditures by the State for each site.

Baseline Measurement: 12 Funded sites

First-year target/outcome measurement: 12 Funded Sites

Second-year target/outcome measurement: 13 Funded Sites

Data Source:

The DMH contractual process for this initiative included specified goals, performance measures,and performance standards for each participating provider. Data is collected from FEP sites on an ongoing basis by statewide coordinators of the program using the Strengths-Barriers-Outcomes form which documents the program strengths, the Barriers encountered, and outcomes in terms of number of referrals and number of clients enrolled at each participating site.

Description of Data:

The Strengths-Barriers-Outcomes format 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 Education involvement. Quarterly Expenditure Reports are also completed by FEP agencies and provided to DMH.

Data issues/caveats that affect outcome measures::

The full potential of the FEP program may be affected by federal restrictions on eligible diagnoses.

Indicator #: 2

Indicator: 1. Number of training events held each fiscal year to increase knowledge and clinical competence and ,2. Number of technical assistance meetings and teleconferences conducted by the statewide coordinators.

Baseline Measurement: N/A -56 consultative meetings in 1st quarter of FY2017.

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

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

Description of Data:

See Above

Data issues/caveats that affect outcome measures::

None

Indicator #: 3

Indicator: Number of clients meeting criteria for FEP enrolled in team services statewide.

Baseline Measurement: N/A - 23 enrolled in 1st quarter of FY2017 -

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

Enrollment data from each participating site aggregated by statewide coordinator retrieved from the Outcome Review Form (ORF) at Baseline and every six months.

Description of Data:

Number of persons meeting eligibility criteria for the FEP program enrolled at each site during each fiscal year. Target is a minimum of five additional enrollees per site per year.

Data issues/caveats that affect outcome measures::

The full potential of the FEP Program may be impacted by the federal restrictions on eligible diagnosis.

Priority #: 5

Priority Area: Use of Data for Planning

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

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

Objective:

Continue to improve and maintain quality data collection and reporting.

Strategies to attain the objective:

Assess access to care by tracking the number of individuals who received treatment partitioned by race, gender, and age.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of adults and number of children /adolescents receiving services from DMH-funded community-based providers.

Baseline Measurement: 72,500

First-year target/outcome measurement: 72,500

Second-year target/outcome measurement: 72,000

Data Source:

DMH funded providers by contract must submit demographic, clinical information and claims data for all individuals receiving services funded using DMH dollars. The DMH provides data specifications to assure consistency of reporting.

Description of Data:

Registration data is submitted directly to the DMH information system which is operated by the DMH's Administrative Services Organization (ASO). Claims data, which is submitted to the state Medicaid agency Healthcare and Family Services (HFS), is returned to the ASO after processing where it is stored with registration information in the DMH data warehouse. This information is used as a basis for developing reports and for analytic purposes, and is the basis for reporting the data used to populate the majority of the URS tables

Data issues/caveats that affect outcome measures::

No access to MCO data.

Priority #: 6

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

Priority Type: MHS

Population(s): SMI, SED, Other (Criminal/Juvenile Justice)

Goal of the priority area:

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

Objective:

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

Strategies to attain the objective:

Maintain the Mental Health Juvenile Justice Initiative.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: 209 youth enrolled in FY2017.

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

MHJJ Program Data Base maintained internally by DMH oversight staff.

Description of Data:

Aggregate the number of youth receiving services from the Mental Health Juvenile Justice program across the year that will be compared to data from subsequent years.

Data issues/caveats that affect outcome measures::

None.

Priority #: 7

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

Priority Type: MHS

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

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 consumer-run wellness programs are increasingly utilized.

Objective:

1.Continue work to increase the number of Certified Recovery Support Specialists and to facilitate their deployment statewide.
2. Increase the use and efficacy of the WRAP model.
3. Develop and establish infrastructure for the introduction and implementation of Wellness Respite programs in Illinois.
4. Continue to inform and empower consumers and families.

Strategies to attain the objective:

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.
2. Enhance competency and encourage WRAP trained and certified facilitators to provide an increasing number of WRAP® classes in the State.
3. Provide educational events and technical assistance to encourage consumer participation and advocacy and provide public education to promote this model.
4. Conduct a series of statewide teleconferences designed to disseminate important information to adult consumers and families across the State.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures::

None.

Indicator #: 2

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

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures::

Indicator #: 3

Indicator: (a) Number of educational events and/or technical assistance appointments regarding Wellness Respite held each year. (b) Number of programs opened during the year.

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

Training agendas and attendance sheets documenting participation.

Description of Data:

Agendas for each event and attendance sheets.

Data issues/caveats that affect outcome measures::

None

Indicator #: 4

Indicator: Number of statewide teleconferences held each year and number of participants per conference call.

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

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

Description of Data:

Teleconference agendas

Data issues/caveats that affect outcome measures::

None

Priority #: 8

Priority Area: Lead in the development and implementation of statewide, unified, state –of –the-art Child and Adolescent Services to promote optimal social and emotional development for all children, adolescents, and young adults with behavioral health needs.

Priority Type: MHS

Population(s): SED, ESMI, Other (Adolescents w/SA and/or MH, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disablities, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Integrate a State of the Art Behavioral Health System in Illinois that ensures service delivery based on Systems of Care Values and Principles, family driven, and emphasizes services that are evidence-based.

Objective:

Objective #1: Identify and establish the most appropriate and best criteria for diagnostic assessment of children from birth through age five that should be consistently used by community child and adolescent mental health providers.
Objective #2: Identify policies and resources necessary to assist Child and Adolescent mental health providers in moving towards a value based purchasing system.
Objective #3: Develop a trauma informed credential for C&A mental health providers similar to the trauma credential that has been developed by the Department of Children and Family Services (DCFS).

Strategies to attain the objective:

Objective # 1: a. Review options and determine if a manual will be adopted for use across Illinois.
b. Develop/adopt a DSM 5-ICD 10 crosswalk for the diagnosis and billing codes.
c. Identify and implement changes to the DMH reporting system.
d. Collaborate with other systems that will be impacted by these changes.
e. Determine any training and technical assistance needed to implement the goals and objectives.
Objective #2: a. Review clinical outcomes tools that need to be added to the Datstat System to assist providers in measuring improved clinical outcomes for children, adolescents, and families.
b. Initiate and make the necessary changes to the Datstat System to incorporate the new tools.
c. Determine any training and technical assistance needed to assist providers in the utilization of the tools and understanding how to measure outcomes.
Objective #3: Review the current DCFS trauma credential and determine if it is consistent with the needs of the larger community based system.
b. Review what other states have adopted related to trauma informed credentials for providers.
c. Develop an Illinois specific trauma informed credential.
d. Determine any training and technical assistance needed to implement the credentialing process.
e. Develop an implementation plan.
f. Implement the plan.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: A set of diagnostic criteria for the assessment of children from Birth to age 5 is adopted and implemented by community providers by the end of SFY2019.

Baseline Measurement: N/A

First-year target/outcome measurement: A DSM 5-ICD10 crosswalk for the diagnosis and billing codes is drafted and adopted. (Contingent on the ICD10 being adopted).

Second-year target/outcome measurement: The set of diagnostic criteria has been piloted and is utilized by community providers.

Data Source:

Changes to the DMH registration system include new diagnosis and billing codes

Description of Data:

New ICD10 codes and diagnoses are in the system.

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: By the end of FY2019, the DATSTAT System will incorporate tools for measuring clinical outcomes that will enable C&A providers to be successful in a value based purchasing system

Baseline Measurement: N/A

First-year target/outcome measurement: A set of clinical outcomes tools that need to be added to the DATSTAT System to assist providers in measuring improved clinical outcomes for children, adolescents, and families is drafted and reviewed.

Second-year target/outcome measurement: Providers receive training and technical assistance in the utilization of the tools in measuring outcomes.

Data Source:

Changes to the DATSTAT system include operational outcome measure tools. Provider attendance in training sessions

Description of Data:

Attendance records of training and technical assistance sessions that support providers reporting usage of the outcome measures

Data issues/caveats that affect outcome measures::

Indicator #: 3

Indicator: By the end of FY2019, specified curriculum-based or evidence-based trauma-informed credentialing will be available in Illinois.

Baseline Measurement:

First-year target/outcome measurement: The written set of requirements, privileges, and applications of a trauma –informed credential is developed, drafted and adopted.

Second-year target/outcome measurement: The credentialing process is implemented as evidenced by the number of providers applying for the credential or having been successful in obtaining the certification.

Data Source:

The implementation plan for initializing the use of the credential.

Description of Data:

Documentation of completion of steps necessary to implement the new credential.

Data issues/caveats that affect outcome measures::

Priority #: 9

Priority Area: Advancement of Community Integration

Priority Type: MHS

Population(s): SMI, Other (Adolescents w/SA and/or MH, Rural, Persons with Disablities, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

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

Objective:

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

Strategies to attain the objective:

During FY 2018 and perhaps beyond, using a range of resources including the provision of open market units, rent subsidies, Permanent Supportive Housing (PSH), Cluster Housing PSH models, 24 hour supervised residential settings, and Community Integrated Living Arrangements (CILA), implement the transition of residents (Williams vs. Rauner Class Members) from the 24 designated Nursing Facilities (NF) (statewide) that are categorized as Institutes for Mental Disease (IMD) to permanent supportive housing or other housing alternatives that provide safe, affordable housing with support services in communities of preference and, in a manner consistent with the national standards for this evidence based supportive housing practice.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of consumers who transition from long term institutional settings/IMDs who access appropriate permanent supportive housing or other housing options. (National Outcome Measure).
Baseline Measurement:	The number of consumers to be transitioned by the end of SFY2017 - transition target number is 400. Note: 380 Class Members were transitioned as of June 30, 2017. Cumulative number of transitions: 2,052.
First-year target/outcome measurement:	400 additional consumers will be transitioned by the end of SFY2018.
Second-year target/outcome measurement:	To Be Determined. NOTE: The Williams vs. Rauner Consent Decree was originally slated to sunset in 2016. The activities of this Consent Decree continued through FY2017 and are budgeted for FY2018. Continuation after the FY2018 fiscal year will be dependent on negotiations between parties and the court decision.

Data Source:

Individuals who receive a permanent supportive housing/bridge subsidy are not required to be registered, enrolled or engaged in mental health treatment services. Therefore, it was necessary to create a special database to track access to and receipt of permanent supportive housing bridge subsidy.

Description of Data:

The data for this indicator will be generated from permanent supportive housing applications of individuals in longer term institutional settings which are stored in the special database, as well as a special PSH outcomes database.

Data issues/caveats that affect outcome measures::

Continuation after the FY2018 fiscal year will be dependent on negotiations between parties and the court decision.

Priority #:	10
Priority Area:	Coordination and facilitation of mental health services for Illinois Servicemembers, Veterans, and their Families (SMVF).
Priority Type:	MHS
Population(s):	Other (Military Families)

Goal of the priority area:

Collaborate with military and state agency partners to improve access to home and community-based mental health services for service members, veterans, and their families.

Objective:

Objective #1: Sustain a coordinated system of care.
Objective #2: Improve quality of community mental health services to servicemen, veterans, and their families.
Objective #3: Build Veteran Service Communities (VSC) throughout the state that can ensure access to Behavioral Health Services.

Strategies to attain the objective:

Objective #1- 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.

Objective #2- Educate and train community providers in military and veteran clinical cultural competence.
Objective #3-Build Veteran Service Communities (VSC) throughout the state that can ensure access to Behavioral Health Services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of collaborative meetings attended by DMH staff representatives that have agendas aimed at completing the strategies and coordination of services.

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

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

Description of Data:

See Above.

Data issues/caveats that affect outcome measures::

None

Indicator #: 2

Indicator: The number of Military and Veteran 101 Clinical Cultural Competency Workshops completed during the fiscal year and the total number of participants each year.

Baseline Measurement: N/A

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

Calendar dates of these events and attendance records of each.

Description of Data:

See Above.

Data issues/caveats that affect outcome measures::

None

Indicator #: 3

Indicator: (a) Number of Veterans Service Communities in the State with active Behavioral Health Services at end of each fiscal year. (b) An Annual Report that describes progress related to expanding the membership of the Behavioral Health Working Group (BHWG) of Illinois Joining Forces (IJF), maintaining a coordinated Crisis Service Intervention System that addresses SMVF needs, and increasing the number of Veteran Service Communities (VSC) throughout the state.

Baseline Measurement: N/A

First-year target/outcome measurement: At least 10 Veterans Service communities statewide with active behavioral health services and a report on the status of completing the behavioral health inventory, coordination of services, and the system of care for SMVF individuals that cites collaborative accomplishments during the fiscal year.

Second-year target/outcome measurement: At least 25 Veterans Service communities statewide with active behavioral health services and a report on the status of completing the behavioral health inventory, coordination of services, and the system of care for SMVF individuals that cites collaborative accomplishments by the end of FY2019..

Data Source:

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

Description of Data:

See Above

Data issues/caveats that affect outcome measures::

None

Priority #: 11

Priority Area: Contingent upon CMS approval of the Illinois Application for a Section 1115 Demonstration Waiver, enhance and improve service coordination through the establishment of Integrated Health Homes.

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Through the implementation of the plan cited in the DHFS application for the Section 1115 Waiver, develop and maintain care coordination by community mental health service agencies ensuring that persons with serious mental illness and their families can receive fully integrated and seamless services in their community.

Objective:

Assist community mental health providers to successfully meet Integrated Health Home certification requirements.

Strategies to attain the objective:

Provide education, focus, technical assistance, and consistent ongoing support for community mental health centers to become integrated health homes.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of community mental health providers meeting the requirements for certification as Integrated Health Homes.

Baseline Measurement: N/A

First-year target/outcome measurement: To be determined when the Waiver is approved and funding becomes available.

Second-year target/outcome measurement: To be determined after the program has begun and initial data becomes available.

Data Source:

TBD

Description of Data:

TBD

Data issues/caveats that affect outcome measures::

No access to DHFS and MCO service data.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention		$0	$0	$0	$0	$0	$0
a. Substance Abuse Primary Prevention							
b. Mental Health Primary*			$0	$0	$0	$0	$0
3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**		$1,497,218	$0	$0	$0	$0	$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			$0	$0	$0	$0	$0
7. Other 24 Hour Care		$14,223,572	$0	$0	$0	$0	$0
8. Ambulatory/Community Non-24 Hour Care		$0	$0	$0	$0	$0	$0
9. Administration (Excluding Program and Provider Level)		$748,609	$0	$0	$0	$0	$0
10. SubTotal (1,2,3,4,9)	$0	$748,609	$0	$0	$0	$0	$0
11. SubTotal (5,6,7,8)	$0	$15,720,790	$0	$0	$0	$0	$0
12. Total	$0	$16,469,399	$0	$0	$0	$0	$0

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

** Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside

Footnotes:

Planning Tables

Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems	$0			
2. Infrastructure Support	$0			
3. Partnerships, community outreach, and needs assessment	$0			
4. Planning Council Activities (MHBG required, SABG optional)	$0			
5. Quality Assurance and Improvement	$0			
6. Research and Evaluation	$0			
7. Training and Education	$0			
8. Total	$0	$0	$0	$0

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

Footnotes:

Environmental Factors and Plan

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

Narrative Question

1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[25] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[26] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[27]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[28] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[29] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[30]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[31] SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[32] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[33] Use of EHRs - in full compliance with applicable legal requirements ? may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[34] and ACOs[35] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[36] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[37]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[38] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[39] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who

experience health insurance coverage eligibility changes due to shifts in income and employment.[40] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[41] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[42] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

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

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[43] SAMHSA recognizes that certain jurisdictions receiving block grant funds ? including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[44] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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

[26] Research Review of Health Promotion Programs for People with SMI, 2012, http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper; About SAMHSA's Wellness Efforts, http://www.promoteacceptance.samhsa.gov/10by10/default.aspx; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, JAMA; 2007; 298: 1794-1796; Million Hearts, http://www.integration.samhsa.gov/health-wellness/samhsa-10x10; Schizophrenia as a health disparity, http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml

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

[28] Social Determinants of Health, Healthy People 2020, http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39; http://www.cdc.gov/socialdeterminants/Index.html

[29] http://www.samhsa.gov/health-disparities/strategic-initiatives

[30] http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/

[31] Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf; American Psychiatric Association, http://www.psych.org/practice/professional-interests/integrated-care; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, http://nasadad.org/nasadad-reports

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

[33] Health Information Technology (HIT), http://www.integration.samhsa.gov/operations-administration/hit; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361; Telebehavioral Health and Technical Assistance Series, http://www.integration.samhsa.gov/operations-administration/telebehavioral-health; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, http://www.americantelemed.org/docs/default-source/policy/ata-best-practice--telemental-and-behavioral-health.pdf?sfvrsn=8; National Telehealth Policy Resource Center, http://telehealthpolicy.us/medicaid; telemedicine, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html

[34] Health Homes, http://www.integration.samhsa.gov/integrated-care-models/health-homes

[35] New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx

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

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

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

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

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

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

[42] Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, http://annapoliscoalition.org/?portfolio=publications; Creating jobs by addressing primary care workforce needs, http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html

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

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

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

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

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

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

   1115 Waiver and Health and Human Services Transformation

   Illinois is one of the largest funders of health and human services (HHS) in the country. With $32 billion spent across its HHS agencies (including the DMH and HFS), amounting to more than 40% of its total budget, the State is deeply invested in the health and well-being of its 12.9 million residents and 3.2 million Medicaid members. There is an urgent need to get more from this

investment: the State must improve health outcomes for residents while slowing the growth of healthcare costs and putting the State on a more sustainable financial trajectory.
To this end, Illinois has embarked on a transformation of its HHS system. The transformation, which was announced by Governor Bruce Rauner in his 2016 State of the State address, “puts a strong new focus on prevention and public health; pays for value and outcomes rather than volume and services; makes evidence-based and data-driven decisions; and moves individuals from institutions to community care to keep them more closely connected with their families and communities.”

The HHS transformation seeks to improve population health, improve experience of care, and reduce costs. It is grounded in five themes:
• Prevention and population health
• Paying for value, quality, and outcomes
• Rebalancing from institutional to community care
• Data integration and predictive analytics
• Education and self sufficiency

The initial focus of the transformation effort is on behavioral health (mental health and substance use) and specifically the integration of behavioral and physical health service delivery. Behavioral health was chosen due to the urgency of the issue as well as the potential financial and human impact. Building a nation-leading behavioral health strategy will not only help bend the healthcare cost curve in Illinois but also help turn the tide of the opioid epidemic, reduce violent crime and violent encounters with police, and improve maternal and child health. There is also a large financial payoff in improving behavioral health: Medicaid members with behavioral health needs (referred to henceforth as “behavioral health members”) represent 25% of Illinois Medicaid members but account for 56% of all Medicaid spending

The focus on behavioral health has been informed by the State’s Healthy Illinois 2021 plan (http://www.healthycommunities.illinois.gov/), which encompasses the State Health Assessment (SHA), the State Innovation Model (SIM) grant awards, and the State Health Improvement Plan (SHIP). Together, these initiatives aim to align plans, processes, and resources to improve the health of Illinois residents. Illinois’ two State Innovation Model (SIM) design grant awards from the Center for Medicare and Medicaid Innovation - a Round One award in 2013 and a Round Two award in 2015 – helped the State to create focused and measurable health improvement strategies and identify behavioral health as a priority. Together, the SHA, SIM, and SHIP work have been foundational to the Illinois’ HHS transformation. Stakeholders have identified several priorities for transformation efforts, including the need to reduce the current siloes in behavioral health care to enable a more efficient system that emphasizes greater integration of physical and behavioral health. This Transformation process is designed to develop a primer Health and Human Service System in Illinois which functions across the life span. Many members of the facilitation team are involved in the process and have been working to ensure systems of care values and principles are embedded into the work.

The 1115 waiver application (See Above under Unmet Service Needs) is a critical component of a broader strategy to help achieve the above goals. The State has already started to integrate physical and behavioral health by carving-in behavioral health into the managed care system and developing a set of proposed State Plan Amendments (SPAs) that support integration. The waiver proposals in the application build on this work to lay the foundation for a truly integrated physical and behavioral health system, centered on members, their families, and their communities. The waiver proposals seek to test new ideas that catalyze innovation in integration and value-based payments. They also seek to test a combination of services that may have been pursued in isolation but promise to be more effective together, tailored more precisely to member needs.
The demonstration, as proposed, has six overarching goals:
1. Rebalance the behavioral health ecosystem, reducing overreliance on institutional care and shifting to community-based care
2. Promote integrated delivery of behavioral and physical health care for behavioral health members with high needs
3. Promote integration of behavioral health and primary care for behavioral health members with lower needs
4. Support development of robust and sustainable behavioral health services that provide both core and preventative care to ensure that members receive the full complement of high-quality treatment they need
5. Invest in support services to address the larger needs of behavioral health members, such as housing and employment services
6. Create an enabling environment to move behavioral health providers toward outcomes- and value-based payments

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

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

Additional activities in this arena are:
• The Williams vs. Quinn Settlement is resulting in an effort to provide optimum services to members of the class who are transitioning to the community from long term care and require primary health care and medical treatment.

• DMH continues to explore and emphasize options for more extensive collaboration with Health Resources and Services Administration (HRSA) funded Federally Qualified Health Centers (FQHCs) particularly in rural areas where the integration of services offers greater access for rural residents.
• DMH continues to emphasize the importance of assisting adult consumers in the completion of applications for Medicaid benefits as individuals with serious mental illnesses who are Medicaid recipients are entitled to the range of health services covered in the Illinois Medicaid plan.
Medicaid Expansion: Legislation enacted by the Illinois General Assembly and signed by the Governor in July 2013 expanded Medicaid coverage to persons below 138% of the Federal Poverty Level. Coverage became available to adults with annual income below 138 percent of the federal poverty line, which is $15,860 for individuals and $21,408 for couples. The measure was expected to enroll 342,000 people by 2017. Prior to this, Medicaid was only available to children, their parents or guardians, adults with disabilities or seniors. Enrollment for the newly eligible population began on October 1, 2013 with coverage starting on January 1, 2014
Integrated Care Program: DMH worked with DHFS to pilot an integrated managed care system which has been implemented in Suburban Cook County and adjacent counties in the Chicago Metropolitan Area (not including the City of Chicago) that includes behavioral health with primary health care. Medicaid AABD (aged, blind and disabled) recipients are being placed into a managed care arrangement with vendors who will be implementing a fully integrated service delivery system.

Care Coordination through Medicaid - The Innovations Project DMH also worked with DHFS on planning the Care Coordination Innovations Project which integrates primary health care and behavioral health. Public Act 96-1510 enacted in 2011, required that at least 50% of recipients eligible for comprehensive medical benefits in all medical assistance programs and other health benefit programs administered by the Department of Healthcare and Family Services (DHFS), be enrolled in a care coordination program by no later than January 1, 2015. The 50% goal was achieved by enrolling medical assistance enrollees from each medical assistance enrollment category, including parents, children, seniors, and people with disabilities. DMH has been working closely with DHFS to assure that the mental health components are properly addressed in carrying out the requirements of this legislation.

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

   The SMHA, DHS/DMH and the SSA, DHS/DASA 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/DASA created a specialized crisis residential model for individuals with co-occuring 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/DASA in Illinois emphasizes services that are consumer-oriented, geographically accessible, comprehensive, bridging continuing care responsibilities between all levels of an integrated system of care. DASA has contracted with Heartland Alliance to fund the Illinois Co-Occurring Center for Excellence (ICOCE) to provide training, technical assistance, and consultation to agencies that provide dual diagnosis treatment to assist providers in acquiring skills that assure the highest quality of integrated care is provided. ICOCE defined its central role as fostering the use of evidence-based practice models for the treatment of co-occurring substance use and mental health disorders. Consultation has also been provided in related areas such as recovery-oriented systems of care, supported employment, illness management, motivation to change and organizational change issues, cultural competence, HIV-AIDS, and trauma. Consultation and training are offered to DASA providers as requested and needed due to limited resources.

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

   and Medicaid? ( ) Yes ( ) No

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

   DASA

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

6. Do the behavioral health providers screen and refer for:

   a) Prevention and wellness education ( ) Yes ( ) No

   b) Health risks such as

      i) heart disease ( ) Yes ( ) No

      ii) hypertension ( ) Yes ( ) No

      viii) high cholesterol ( ) Yes ( ) No

      ix) diabetes ( ) Yes ( ) No

   c) Recovery supports ( ) Yes ( ) No

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

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

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

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.

The list of over 25 organizations that supported passage of the law included professional and trade associations and consumer organizations which have been active in educating their constituencies.

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

Both the SMHA and the SSA have been involved in the federal parity academies both for commercial insurance as well as Medicaid, partnering with the Department of Insurance and the Department of Healthcare and Family Services, respectively, as SME for behavioral health care needs in the state.

Please indicate areas of technical assistance needed related to this section

Footnotes:

2. Health Disparities - Requested

Narrative Question

In accordance with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities[45], Healthy People, 2020[46], National Stakeholder Strategy for Achieving Health Equity[47], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)[48].

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

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[49]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[50]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[51]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

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

[45] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[46] http://www.healthypeople.gov/2020/default.aspx

[47] http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf

[48] http://www.thinkculturalhealth.hhs.gov

[49] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[50] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

[51] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

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 / No

    b) Ethnicity — Yes / No

    c) Gender — Yes / No

    d) Sexual orientation — Yes / No

    e) Gender identity — Yes / No

    f) Age — Yes / No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? — Yes / No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? — Yes / No

4. Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? — Yes / No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) standard? — Yes / No

6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care? — Yes / No

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

Footnotes:

3. Innovation in Purchasing Decisions - Requested

Narrative Question

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

Health Care Value = Quality ? Cost, (V = Q ? C)

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

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

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[52], The New Freedom Commission on Mental Health[53], the IOM[54], and the NQF[55]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[56] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

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

SAMHSA's Treatment Improvement Protocol Series (TIPS)[57] are best practice guidelines for the SUD treatment. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[58] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and

training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

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

---

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

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

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

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

[56] http://psychiatryonline.org/

[57] http://store.samhsa.gov

[58] http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf

Please respond to the following items:

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

2. Which value based purchasing strategies do you use in your state (check all that apply):

   a) ☐ Leadership support, including investment of human and financial resources.

   b) ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.

   c) ☐ Use of financial and non-financial incentives for providers or consumers.

   d) ☐ Provider involvement in planning value-based purchasing.

   e) ☐ Use of accurate and reliable measures of quality in payment arrangements.

   f) ☐ Quality measures focus on consumer outcomes rather than care processes.

   g) ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).

   h) ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

   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.

Footnotes:

Environmental Factors and Plan

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

Narrative Question

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

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

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

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

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? (•) Yes ( ) No

2. Has the state implemented any evidence based practices (EBPs) for those with ESMI? (•) Yes ( ) No

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

   The State has trained twelve teams to provide Coordinated Specialty Care through the FIRST model developed by the BeST Center at NEOMED in Ohio, which includes psychiatric medications and services, Family Psychoeducation, Individual Resilience Training, Supported Employment (IPS) and Supported Education, and Case Management. Teams consist of a prescriber - either psychiatrist or advance practice nurse trained in Evidence Based Medication Management; a full-time team leader who functions as a clinician, a supervisor, and provides outreach to potential community referral sources; a therapist; a supported employment/education specialist, and a case manager.

3. How does the state promote the use of evidence-based practices for individuals with a ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

   Each of the twelve teams utilizes the EBPs described above, and each individual and family served is allowed choice among the five modalities of CSC contained within the BeST Model. The State has also trained two clinicians employed by DMH Central Office who serve as technical advisors to the teams, providing ongoing consultation, training and support through regular teleconferences, monthly team leader meetings, and availability for additional technical support to all team members as needed. All prescribers on the teams, as well as the DMH Medical Director, have received teh Evidence Based Medication Management in FEP training from BeST, which includes Shared Decision Making, Initial Treatment approaches and Maintenance Treatment needs.

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

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

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

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

   The State will continue to support all EBPs listed above. In addition, the State will be introducing Cognitive Behavior Therapy for psychosis to all team leaders and therapists in FY18. This will involve training in the model for these team members as well as DMH clinicians who will provide technical support. In addition, all team members will receive cross training in the application of CBT-p principles as it applies to their role on the team. Ongoing clinical supervision will be provided monthly to ensure accurate application of the model.

8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?

   As described above, CBT-p will be introduced through training and supported through supervision and technical support. In addition, eligibility criteria policies will be reviewed in light of new direction from SAMHSA on the move from FEP to ESMI. The current twelve teams will continue to receive technical assistance and training, and the State intends to develop at least one additional team, subject to funding availability.

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

   The State utilizes the Outcome Review Form developed by BeST. It is required to be administered by the team at the time of intake, and then every 6 months. Data is reported to the State, and analyzed by our FEP technical experts, who provide feedback to the teams during regular calls, and is also used in the internal DMH steering committee for planning purposes.

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

    Currently, Illinois requires a diagnosis of Schizophrenia, Schizoaffective Disorder, Schizophreniform Disorder, Other Specified/Unspecified Schizophrenia Spectrum or Other Psychotic Disorder, consistent with our understanding of the FEP requirements for eligibility. As previously stated, Illinois understands that the move from FEP to ESMI will expand eligibility for the set aside, and we have requested additional guidance from SAMHSA related to this, with the intention of revising our policies accordingly.

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

    Illinois chose to implement a system wide approach to FEP, with a focus on diverse geographic areas, to help inform our policy development related to modifications that may be needed to sustain the model across a variety of settings. We believe this will serve us well as we move to bring the model to scale across our diverse state.

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

    We continue to struggle with private insurance, which refuses to fund all pieces of the CSC model. Without the support of private insurers, our providers may not be able to sustain their programs if the set aside money is ever lost. This is a challenge for scalability as well.

Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

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

1. Does your state have policies related to person centered planning? ( ) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

   Through administrative rule, the state requires active participation of individuals, parents/guardians as applicable, and any chosen collaterals in the assessment and service planning process. Providers are then required to document this participation in the plan created, and confirm the participation through signature of the individual/parent/guardian, as applicable. This rule also requires providers to explain the results of all assessments and treatment recommendations to the individual/parent/guardian as applicable.

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

   All planning is expected to be person-centered, as supported by the administrative rule described above. The individual, family and/or collaterals as appropriate, meet with the treatment provider to discuss the outcomes of assessments and treatment recommendations. The plan of care is then determined based upon this discussion of recommendations, with individual choice being emphasized. Through administrative rule, providers are required to review the plan no less than once every six months with the individual/parent/guardian/collaterals as appropriate, and make modifications based upon the review of progress. Such modifications are to be consistent with the individual's choices and treatment preferences.

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

   The State is currently in the process of implementing the Illinois Medicaid Comprehensive Assessment of Needs and Strengths. This project has been in development for the past two years, and is being rolled out in stages, the first being within the Child/Adolescent system. The tool was developed through a multi-agency effort, and is based on the standardized CANS developed by Chapin Hall. This tool will be used across the system of care to enhance communication across providers and with the family being served.

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

Footnotes:

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds,the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction? ( ) Yes ( ) No

2. Are there any concretely planned initiatives in our state specific to self-direction? ( ) Yes ( ) No

   If yes, describe the currently planned initiatives. In particular, please answer the following questions:

   a) How is this initiative financed:

   b) What are the eligibility criteria?

   c) How are budgets set, and what is the scope of the budget?

   d) What role, if any, do peers with lived experience of the mental health system play in the initiative?

   e) What, if any, research and evaluation activities are connected to the initiative?

   f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

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

   Please indicate areas of technical assistance needed to this section.

Footnotes:

Environmental Factors and Plan

7. Program Integrity - Required

Narrative Question

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

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

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

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? ( ) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard? ( ) Yes ( ) No

   Does the state have any activites related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed to this section

Footnotes:

Environmental Factors and Plan

8. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation[59] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

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

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

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

[59] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

2. What specific concerns were raised during the consultation session(s) noted above?

   Does the state have any activites related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed to this section

Footnotes:

Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring 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 rehabilitation services for individuals with mental illnesses as well as individuals with co-occurring disorders.

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

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

   Please describe as needed (for example, best practices, service needs, concerns, etc)

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

3. Describe your state's case management services

   Case management is provided as a set of Medicaid Rehabilitation Option services to individuals in need of services across the system of care, who require assistance in accessing those services and/or obtaining referral to such services..

4. Describe activities intended to reduce hospitalizations and hospital stays.

   The State Plan provides for multi-disciplinary team services available to individuals with a history of or at risk for multiple hospitalizations. In addition, the State has sponsored the piloting of programs aimed at reducing hospital stays.

Criterion 2: Mental Health System Data Epidemiology

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

Criterion 2

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

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

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

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	526,080 (5.4%)	100,400
2.Children with SED	111,117 (7.0%)	35,600

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

Adults

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

Children and Adolescents

For an estimate of Children and Adolescents with Serious Emotional Disturbance, Illinois has used the 7% estimate provided in the CMHS notice in the Federal Register, Volume 63, Number 137, July 17, 1998 based on the midpoint of the number estimated at the lower limit of a level of functioning of 50 (LOF=50) and the number estimated at the upper limit of that level of functioning (LOF=50 to 60). The figure has been updated by CMHS using 2011 census information to 111,117 or 7% of the population of children and adolescents aged 9 to 17 based on a 18.2% (FY2011) poverty rate. The number of youth with Serious Emotional Disturbance (eligible population) reported served in FY2012 was 35,670. When viewed in conjunction with the prevalence rate estimates provided above, DMH is purchasing services for approximately 32% of the child/adolescent population that needs mental health services. As with the adult estimates, some individuals in need of services, may be receiving those services from providers who do not contract with DMH for service delivery.

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

Narratve Question

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

Criterion 3

Does your state integrate the following services into a comprehensive system of care?

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

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

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

Criterion 4

Describe your state's targeted services to rural and homeless populations and to older adults

Homeless

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

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

PATH program services in the state are:

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

Comprehensive community mental health services, case management and crisis intervention

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

Access to community resources (e.g.: dental, vision, clothing, food pantries, bus/train cards)
• Connection with hospitals/clinics, transportation to appointments and benefits representatives
• Referrals/linkage to primary healthcare services and substance abuse treatment programs
• Securing personal documentation (e.g.: birth certificates, state ID’s and social security cards)
• Assistance in obtaining employment, educational and vocational opportunities
• Provision of hygienic items, clothing and resources for survival in hot and inclement weather
• Completion of applications for public entitlements and benefits (SSI/SSDI, Medicaid, SNAP)
• Linkage w/landlords, moving expenses, 1x security deposits and payments to avoid eviction.

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

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

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

• To augment the limited supply of psychiatrists, DMH is working with professional associations to make available the services of specialty professionals such as Psychologists with prescribing authority and Advance Practice Nurses with psychiatric specialization
• DMH is looking into ways to expand tele-psychiatry, which could be particularly beneficial to rural areas
• DMH no longer restricts the Medicaid certification of mental health providers, resulting in the number of providers growing more than 20% in the last 5 years
• DMH and DASA 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 privately operated hospitals to assure better access to appropriate treatment.
• DMH is working with DASA 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.

Elderly:
The DMH collaborates with the Illinois Department on Aging (DOA) to increase training opportunities in the geriatric field and to improve the quality and accessibility of services for elderly persons with mental illnesses.

Criterion 5: Management Systems

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

Criterion 5

Describe your state's management systems.

• IDHS/DMH funds our community partners with a combination of State General Revenue Funds, Federal Funds, and Other State Funds.
• Illinois has a regional staff structure which houses central office staff in each of the regions to be readily available to providers for on-site training, or technical assistance.
• When major system or program changes occur IDHS/DMH provides webinar trainings to all providers impacted by the system or program change.
• IDHS/DMH intends to expend the grant funds for the fiscal years involved by funding residential services for individuals with a SMI.

Footnotes:

Environmental Factors and Plan

12. Quality Improvement Plan- Requested

Narrative Question

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

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017? Yes No

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.

Footnotes:

13. Trauma - Requested

Narrative Question

Trauma [60] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with.

These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[61] paper.

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

61 *Ibid*

Please respond to the following items

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

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

Footnotes:

Environmental Factors and Plan

14. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[62]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[63]

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

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

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

[63] http://csgjusticecenter.org/mental-health/

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services? ( ) Yes ( ) No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? ( ) Yes ( ) No

3. Does the state provide cross-trainings for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system? ( ) Yes ( ) No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances? ( ) Yes ( ) No

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

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

Footnotes:

15. Medication Assisted Treatment - Requested

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient's needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? ( ) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly, pregnant women? ( ) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds? ( ) Yes ( ) No

   a) [ ] Methadone

   b) [ ] Buprenophine, Buprenorphine/naloxone

   c) [ ] Disulfiram

   d) [ ] Acamprosate

   e) [ ] Naltexone (oral, IM)

   f) [ ] Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately? ( ) Yes ( ) No

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

   Please indicate areas of technical assistance needed to this section.

   **Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

Footnotes:

16. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.[64] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises[65],

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

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

[64] http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848

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

Please respond to the following items:

1. Crisis Prevention and Early Intervention
   - a) é Wellness Recovery Action Plan (WRAP) Crisis Planning
   - b) é Psychiatric Advance Directives
   - c) é Family Engagement
   - d) é Safety Planning
   - e) é Peer-Operated Warm Lines
   - f) é Peer-Run Crisis Respite Programs
   - g) é Suicide Prevention
2. Crisis Intervention/Stabilization
   - a) é Assessment/Triage (Living Room Model)
   - b) é Open Dialogue
   - c) é Crisis Residential/Respite
   - d) é Crisis Intervention Team/Law Enforcement
   - e) é Mobile Crisis Outreach
   - f) é Collaboration with Hospital Emergency Departments and Urgent Care Systems
3. Post Crisis Intervention/Support
   - a) é WRAP Post-Crisis
   - b) é Peer Support/Peer Bridges

c) é Follow-up Outreach and Support

d) é Family to Family Engagement

e) é Connection to care coordination and follow-up clinical care for individuals in crisis

f) é Follow-up crisis engagement with families and involved community members

g) é Recovery community coaches/peer recovery coaches

h) é Recovery community organization

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

Please indicate areas of technical assistance needed to this section.

Footnotes:

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual?s mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.
SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:
Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
In addition, SAMHSA identified 10 guiding principles of recovery:

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

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.
States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Clubhouses
- Drop-in centers
- Recovery community centers
- Peer specialist
- Peer recovery coaching
- Peer wellness coaching
- Peer health navigators
- Family navigators/parent support partners/providers
- Peer-delivered motivational interviewing
- Peer-run respite services
- Peer-run crisis diversion services
- Telephone recovery checkups
- Warm lines
- Self-directed care
- Supportive housing models
- Evidenced-based supported employment
- Wellness Recovery Action Planning (WRAP)
- Whole Health Action Management (WHAM)
- Shared decision making
- Person-centered planning
- Self-care and wellness approaches
- Peer-run Seeking Safety groups/Wellness-based community campaign
- Room and board when receiving treatment

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery

Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.
Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

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

   a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? ( ) Yes ( ) No

   b) Required peer accreditation or certification? ( ) Yes ( ) No

   c) Block grant funding of recovery support services. ( ) Yes ( ) No

   d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?

   A concerted effort has been made to ensure that persons in recovery and family members 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 persons in recovery and parents of children with serious emotional disturbances has increased. Persons in recovery and/or family members co-chair the IMHPAC, as well as all IMHPAC sub-committees.

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

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

   It is the vision of the DMH that all persons with mental illnesses recover, and are able to participate fully in life in the community. This vision and the mission of the Division are derived from recovery-based values. As such, recovery and recovery support services are embedded within the framework of the overall work of the DMH.

   The Deputy Director for Wellness & Recovery Services oversees the work of 18 civil service employees, all of whom are persons in recovery. Ten of these staff work in 5 of the state-operated hospitals, and 8 of them work in the region offices. Through this state workforce, known as the Recovery Services Development Group, multiple statewide initiatives have been successfully planned, developed and executed. Those initiatives include the Certified Recovery Support Specialist (CRSS) competency training; Wellness Recovery Action Plan (WRAP) facilitator training; Recovery & Empowerment Statewide calls, which provide education and support for hundreds of individuals each month; Recovery Conferences, provided annually in each region; the Illinois Warm Line; the Recovery & Empowerment Handbook; and the development and support of Living Room programs (recovery support and crisis diversion) in multiple counties.

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

   N/A

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

   Certified Recovery Support Specialist (CRSS). CRSS is the professional credential for individuals providing peer recovery support services in Illinois. It is a competency-based credential, managed by the Illinois Certification Board. In order to obtain the CRSS, individuals must complete:
   o 100 hours of training/education
   o 2,000 hours on-the-job experience
   o 100 hours of supervision
   o CRSS exam
   The CRSS is required for positions with the State of Illinois in state hospitals and region administration and as part of Medicaid reimbursed team services (ACT & CST) and BIP Enhanced Services. The CRSS credential assures competence in advocacy, professional responsibility, mentoring, and recovery support.

   DMH provides CRSS Competency Training in three locations annually. The curriculum for this training is developed around the four domains for competency (advocacy, professional responsibility, mentoring & recovery support). New modules are developed every year to ensure that all CRSS staff are receiving the most current, up-to-date and relevant information in the field.

   As of July 2017, 208 individuals with CRSS certification were active in the State, and all were in good standing with the Illinois Certification Board (ICB). Information regarding this credential can be found at http://www.iaodapca.org/forms/crss/CRSS_Model.pdf

   Wellness Recovery Action Plan (WRAP). DMH provides WRAP® Facilitator Training bi-annually. As of June 2017, 419 individuals

have been trained and certified as WRAP Facilitators in Illinois. Of those, 174 (42%) are actively participating in Refresher training. Twenty-four hours of Refresher training are required every two years to be re-certified. DMH provides Refresher training in four sites, quarterly. Seventy-eight (44%) of the active facilitators achieved re-certification this year.

Recovery & Empowerment Statewide Calls. DMH conducts a series of statewide teleconference calls designed to disseminate important information to individuals receiving services across the State. The goal of the Recovery & Empowerment Statewide Calls is to provide an educational forum for individuals receiving services to identify the topics most important to them, to present information on those topics in a hopeful, recovery-oriented manner by individuals with lived experience, and to empower individuals to take an active, participatory role in their recovery through participatory dialogue on the calls. Ten teleconferences are conducted annually. As of June 2017, 100 Recovery & Empowerment Calls have been held in Illinois. On average, 499 participants joined per month in 2016. Over the last 10 years people have dialed into the call over 40,000 times. On evaluation surveys, 89.58% of the questions were evaluated as Very Good.

Recovery Conferences. DMH Recovery Support Specialists work with committees comprised of persons in recovery to design, plan and convene annual recovery conferences. Recovery Conferences are held in each DMH region with keynote presentations and workshops provided by persons in recovery. The average attendance at these conferences is 200–500 per conference. With four locations in 2016, a total of 1,250 individuals attended across the state.

• The Illinois Warm Line. Under direction of the DMH, the Illinois Mental Health Collaborative operates the Illinois Warm Line which provides proactive, wellness-focused, self-directed support. The Warm Line is staffed by five Peer & Family Support Specialists and is available to all Illinois residents. The service is provided toll-free Monday through Friday, 8am to 5pm, except on holidays. In FY17, the Warm Line averaged 1,026 calls per month. During FY17, the Warm Line received 12,313 calls. This is a 41% increase in yearly call volume compared to the previous FY and a 106% increase over FY15. As of June 2017, the Illinois Warm Line has responded to 49,859 calls for peer and family support by telephone.

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

Footnotes:

18. Community Living and the Implementation of Olmstead - Requested

Narrative Question

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

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

Please respond to the following items

1. Does the state's Olmstead plan include :

   - housing services provided. ( ) Yes ( ) No
   - home and community based services. ( ) Yes ( ) No
   - peer support services. ( ) Yes ( ) No
   - employment services. ( ) Yes ( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? ( ) Yes ( ) No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

   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.

Footnotes:

19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community[66]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24[67]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death[68].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21[69]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

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

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs[70].

According to data from the 2015 Report to Congress[71] on systems of care, services:

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

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

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

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

---

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

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

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

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

[70]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010

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

---

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

   a) The recovery and resilience of children and youth with SED? ( ) Yes ( ) No

   b) The recovery and resilience of children and youth with SUD? ( ) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:

   a) Child welfare? ( ) Yes ( ) No

   b) Juvenile justice? ( ) Yes ( ) No

   c) Education? ( ) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

   a) Service utilization? ( ) Yes ( ) No

   b) Costs? ( ) Yes ( ) No

   c) Outcomes for children and youth services? ( ) Yes ( ) No

4. Does the state provide training in evidence-based:

   a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ( ) Yes ( ) No

   b) Mental health treatment and recovery services for children/adolescents and their families? ( ) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

   a) to the adult behavioral health system? ( ) Yes ( ) No

   b) for youth in foster care? ( ) Yes ( ) No

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

   The Screening Assessment Support Services (SASS) initiative is a cross agency approach to meeting the needs of children and adolescents experiencing a crisis that may necessitate hospitalization. The collaboration is across the State Mental Health Authority, the State Medicaid Authority and the State Child Welfare Authority and provides access to immediate assessment and additional supports to the youth and family experiencing the crisis. The Choices pilot project which set the groundwork for changes in managed care contracts and the plan for children's integrated health homes was recently completed as a comparison to SASS. This project cut the admissions rate to 23% for youth presenting in crisis, as compared to a 45-55% admission rate outside the pilot.

   The Specialized Family Support Program (SFSP), implemented pursuant to the Custody Relinquishment Prevention Act (the Act), 20 ILCS 540/1 et seq., is a collaborative effort between the Illinois Departments of Children and Family Services (DCFS), Healthcare and Family Services (HFS), 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. The 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. Through leveraging existing state resources and altering key programmatic policies to accommodate the specialized needs of this population, the SFSP seeks to establish a pathway for youth at risk of custody relinquishment to receive services through the appropriate State child-serving agency. The goals of the SFSP are to:

• Deflect eligible youth from entering DCFS care solely to obtain behavioral health treatment;
• Determine the most appropriate treatment services to Child at Risk of Custody Relinquishment and their family;
• Determine the most appropriate treatment services for the eligible population through a comprehensive, standardized assessment process; and
• Link eligible youth and their families to services at the right intensity and level of care in a timely manner.

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

The State has been engaged in an HHS transformation for the past three years that involves all of the child serving agencies, who are working together to transform the system of care. On February 18, 2016 Governor Bruce Rauner signed an Executive Order creating the Governor's Cabinet on Children and Youth (aka Children's Cabinet). This Cabinet has been charged with the creation of a strategic vision for education and health and human services by bringing together all state entities that interact with children into a central unit. It is a goal of this Cabinet to reduce the fragmented system that currently exists, while working to effectively identify and address any barriers to agency collaboration. This Cabinet will also provide funding and policy recommendations while promoting awareness of important issues facing children, adolescents and their families.

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

Illinois is a System of Care State, and we have been working towards designing a truly integrated system of care, but our efforts are delayed due to EPSDT litigation which is preventing us from moving forward in implementing the design until the lawsuit is settled, as terms of that will dictate many facets of the system. This is not an area where technical assistance is necessarily needed, but we wanted to note this as it relates to our inability to answer yes to the questions in Criterion 3 of section C10.

Footnotes:

Environmental Factors and Plan

20. Suicide Prevention - Required MHBG

Narrative Question

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

Please respond to the following items:

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

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

   The SAMHSA 2015 Behavioral Health Barometer for Illinois, reports that approximately 355,000 adults (3.7% of all adults in Illinois) per year in 2013-2014 had serious thoughts of suicide within the year to being surveyed. The percentage did not change significantly from 2010-2011 to 2013-2014. More than 1,000 persons die by suicide each year in the state and suicide fluctuates yearly between being the second or third leading cause of death for adolescents. Interest, organized efforts, and advocacy for suicide prevention in Illinois resulted in legislative action. In 2004, the Suicide Prevention, Education and Treatment Act (PA093-0907) was passed by the General Assembly and signed by the Governor directing the Illinois Department of Public Health (IDPH) to appoint the Illinois Suicide Prevention Strategic Planning Committee composed of representation of statewide organizations and local agencies that focus on the prevention of suicide and support services to survivors. To unify planning and suicide prevention efforts, an alliance was formed between a coalition of stakeholders and the strategic planning committee that was recognized in law by the General Assembly in 2008. The mission of the Illinois Suicide Prevention Alliance (the Alliance) as stated in the law is “to reduce suicide and its stigma throughout Illinois by collaboratively working with concerned stakeholders from the public and private sectors to increase awareness and education, provide opportunities to develop individual and organizational capacity in addressing suicide prevention, and advocate for access to treatment.”
   Recently, the thrust of Illinois suicide prevention has been to develop training opportunities, increase public and professional awareness of state and local suicide prevention resources in Illinois, and increase opportunities for linkages. Activities have included a Webinar series on available Illinois resources such as LOSS (Loving Outreach to Survivors of Suicide); a statewide suicide prevention conference, a “Zero Suicide” workshop with Mike Hogan that resulted in a number of CMHCs and other providers signing on to implement this comprehensive approach; an event for addiction / substance abuse professionals co-sponsored with IODAPCA, and plans for working on training for Juvenile Justice professionals.

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

   In 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 is now a standing committee of the Alliance in order to potentiate both ISPA and IJF resources.

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

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

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

5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted? ( ) Yes ( ) No

If so, please describe the population targeted.

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

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

We are hopeful that our grant applications will be approved. Statewide training in the Zero Suicide approach will be beneficial in promoting the recognition of suicide as an important issue to be addressed and help to reduce the incidence of suicide in the State.

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

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

Footnotes:

21. Support of State Partners - Required MHBG

Narrative Question

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

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

Please respond to the following items:

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

2. Has your state identified the need to develop new partnerships that you did not have in place? ( ) Yes ( ) No

   If yes, with whom?

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

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 Disabilites Education Act.

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

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

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.

Footnotes:

Environmental Factors and Plan

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

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[72]

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

[72] http://beta.samhsa.gov/grants/block-grants/resources

Please respond to the following items:

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...)

   a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

   Not Applicable

   b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into i — Yes / No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linquistic, rural, suburban, urban, older adults, families of young children)? — Yes / No

3. Please indicate the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

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

   Each DMH Community Comprehensive Service Region (CCSR) is represented on the Council. Providers, consumers, family members and parents of children with SED who are members of the Council may also act in an advisory capacity in the Regions. State employees representing principal state agencies with respect to mental health, education, criminal justice, vocational rehabilitation, housing, and a variety of social services as well as representatives of organizations that are significant stakeholders and advocates are full members of the Council. Expansion of the Council membership to encompass behavioral health including representation of the Alcoholism and Substance Abuse community of providers and consumers, primary health care, 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, and Adult Community Services. Other committees may be appointed as needed. The Council as a whole meets six times a year to review new developments, monitor the progress of initiatives, and discuss problematic issues in the mental health service system. Each subcommittee also meets at least six times a year, during alternating months of the full council meeting. Each subcommittee is co-

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

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

In April 2016, concern was raised that the Council was not compliant with requirements of the Illinois Open Meetings Act. Clarification as to whether the Council is subject to these legal requirements was requested from the Attorney General of Illinois. To avoid penalties prescribed in the Act, the Council temporary suspended its business with the expectation that a response would be forthcoming. In June 2017, the Attorney General advised the Council to proceed under the guidelines of the Open Meetings Act and assured that there will be no repercussions. The Attorney General has not yet issued an opinion regarding the applicability of the Open Meetings Act to the functions and responsibilities of the Illinois Mental Health Planning and Advisory Council. Both DMH and IMHPAC appreciate SAMHSA's ongoing support and recent communication with the Office of the Attorney General that advised them of federal requirements.
The Council reconvened in July 2017 and moved immediately into review of an unfinished rough draft of the FY2018-FY2019 Plan. Their comments and concerns about the text and the content of the plan are embedded in this submission.

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.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[73]

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

Footnotes:

DRAFT- **Illinois Mental Health Planning and Advisory Council**
Special Meeting to Review FY18-19 Mental health Block Grant Application
Minutes
August 10, 2017
1:00 to 3:00 p.m.

Attendees in Chicago:
John Shustizky, Andrea Cooke, Margo Roethlisberger, Ray Connor, Irwin Kerzner

Attendees in Springfield: Leanne Reinart, Doug Woods, Joanne Furnas (for Lynn O'Shea)

Attendees by Telephone: Emily Miller, Cindy Daxenbichler, Ron Melka, Dianne Knabbe

Call to Order:
The Special Meeting was called to order by John Shustitzky at 1:10 p.m.

Special Meeting to Review the Draft FY 2018-2019 Mental Health Block Grant Application and Plan:
It was noted that the document being reviewed was a rough draft of the Mental Health Block Grant Application and Plan; work is needed to incorporate statewide feedback and outcomes through the September 1st deadline. Discussion was held on each section of the block grant on work that has been completed thus far; feedback was shared.

Leanne Reinart: It is time for the State to submit the Block Grant application. SAMHSA representatives will visit next week. The following 2 weeks will be focused on completing a final version to send to SAMHSA. During that time the application will posted for public comment. Areas of need identified in the grant will include more detail than can be funded.

Irwin Kerzner: It was noted this is a draft. Information from the application will be transferred to the SAMHSA website. SAMHSA provided a template for this purpose with questions to be answered. There is a large increase in the number of agencies providing services, especially Children's services. Irwin reviewed the section about data from the collaborative and effects of the economic recession. Planning steps were reviewed - much was information was taken from past submissions. Comment: substance abuse program expenses are reported separately from mental health expenses. Irwin confirmed this.

Ms. Reinart: Clarified that this application is the Block Grant for Mental Health. DASA also completes one for Substance Abuse services. The SAMSHA visit scheduled for next week is a consolidation of the two different division visits, though grants are separate. The Mental Health application still needs methodology updates and additions.

Doug Woods: State of the art data collection on identified goal areas is occurring, although there are still gaps which DMH is currently working on.

Ms. Reinart: The Collaborative is the data collection source, and gets their information from providers. The HFS claims' system is antiquated. Demographics and types of services provided are easy to access, but claims data is difficult to access. The two data systems don't interface with each other. Work is needed to share/exchange information. Discussion was had on internal restructuring. Further information will be forthcoming in the future.

The following tables are being submitted: (see handout FY2018-FY2019 Community Mental Health Services Block Grant Application for further detail)

Table	Priority Area:	Priority Type
1.1	Continue to develop and improve the array of clinical and support services available for adults and children	Mental Health Services
1.2-1 ACT	Promote Provision of Evidence Based and Evidence-Informed Practices	Mental Health Services
1.2-2 IPS	Promote Provision of Evidence Based and Evidence-Informed Practices	Mental Health Services
1.3	FEP Set-Aside: Implementation of Specialized Programming and Evidence-Based Services for persons experiencing *First Episode Psychosis*.	Mental Health Services
1.4	Use of Data Planning	Mental Health Services
1.5	Justice Draft- maintain effective systems to serve the forensic needs of justice-involved consumers of services.	Mental Health Services
1.6	Expansion of the scope of consumer and family participation through advancement of the recovery vision and family driven care.	Mental Health Services
1.7	Lead in the development and implementation of statewide, unified, state-of-the-art Child and Adolescent Services to promote optimal social and emotional development for all children, adolescents, and young adults with behavioral health needs.	Mental Health Services
1.8	Williams Draft- Advancement of Community Integration	Mental Health Services
1.9	Coordination and facilitation of mental health services for Illinois Service Members	Mental Health Services

Open discussion and review was led by Mr. Kerzner (See table above and Block Grant Application). Discussion highlighted evidence based ACT and IPS (1.2-1 & 1.2-2).

Ms. Reinart: Illinois is recognized as a leader in Individual Placement and Support (IPS) services. She discussed the set aside for FEP- first episode psychosis. 11-12 First Illinois teams are currently working throughout Illinois. Objectives of the program were reviewed. Marketing and outreach was identified as crucial to the success of the FEP program. Program data still being gathered; Table on page 47 shows enrollees in FEP. The Recovery table is just

about complete. There was an emphasis on increasing recovery support specialists. WRAP Training also needs to be increased. A new service will be added- wellness respite run by consumers. There was discussion to add more information to the WRAP section in table 6. DMH will need to work with chosen MCO'S to make sure services are provided appropriately and billed accurately.

Child and Adolescent Services (Table 7) discussed. Objectives will need to span over a 2-year period. Indicators discussed are still in draft stage. It is anticipated that the proposed trauma informed care credentialing will be in place by 2019. Discussion was had on the new Diagnostic methodology for children. It is anticipated that new training will be available on the new methodology. Evidence based practice for early intervention was discussed. Permanent supportive housing is at a standstill due to lack of funds.

Table 9 Veteran's: indicators/objectives including cultural competency around veteran's needs was discussed, including: Objectives #1 (sustain a coordinated system of care) Objective #2 (improve the quality of community mental health services to servicemen, veterans and their families and, Objective #3 (build Veteran Service Communities (VSC) throughout the State that can ensure access to Behavioral Health Services). Discussion occurred on Section C Environmental Factors and Plan - (Block Grant pgs. 37-51).

There is a clear need for further data for LGBTQ Community- specifically services available and services which are lacking to serve the LGBTQ community. Statutory Criteria for MHBG is a new requirement. Criterion discussed - pages 52-54.

State hospitals and jail services/needs were discussed pertaining to Mental Health Recovery Services section which needs to be updated. The suicide prevention section was updated to include 2015 statistics and the training opportunities to increase public and professional awareness of State and Local suicide prevention resources in Illinois and opportunities to increase linkages. Two grants were recently submitted around the goal of zero suicide: (1.) A Suicide Prevention Grant submitted on 4-14-2017- a pilot project designed to bring five counties in Southern Illinois to Zero Suicide status. (2.) A Zero Suicide Grant submitted 7-14-2017 which focuses on statewide training and education to achieve a Zero Suicide status in State Hospitals and Community Mental Health Services. There has been no response to either application as yet. A follow up discussion will be scheduled to review the final application.

Adjournment

A motion for adjournment was made and carried unanimously. Meeting adjourned at 3:00 p.m.

Respectfully Submitted,

Joanne Furnas
Substituting for Council Secretary Lynn O'Shea

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2018 End Year: 2019

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Mary Ann Abate	Providers	Rosecrance Health Network (Janet Wattles)	9134 River View Trail Roscoe IL, 61073 PH: 815-623-6740	mabate@rosecrance.org
Cindy Backstein	Parents of children with SED		26 Amberly Road Springfield IL, 62712 PH: 217-498-8774	backstein@mchsi.com
Wendy Blank	State Employees	Illinois Department of Corrections	Stateville CC Crest Hill IL, 60403 PH: 815-727-3607	Wendy.Blank@DOC.Illinois.gov
John Brien	Family Members of Individuals in Recovery (to include family members of adults with SMI)		9726 S. Seeley Ave. Chicago IL, 60643 PH: 773-756-7789	Johnbrien312@att.net
Georgianne Broughton	Providers	Community Resource Center	101 South Locust Centralia IL, 62801 PH: 618-533-1391 FX: 618-533-0012	gbroughton@crconline.info
Terry Carmichael	Others (Not State employees or providers)	Community Behavioral Health Assn (CBHA)	3085 Stevenson Drive Springfield IL, 62703 PH: 217-585-1600	tcarmichael@cbha.net
Michele Carmichael	State Employees	Illinois State Board of Education	100 N. 1st Street Springfield IL, 62777-0001 PH: 217-782-5589	mcarmich@isbe.net
N'Dana Carter	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		4915 S. Washington Park Court Chicago IL, 60615 PH: 773-624-6281	Topergoqueen918@gmail.com
Edwin Chandraseker	Providers	Asian Health Coalition	180 W. Washington, Suite 1000 Chicago IL, 60602 PH: 312-372-7070 FX: 312-372-7171	edwin@asianhealth.org
Ray Connor	Parents of children with SED		1218 N. Grove Ave Oak Park IL, 60302 PH: 847-426-3692 FX: 847-649-8915	rayconnor@comcast.net
Andrea Cooke	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		11324 S. Langley Ave. Chicago IL, 60628 PH: 708-381-9088	a-cooke@sbcglobal.net
Cindy Daxenbichler	Parents of children with SED		114 Daddono Circle Bloomington IL, 61701 PH: 309-642-1080	Taurus463@gmail.com

Cara Emrich	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		402 N. Ward Street Benton IL, 62812 PH: 618-513-9762	c.emrich.tigerlily@gmail.com
Sondra Frazier	Parents of children with SED		6957 S. Jeffery Blvd. Chicago IL, 60649-1521 PH: 773-324-6644	Slfrazier6@aol.com
A.J French	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2735 E. Broadway Alton IL, 62002 PH: 618-792-2049	aj.french@giftofvoice.com
Fred Friedman	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Next Steps, NFP	2442 N. Kilbourn Ave Chicago IL, 60639 PH: 773-661-6705	fred@nextstepsnfp.org
Mark Heyrman	Others (Not State employees or providers)	Legal Assistance Foundation-Univ. of Chicago	6020 S. University Ave. Chicago IL, 60637 PH: 773-753-4440 FX: 773-702-2063	m-heyrman@uchicago.edu
Dennis Hopkins	Providers	Iroquois Mental Health Center	323 West Mulberry Street Watseka IL, 60970 PH: 815-432-5241	dhopkins@imhc.net
Anne Irving	Others (Not State employees or providers)	AFSCME	29 N. Wacker Dr. Chicago IL, 60601 PH: 312-641-6060 FX: 312-346-1016	AIrving@afscme31.org
Steve Langley	Providers	Stepping Stones of Rockford, Inc	706 N. Main Street Rockford IL, 61103 PH: 815-963-0683 FX: 815-963-6018	sel@ssrinc.org
Nanette Larson	State Employees	IDHS Division of Mental Health	200 S. 2nd Street Pekin IL, 61554 PH: 309-346-2094	Nanette.Larson@illinois.gov
Pearl Madlock	State Employees	IL Housing Development Authority	401 N. Michigan Ave. Chicago IL, 60611 PH: 312-836-5354 FX: 312-832-2191	pmadlock@ihda.org
Daniel Martinez, MD	Providers	Lutheran Social Services	4840 W. Byron St Chicago IL, 60641 PH: 773-282-7800	dmartinez@discoverccs.org
Robin D. McGinnis	Providers	Infant Welfare Society	3600 W. Fullerton Ave Chicago IL, 60647 PH: 773-782-5018	mcginnisr@infantwelfare.org
Ronald R. Melka	Others (Not State employees or providers)	Lyons Township Mental Health Commission	PH: 708-352-2992 FX: 708-354-7212	ltmhc@lyonsts.com
Emily Miller	Others (Not State employees or providers)	IL Association of Rehabilitation Facilities	206 South Sixth Street Springfield IL, 62701 PH: 217-753-1190 FX: 217-525-1271	emiller@iarf.org

Orson Morrison	Providers	DePaul University Family & Community Services	2219 N. Kenmore St Chicago IL, 60614 PH: 773-325-7787	omorrison@depaul.edu
Mike Nance	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		365 East Waggoner St. Decatur IL, 62526-4695 PH: 217-423-4715	Mnance62@gmail.com
Lynn O'Shea	Providers	Association For Individual Development	309 W. New Indian Trail Court Aurora IL, 60506 PH: 630-966-4001 FX: 630-844-9884	loshea@the-association.org
Gene Oulvey	State Employees	IDHS Division of Rehabilitation Services	618 E. Washington, 3rd Floor Springfield IL, 62794 PH: 217-720-9378 FX: 217-524-7549	Gene.Oulvey@illinois.gov
Anita Overturf	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1464 Queeny Ave Sauget IL, 62206 PH: 618-974-8424	Anitaoverturf.crss@gmail.com
Lee Ann Reinert	State Employees		600 E. Ash Springfield IL, 62703 PH: 217-782-0059 FX: 217-785-3066	Lee.Reinert@illinois.gov
Margo Roethlisberger	Providers	Ada S. Mckinley Community Services	98 Chelsea Avenue Sugar Grove IL, 60554 PH: 630-466-5086	mroethlisberger@adasmckinley.org
John Shustitzky	Providers		675 Rockefeller Road Lake Forest IL, 60045 PH: 847-482-1638	jwshust@gmail.com
Amy Starin	Others (Not State employees or providers)		405 S. Euclid Ave Oak Park IL, 60302 PH: 773-296-2625	Astarin@parenthesis-info.org
Jean Summerfield	State Employees	IL Department of Healthcare and Family Services	401 S.Clinton Street Chicago IL, 60607 PH: 312-814-6784	Jean.Summerfield@illinois.gov
Christine Walker	Parents of children with SED		399 Ridge Avenue Winnetka IL, 60093 PH: 847-446-6436	critique@sbcglobal.net

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2018 End Year: 2019

Type of Membership	Number	Percentage
Total Membership	37	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	7	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	1	
Parents of children with SED*	5	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers)	6	
Total Individuals in Recovery, Family Members & Others	19	51.35%
State Employees	7	
Providers	11	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	18	48.65%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Persons in recovery from or providing treatment for or advocating for substance abuse services	0	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

The Illino

Footnotes:

Environmental Factors and Plan

23. Public Comment on the State Plan - Required

Narrative Question

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

Please respond to the following items:

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

a) Public meetings or hearings? (•) Yes ( ) No

b) Posting of the plan on the web for public comment? (•) Yes ( ) No

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

If yes, provide URL:

The URL will be: http://www.dhs.state.il.us/page.aspx?item=43686

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

Unfortunately, this year the Illinois Mental Health Planning Advisory Council (MHPAC) suspended its business temporarily due to concerns about violations of the Illinois Public Meetings Act (See Section C-22 above for information). It reconvened in early July and moved immediately into reviewing the FY2018-FY2019 Block Grant Plan. (3) The final state block grant application and proposed plan will be posted on the web site for the Division of Mental Health (www.dhs.state.il.us). The public can access this DHS DMH Internet site. Interested parties have been instructed to contact Lee Ann Reinert, DMH Deputy Director of Policy, Planning, and Innovation to provide comment. Contact information will be provided on the website. Comments from the public submitted after the final draft of the plan is posted will be reviewed by the IMHPAC Executive committee and discussed with Council membership in upcoming meetings. As always, DMH will be receptive to constructive comments and will move, with notification to SAMHSA, to modify the plan as needed.

Footnotes: