Illinois

UNIFORM APPLICATION
FY 2010 - STATE PLAN

COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 08/06/2008 - Expires 08/31/2011

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Center for Mental Health Services
Division of State and Community Systems Development
Introduction:
The CMHS Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane. Rockville. MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0168.
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STATE NAME: Illinois
DUNS #: 6919071

I. AGENCY TO RECEIVE GRANT
AGENCY: Illinois Department of Human Services
ORGANIZATIONAL UNIT: Division of Mental Health
STREET ADDRESS: 160 North LaSalle Street, 10th Floor
CITY: Chicago STATE: IL ZIP: 60601
TELEPHONE: 312-814-4948 FAX: 312-814-2964

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT
NAME: Carol L. Adams, Ph.D TITLE: Secretary
AGENCY: Illinois Department of Human Services
ORGANIZATIONAL UNIT: Division of Mental Health
STREET ADDRESS: 401 South Clinton Street
CITY: Chicago STATE: IL ZIP CODE: 60601
TELEPHONE: 312-793-1533 FAX:

III. STATE FISCAL YEAR
FROM: 07/01/2009 TO: 06/30/2010

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION
NAME: Mary E. Smith, Ph.D TITLE: Associate Director, Decision Support, Research and Evaluation
AGENCY: Illinois Department of Human Services
ORGANIZATIONAL UNIT: Division of Mental Health
STREET ADDRESS: 160 North LaSalle Street, 10th Floor
CITY: Chicago STATE: IL ZIP: 60601
TELEPHONE: 312-814-4948 FAX: 312-814-2964 EMAIL: MaryE.Smith@illinois.gov
Illinois

Executive Summary

Please respond by writing an Executive Summary of your current year's application.
FY 2010 MENTAL HEALTH BLOCK GRANT APPLICATION
EXECUTIVE SUMMARY

The Illinois Department of Human Services-Division of Mental Health (DMH) is responsible for managing and purchasing a comprehensive array of services that provide effective treatments to people most in need of publicly funded mental health care. The policies and practices of the DMH focus on fostering coordination and integration of services provided by DMH funded community agencies, private hospitals, and state hospitals across Illinois. A range of collaborative initiatives increase coordination with other state agencies whose services are accessed by individuals receiving mental health services. The FY2010 Mental Health Block Grant Plan reflects these coordination efforts as well as an emphasis on developing and directing care which is consumer and family driven. DMH is actively continuing to transform the mental health service delivery system in Illinois to one that is recovery-oriented. These efforts include increasing consumer and family involvement in planning and implementation activities, expanding the focus on planning and implementation of evidenced-based practices, and continued planning for the transition to a fee-for-service system from a primarily grant-based funding system. A wide array of stakeholders representing consumers, family members of individuals with mental illnesses, advocates and public service agencies purchasing or providing treatment to individuals with mental illnesses participate in these efforts. The anticipated outcome is the continued enhancement of activities that support the recovery-orientation of the mental health system and address the needs of consumers and their families.

Significant fiscal challenges are confronting the Illinois and the Illinois mental health service system in FY 2010. The DMH Fiscal Year 2010 community mental health services budget has been cut by 8% or approximately 42 million dollars. The impact of this reductions is described at various points in the plan narrative. The Division continues to work diligently to increase revenue from Medicaid and to seek grant funding to support programmatic efforts. In FY2010, the emphasis will be on maintaining core services and access to them.

During FY 2010, the efforts of the DMH remain focused on: (1) sustaining the significant accomplishments of recent years, (2) continuing the maintenance and development of the public mental health service system through joint planning, coordination and implementation efforts, (3) emphasizing consumer education, recovery-orientation and enhanced consumer and family involvement in planning and evaluation activities, (4) planning efforts to continue transformation of the Illinois Mental Health service delivery system, and (5) continuing development and initiation of strategies to expand access to evidence-based practices. The format of this FY2010 plan reflects these themes, and is synchronized with the overall planning process of the DMH.
Plan Organization
As the Illinois Mental Health Authority, the DMH is responsible for public mental health services for both children and adults. The presentation of the FY2010 plan reflects this service integration and is organized in compliance with the SAMHSA CMHS format which calls for two separate plans—one for adults and one for children. This organization is reflected in the Narrative, as well as in the performance indicators that relate to the plan. To reduce redundancy where there are sections of narrative applicable to both adults and children these are in the Adult Plan and referenced in the Child plan. When different sections of the same plan cover the same subject, references are made to the section that has the more complete presentation of the material.

The following are highlights of this year’s application and plan:

- **Continuation of the permanent supportive housing initiative** which has been designed to accommodate at least 600 consumers by the end of FY2011.
- A procurement process for an **Administrative Services Organization (ASO)** led to the selection, in Fall 2007, of a national behavioral health company to assist DHS/DMH in implementing a number of contractual objectives. The ASO, called the Illinois Mental Health Collaborative for Access and Choice (MHCAC), has been operational through 2008 and 2009. The assistance provided by the MHCAC encompasses a broad spectrum of administrative activity.
- **Say It Out Loud** is a groundbreaking new statewide public awareness campaign launched in May, 2008 to promote mental health by presenting accurate and positive representations about mental illness and diminishing the barriers that prevent people from seeking or offering help and support. It is co-sponsored by IDHS/DMH and the Illinois Children's Mental Health Partnership.
- DMH, working with the Mental Health Collaborative for Access and Choice (MHCAC), **has redesigned the management information system (MIS)** to include a data warehouse that will house eligibility, registration, billing/services information, a provider database, and service authorization in one place and updating key clinical and demographic fields that will be used to track consumer outcomes over time.
- Access to the new **Certified Recovery Support Specialist** (CRSS) credential became available through the Illinois Certification Board (ICB) beginning in July of 2007. Individuals are certified as having met specific predetermined criteria for essential competencies and skills and are recognized for their ability to provide quality services.
- A statewide mental health/criminal justice needs assessment and system mapping initiative funded by a **SAMHSA Transformation Transfer Initiative** grant that is helping to inform the system transformation process in Illinois.
- This year, DMH funded child serving agencies will be required to participate in the newly established **web-based Clinical Outcomes Analysis System** from which reports showing data trends in service outcomes can be generated for feedback to clients and families, providers, and to DMH.C&A Services.
- **An education and training initiative for mental health providers in support of mental health trauma work** with children and families who have experienced trauma as a result of physical abuse, neglect, sexual abuse or domestic violence.
that has an effect on their behavior, performance and adjustment.

- Use of block grant dollars to promote **consumer-to-consumer outreach** and mentoring;
- The continuing investment of block grant dollars to increase and improve **psychiatric leadership and services**.
- Enhancing mental health services for children and adolescents through a range of pilot projects in services to **transitioning youth, tele-psychiatry in rural areas, early intervention, early childhood services**, and consultation on early childhood development and clinical intervention.
- Continuing to develop strategies to increase access to **evidence-based practices**;
- Establishing linkages with **jails, juvenile detention facilities, and the Courts** to serve adjudicated consumers.
- Providing training and consultation to community-based staff serving children and adolescents in **Evidence-Informed Practices**.
- Working collaboratively in consultation with schools to expand **early intervention and prevention** in mental health, and
- Initiatives for elderly persons in **rural areas** that are aimed at providing consultation and promoting the integration of mental health services in meeting the needs of **older adults**.

**Mental Health System Performance Indicators**

The FY2010 plan contains Illinois-specific performance indicators, as well as indicators relating to the SAMHSA CMHS National Outcome Measures (NOMS). The system performance indicators are described in a separate section of each plan and clearly referenced in the plan narrative so that the reader may cross-reference them, or simply review them as a set. The Illinois specific indicators are used to monitor the impact of the mental health services that are purchased on behalf of mental health consumers. These indicators include information that is collected and reported as part of the CMHS Uniform Reporting System. This ability to track values of indicators across time has assisted in identifying issues that need to be addressed within the public mental health service system and have served as a basis for planning. Additional indicators are added as required to meet the priorities of mental health system development.
Attachment A. COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT
FUNDING AGREEMENTS

FISCAL YEAR 2010

I hereby certify that ___________________________ agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:
Subject to Section 1916, the State[1] will expend the grant only for the purpose of:
i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:
ii. Evaluating programs and services carried out under the plan; and
iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912
(c)(1)& (2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms “adults with a serious mental illness” and “children with a severe emotional disturbance” and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:
(a)(1)(C) In the case for a grant for fiscal year 2010, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

[21. The term State shall hereafter be understood to include Territories.]
(A) Services principally to individuals residing in a defined geographic area (referred to as a “service area”)
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:
The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
   (i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
   (ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:
(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and

(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]

(c) The State will:
(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:
(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section.

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.
CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee’s workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--

(1) The dangers of drug abuse in the workplace;

(2) The grantee’s policy of maintaining a drug-free workplace;

(3) Any available drug counseling, rehabilitation, and employee assistance programs; and

(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--

(1) Abide by the terms of the statement; and

(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central
point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. 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).

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

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

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

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

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, 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.

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

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

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

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Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

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11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Signature: __________________________
Print Name: _________________________
Title: ____________________________
Telephone No.: _____________________ Date: __________

Authorized for Local Reproduction
Standard Form - LLL (Rev. 7-97)
INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., “RFP-DE-90-001.”

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No.0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.
ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

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 nondiscrimination 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.


OMB Approval No. 0348-0040

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET.
SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.
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).


14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL

APPLICANT ORGANIZATION

Illinois Department of Human Services/Division of Mental Health

DATE SUBMITTED

Secretary, Department of Human Services
Illinois

Public Comments on State Plan

Section 1941 of the Block Grant legislation stipulates that as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State Plan. States will make the mental health plan public in such a manner to facilitate comment from any person (including Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

States should describe their efforts and procedures to obtain public comment on the plan on the plan in this section.
ILLINOIS MENTAL HEALTH PLANNING COMMITTEE COMMENTS ON THE FY2010 APPLICATION

Public Comment on the FY 2010 Illinois Mental Health Block Grant Application

The development of the state mental health block grant plan is made available for public comment in several 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 the Illinois Alliance for the Mentally Ill. 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 meeting at which the plan is discussed and provide feedback and comments. (3) During its development, the FY2010 plan was reviewed by the Planning Committee of the MHPAC. Four formal meetings to review the plan were held (June 4th, June 26th, July 9th, and July 27th). The Block Plan has also been discussed at all MHPAC meetings in the past year. Formal review of the Plan by the Council occurred on July 9th pursuant to a report by the Planning Committee and was discussed again at a specially convened meeting on July 30th. Notice of the availability of the plan via the web was emailed to all Council members on April 24th with a request for input and recommendations by May 30th to inform the drafting process which was initiated then. (4) A Notice requesting public comment was posted on the DHS Website in May and successive drafts of the Plan were posted as they were completed. Comments received from the Council and other stakeholders have been reviewed by the Planning Committee and the Council. These comments were addressed in the plan that is being submitted. The detailed comments are displayed below. (5) 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) by September 12, 2009. The public can access this DHS DMH Internet site. Interested parties have been instructed to contact Dr. Mary E. Smith to provide comment. Contact information is provided on the website.

Detailed Comments and Responses

The FY2010 Block Grant Application and Plan was reviewed and discussed in the Planning Committee during the course of three meetings. On 6/4/09 objectives from the FY2009 Plan were reviewed. The First Draft (6/15/09) was reviewed at two meetings—on June 26, 2009 and July 9, 2009. The following comments and suggestions were made and responses to them are italicized. These comments impacted the content of the Narrative which was largely updated for the Second Draft (7/23/09). The Planning committee reviewed the Second Draft on July 27, 2009. Subsequently the FY2010 Application and Plan was extensively discussed in the entire Council at a Special Meeting convened on July 30, 2009. Written comments received from members of the Council prior to that meeting are attached at the end of this document.
FROM 6/4/09:
Objective A1.1 (Consumer Education)- The last indicator is actually the indicator for Objective A1.2.
This is redundant and will be changed in FY2010.

Objective A1.3 (Recovery Training)- The word “in-service” in the title is misleading.
Thanks for catching that. The word was deleted from the FY2010 objective.

Objective A1.5 (Medication Algorithms)- The indicators simply look at the numbers of training sessions but not the qualitative aspects. Incorporation of what’s being learned should be included.
Your comment was forwarded to Dr. Bruce to see if he had any thoughts about how to respond to this suggestion. Per ensuing conversation, the FY2010 objective was modified to include the introduction of documentation and reporting of the competency attained by participants in the use of medication algorithms through the training provided. Additionally, for FY2010, Dr. Bruce included updating the algorithms and updating the website as important program objectives. These items have now been included in the objective for FY2010.

Objective A1.9 (Say It Out Loud Campaign)- The timing and spacing of materials developed for dissemination that address resource and access issues is important. The Say IT Out Loud materials have been sent to agencies and end up sitting without adequate follow-up for a long period of time and then new materials suddenly show up. It would be better to tie the materials to specific areas of interest as they are advanced by the campaign.
This observation and suggestion was forwarded to Michael Pelletier. His response (7/8/09) follows:

“The Campaign was built Pyramid style or "TUPPERWARE" party style where one person tells another, who tells another etc - materials were sent to agencies who agreed to be the local partygivers and we also provide them with training and toolkits. SIOL was never meant to be the individual marketer (salesman) at each agency.
2) SIOL is not funded in FY10 so ANY actions will be dependent on very limited time/effort from one staff member and myself which really also means agencies are MORE than ever responsible for their own fate in distributing/selling of the SIOL concept - we just provide the tools and the materials.”

Objective A1.14 (Monitoring UST Length of Stay)- This objective is confusing and not understandable in view of the many other monitoring objectives. Wouldn’t it be better to have this as an indicator in an objective with deals with those individuals unfit to stand trial.
This was discussed at length with Dr. Freeman. Since monitoring length of stay in the state hospitals is a bed capacity issue, it does not fit well with outpatient objectives. Language and formatting have been added to the Narrative to reduce the confusing nature of multiple monitoring systems for different populations and to clarify the role of this objective.
Objective C1.3 (Evidence-Informed Practice)- This objective should be updated since extensive work has been done in this area.

Agreed. The progress of this initiative was documented in the FY2010 First Draft and was subsequently revised to provide more substance and clarification in the Second Draft.

Objective C1.4 (ICG Community Services)- Title should reflect Severe Mental Illness. Can there be an indicator which demonstrates or describes improvement rather than just numbers of youth served? Can the number of youth transitioning from residential programs be included?

These issues were discussed with Dr. Harkins. The ICG program is introducing the Ohio Scales and Columbia Impairment Scale as outcome measures for ICG recipients and this is being incorporated into the FY2010 objective for the program. The ICG program does not collect data on the number of recipients transitioning from residential programs to the community.

FROM 6/26/09 (First Draft):

Adult-New Developments And Issues (pp7-12)
What about the Budget?
A preliminary description of the outcome of FY2010 budget deliberations and the impact upon community mental health services was inserted in this section (Second Draft). It is being updated and appropriately revised as definitive information becomes available.

Where is the expenditure of block grant dollars located?
Block grant expenditures were provided in an e-mail to committee members and the Grant Expenditure Manner Section was updated to show FY2009 allocation (increase of $80,000) and FY2009 information on the expenditure of block grant funds for community support, psychiatric leadership, and special projects. As the final allocations for FY 10 were not yet finalized due to the fact that there was no approved budget, the committee was referred to the dollar allocations for FY2009 that were included in the FY2009 application and the dollar allocations for FY 2008 which were included in the FY 2008 Block Grant Implementation Report.

Adult- Legislative Initiatives and Changes p.12
There is nothing new yet as the Governor hasn’t signed off on the proposal for a Veteran’s Court, or the proposal for requiring redirection of funds from state hospital closures to community services, nor the proposal that Medicaid eligibility be maintained for incarcerated persons.

Child-Overview (pp.19-20)
A descriptive paragraph should be inserted which lists the state agencies other state level resources that fund and provide mental health services to youth. (R. Connor)
We agreed and have provided a descriptive paragraph in this section.

Child-New Developments and Issues (p.20)
A brief description of the Family Driven Care Initiative should be inserted
Agreed and Done!

**Adult-Service System Strengths and Weaknesses (page 22)**
The array of core services available to adults with SMI is cited as a strength, but what is the good of it if not accessible. It is like a buffet put out for people who can’t afford to eat anything. (F. Friedman)

*Your observation is appreciated.*

**Adult- Unmet Service Needs (p.24)**
Access should be addressed here. (J. King, F. Friedman)

An unmet service need is generally defined as a particular service that is needed by a number of persons that is largely non-available. There is currently no evidence that persons coming to mental health centers for basic services are being turned away or are sitting indefinitely on waiting lists. The issue of access is more properly addressed in the Quantitative Targets and the access indicators of the Goals – Action Plans section.

**Adult-Plans to Address Unmet Service Needs (p.24)**
Emphasize the maintenance of key community-based services. (L. Denson)

Agreed. We have listed this as the first priority in this section.

**Adult- Establishment of a System of Care (pp35-47)**
Re Forensic Services: Clarify the data presented in the paragraph on linkage services in Will, Peoria, Jefferson and Marion Counties. What happened to the people who weren’t getting services in 30 days? (J. King) pg.42

The data has been clarified and the paragraph has been rewritten more clearly. We have no information about the 177 individuals who were not following through at 30 days.

**Adult-Available Services (p.49)**
Psychiatric Services- How can quality be improving when it appears to be going downhill. How do we know it is improving? There is no evidence to support it. Psychiatrists are seeing more patients in shorter time spans (F. Friedman). Telepsychiatry services could serve as a good quality indicator. (Dr. D. Martinez)

*These observations are appreciated.*

**FROM 7/9/09:**

**Adult-Available Services**

Case Management- The plan calls for face-to-face linkage within seven days post-discharge. (pg 57) Is there data confirming the number of persons actually linked within seven days? (J. King)

The data item was followed for several years as part of the CONNECT97 initiative of 12 years ago. It has since been discontinued. Continuity of Care Agreements continue to be required in every service contract with providers.

Community Support Teams- The plan says that CST providers are required to deliver 60% of their services in natural settings. (pg 58) How is that being measured and tracked? (J. King)

Community Support teams are only a little more than a year old. We are developing the performance measures, baseline data, and the data collection mechanisms for this service. In the past we collected similar data for SASS hours in the community and ACT services in natural settings.
Hospital Admissions- Contradictory data on admissions exists between what is cited in the narrative (pp.59-60) and what is documented in the URS tables. (J. King)

Erroneous data exists in one of the URS Tables and this data will be checked out and corrected.

Medication Algorithms-There should be an indicator reflecting the quality of the training provided and not just quantitative information about numbers at each level.(page 62) An algorithm for Anxiety Disorders should be developed. (Dr. D. Martinez)

Dr. Bruce was receptive to these ideas and as stated above, the objective has since been modified.

Adult- Quantitative Targets
There are no objectives cited to increase access. You don’t say how you will increase access. (J. King)

With the budget cuts we are experiencing this year, it would be foolhardy to talk about increasing access. Generally, we monitor access from year to year as we cannot project increases, especially if there is no new initiative we can pin our hopes on. However, many of the objectives such as PSH, PATH, Say It Out Loud are pieces in the mosaic.

Adult- Outreach To Homeless (pp. 67-72)
Continuums of Care- In reference to: “To engage persons who are homeless in these critical services, a team of clinicians provides on-site assessments and linkage to mental health services at the emergency shelters.” (pg.72). What agency does this? (J. King, C. St.Clair)

As we usually do not identify agencies or persons in the block grant narrative, we think that the description given on page 72 is sufficient for the Application. It reads:

In suburban Cook County, HUD funds support Project WIN (Wellness Initiative Network), which is a multi-agency, multi-service collaboration to provide coordinated care in the areas of mental health, medical health, and substance abuse treatment. To engage persons who are homeless in these critical services, a team of clinicians provides on-site assessments and linkage to mental health services at the emergency shelters.

However, for the purpose of local awareness, here is more detailed information:
Project WIN is led by Pillars and includes Family Services and Mental Health of Oak Park/River Forest (now renamed Thrive Counseling Center) and Grand Prairie Services. During the fall-winter-early spring months when overnight shelter is provided thru rotating PADS sites (Providing Alternatives for Decent Shelter- usually faith community meeting sites that allow cots to be set up 1 night a week and persons then need to get to the next site the next day), Project WIN mental health agencies go to the PADS sites to develop mental health linkage. The remainder of the year they work with the 12 month a year PADS case management sites to add mental health linkage capacity. Project WIN serves West and South Suburban Cook County. The VA, a primary health care provider, and the South Suburban Council on Alcoholism are also integral to WIN as well as West Suburban PADS, South Suburban PADS, and BEDS (a West Suburban emergency shelter program).

Adult- Older Adults
RE: “It is conservatively estimated that 15-25% of individuals over age 60 experience symptoms of mental disorders as they are considered to have a higher incidence than
other age groups due to increasing number of life stressors.” (pg.74). What is the source for this information? (J. King)

This general information is a frequently stated statistical view of symptoms of mental illness in the aging population and has been cited by the Illinois Department On Aging and others. However, for a more detailed presentation based on definitive research, please see U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General, Rockville, MD, 1999. The Report devotes an entire chapter to mental health issues in older adults and states that: “a substantial proportion of the population 55 and older –almost 20 percent of this age group-experience specific mental disorders that are not part of “normal” aging. (Page335) Estimated prevalence rates for this population are: Anxiety Disorder-11.4%; Mood Disorder-4.4%; Schizophrenia-0.6%; Somatization-0.3%; Severe Cognitive Impairment-6.6% and, Any Disorder-19.8%.

**Adult- Emergency Service Provider Training (pg.80)**

It would be good to have updated information on CIT training included here. (Dr. D. Martinez)

Good Point! A statement on the training of CIT officers by the Community Reintegration Initiative has been added to the text here.

**CHILD PLAN**

**Child- Establishment of System of Care**

Evidence- Informed and Evidence-Based Practices- (pp.85-86) The presentation would be strengthened by linking the dot points of the progress report to the five pronged strategy discussed in the preceding paragraph. (R.Connor)

Agreed and Done!

ICG Community Services- the reference to Rule 132 (page 88) is confusing. Cite Illinois Medicaid Rule (Rule 132). (C. St. Clair)

Done

C&A Performance Indicators-Outcome Data from the C&A Outcomes Analysis (Objective C2.1) could be referenced here. (R. Connor)

Agreed and Done!

**Child-Available Services**

RE: “For pre-school children ages 3-5 years, the number receiving special education services is increasing annually (6.44% in 2004, 4.66% in 2005, and 2.12% in 2006).” (pg. 94) Numbers cited differ from statement. Please reconcile. (Dr. D. Martinez)

Thanks for catching the typo. The sentence should say: “decreasing annually”

**Child- Quantitative Targets (pp.99-102)**

Demographic information was cited for adults, but not for children. Race and Ethnic data would be helpful in looking at possible disparities in service provision. (J. King)

This is a good point. We are pursuing the demographic breakout for children in the State from census data with the idea of some comparative study of the FY2008 and FY2009 demographic characteristics of the children and adolescents receiving services in our system.

**Child- System of Integrated Services**

Mental Health and Juvenile Justice- What is the explanation for the increase in the percentage of youth who are rearrested? (page 107) (Dr. D. Martinez)
The MHJJ program cannot offer a substantive explanation for the 4.4% increase in the re-arrest rate at present but is looking into it. Reducing the recurrent involvement of youth with SED in the Juvenile Justice sector is a priority of the program. It is too early to tell if this is simply a phenomenon that occurred this year or a developing trend which needs to be addressed by the program.
II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

States are required to provide systems of integrated services for children with serious emotional disturbances (SED). Each year the State shall expend not less than the calculated amount for FY 1994.

Data Reported by:
State FY ___X___ Federal FY ______

State Expenditures for Mental Health Services

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<tr>
<th>Calculated FY 1994</th>
<th>Actual FY 2008</th>
<th>Estimate/Actual FY 2009</th>
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Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.
III. MAINTENANCE OF EFFORT (MOE) REPORT

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State’s request for exclusion.

States are required to submit State expenditures in the following format:

**MOE information reported by:**

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**State Expenditures for Mental Health Services**

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<td>$428,645,083</td>
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MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.
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<td>Anselmo, Frank</td>
<td>Others(not state employees or providers)</td>
<td>Community Behavioral Health Assn</td>
<td>3085 Stevenson Drive Springfield,IL 62703 PH:217-585-1600 FAX: <a href="mailto:fanselmo@cbha.net">fanselmo@cbha.net</a></td>
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<td>Ayres, Cassie</td>
<td>Others(not state employees or providers)</td>
<td>Illinois Association of Rehabilitation Facilities</td>
<td>206 South Sixth Street Springfield,IL 62701 PH:217-753-1190 FAX:217-525-1271</td>
<td><a href="mailto:cayres@hso.net">cayres@hso.net</a></td>
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<td>Barnes, Kimberly</td>
<td>Family Members of Children with SED</td>
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<td>P.O. Box 185 Shawneetown,IL 62984 PH:618-269-3670 FAX:</td>
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<td>Blank, Wendy</td>
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<td>16830 South Rt. 53 Crest Hill,IL 60403 PH:815-727-3607 FAX:</td>
<td><a href="mailto:Wendy.Blank@DOC.Illinios.gov">Wendy.Blank@DOC.Illinios.gov</a></td>
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<td>Boyd, Cheryl</td>
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<td>Franklin-Williamson Human Services</td>
<td>Franklin Williamson Human Services 902 West Main Street West Frankfort,IL 62896 PH:618-937-6483 FAX:618-937-1440</td>
<td><a href="mailto:Cheryl.Boyd@whs.org">Cheryl.Boyd@whs.org</a></td>
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<td>Burchell, Juana</td>
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<td>Education</td>
<td>100 North 1st Street Springfield,IL 62777 PH:217-782-5589 FAX:</td>
<td><a href="mailto:jburchel@isbe.net">jburchel@isbe.net</a></td>
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<td>805 19th Street Rock Island, IL 61201 PH:309-793-4993 FAX:</td>
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<td>226 Lincoln Parkway Crystal Lake IL 60014 PH:815-455-1391 FAX:</td>
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</tr>
<tr>
<td>Pluta, William</td>
<td>State Employees</td>
<td>Housing</td>
<td>Illinois Housing Development Authority 401 North Michigan Avenue, suite 900 Chicago, IL 60611 PH:312-836-5354 FAX:312-832-2191</td>
<td><a href="mailto:wpluta@ihda.org">wpluta@ihda.org</a></td>
</tr>
<tr>
<td>Name</td>
<td>Type of Membership</td>
<td>Agency or Organization Represented</td>
<td>Address, Phone and Fax</td>
<td>Email (If available)</td>
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<th>Type of Membership</th>
<th>Agency or Organization Represented</th>
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<tr>
<td>Schneider, Beth</td>
<td>Consumers/Survivors/Ex-patients(C/S/X)</td>
<td></td>
<td>444 West Frontage Road Northfield, IL 60076</td>
<td><a href="mailto:bschneider@wilpower.org">bschneider@wilpower.org</a></td>
</tr>
<tr>
<td>Shustitzky, John</td>
<td>Providers</td>
<td>Pillars</td>
<td>333 North LaGrange Road LaGrange Park, IL 60526</td>
<td><a href="mailto:jshustitzky@pillarscommunity.org">jshustitzky@pillarscommunity.org</a></td>
</tr>
<tr>
<td>Sorrells, Anita</td>
<td>Family Members of Children with SED</td>
<td></td>
<td>2009 Windsor Street Pekin, IL 61554</td>
<td><a href="mailto:anitasorrels@insightbb.com">anitasorrels@insightbb.com</a></td>
</tr>
<tr>
<td>St.Clair, Cathy</td>
<td>Consumers/Survivors/Ex-patients(C/S/X)</td>
<td></td>
<td>6301 North Sheridan Road #8D Chicago, IL 60660</td>
<td><a href="mailto:cstclair@centerforprogress.org">cstclair@centerforprogress.org</a></td>
</tr>
<tr>
<td>Thomas, Lisa</td>
<td>Family Members of Children with SED</td>
<td></td>
<td>1775 Kings Gate Lane Crystal Lake, IL 60014</td>
<td><a href="mailto:Thomas.Lora@sbcglobal.net">Thomas.Lora@sbcglobal.net</a></td>
</tr>
<tr>
<td>Thomas, Lora</td>
<td>Others(not state employees or providers)</td>
<td>NAMI Illinois</td>
<td>218 West Lawrence Springfield, IL 62704</td>
<td><a href="mailto:Thomas.Lora@sbcglobal.net">Thomas.Lora@sbcglobal.net</a></td>
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<tr>
<td>Name</td>
<td>Type of Membership</td>
<td>Agency or Organization Represented</td>
<td>Address, Phone and Fax</td>
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<tr>
<td>Vyverberg, Robert Ed.D.</td>
<td>State Employees</td>
<td>Mental Health</td>
<td>5407 North University Peoria,IL 61614 PH:309-693-5228 FAX:</td>
<td><a href="mailto:Robert.Vyverberg@illinois.gov">Robert.Vyverberg@illinois.gov</a></td>
</tr>
<tr>
<td>Ware, Frank</td>
<td>Providers</td>
<td>Janet Wattles Mental Health Center</td>
<td>526 West State Street Rockford,IL 61101 PH:815-968-9300 FAX:</td>
<td><a href="mailto:fware@janetwattles.org">fware@janetwattles.org</a></td>
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<tr>
<td>Weissman, Sidney MD</td>
<td>State Employees</td>
<td>Other</td>
<td>676 St. Clair, Suite 1760 Chicago,IL 60611 PH: FAX:</td>
<td><a href="mailto:Sidney.Weissman@med.va.gov">Sidney.Weissman@med.va.gov</a></td>
</tr>
<tr>
<td>Wells, Don P</td>
<td>Consumers/Survivors/Ex-patients(C/S/X)</td>
<td>Lyons Township Mental Health Commission</td>
<td>6404 Joliet Road Countryside,IL 60525 PH:708-352-2992 FAX:708-354-7212</td>
<td><a href="mailto:ltmhc@lyonsts.com">ltmhc@lyonsts.com</a></td>
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### TABLE 2. Planning Council Composition by Type of Member

<table>
<thead>
<tr>
<th>Type of Membership</th>
<th>Number</th>
<th>Percentage of Total Membership</th>
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<tr>
<td>TOTAL MEMBERSHIP</td>
<td>53</td>
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<tr>
<td>Consumers/Survivors/Ex-patients(C/S/X)</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Family Members of Children with SED</td>
<td>9</td>
<td></td>
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<tr>
<td>Family Members of adults with SMI</td>
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<tr>
<td>Vacancies(C/S/X and Family Members)</td>
<td>0</td>
<td></td>
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<tr>
<td>Others(not state employees or providers)</td>
<td>6</td>
<td></td>
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<tr>
<td><strong>TOTAL C/S/X, Family Members and Others</strong></td>
<td>33</td>
<td>62.26%</td>
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<tr>
<td>State Employees</td>
<td>8</td>
<td></td>
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<tr>
<td>Providers</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Vacancies</td>
<td>0</td>
<td></td>
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<tr>
<td><strong>TOTAL State Employees and Providers</strong></td>
<td>20</td>
<td>37.74%</td>
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</table>

**Note:** 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State Employee and Provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services. 4) Totals and Percentages do not include vacancies.
Illinois

Planning Council Charge, Role and Activities

State Mental Health Planning Councils are required to perform certain duties. If available, a charter or a narrative summarizing the duties of the Planning Council should be included. This section should also specify the policies and procedures for the selection of council members, their terms, the conduct of meetings, and a report of the Planning Council’s efforts and related duties as mandated by law:

reviewing plans and submitting to the State any recommendations for modification serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State, the role of the Planning Council in improving mental health services within the State.

<STRONG>In addition to the duties mandated by law, States should include a brief description of the role of the Planning Council in the State’s transformation activities that are described in Part C, Section II and Section III. </STRONG>
IV. State Mental Health Planning Councils

1. The IMHPAC bylaws include the role and purpose of the Council as well as the membership requirements.

By-Laws of the Illinois Mental Health Planning and Advisory Council (IMHPAC)

ARTICLE I - NAME

The name of this unincorporated association shall be the Illinois Mental Health Planning and Advisory Council (the “Council”).

ARTICLE II - PURPOSE

The purposes of the Council shall be: (1) to exchange information and develop, evaluate and communicate ideas about mental health planning, (2) to review and make recommendations regarding the Federal Mental Health Services Block Grant plan for mental health services in the State of Illinois, (3) to advise the Illinois Department of Human Services Division of Mental Health and other departments, divisions and agencies of state government concerning proposed and adopted plans affecting mental health services provided or coordinated by the state and the implementation thereof; (4) to monitor, review and evaluate the allocation and adequacy of mental health services in Illinois and to advise the Illinois state government concerning the need for and quality of services and programs for adults with mental illness and children and adolescents with serious emotional disturbances, and (5) to develop and take advocacy positions concerning legislation and regulations affecting mental health.

ARTICLE III - MEMBERSHIP

Section 1. Qualifications

Council membership composition shall follow the guidelines set forth in P.L. 102-321 and any subsequent federal regulation. The Council shall have at least 45 and no more than 55 members. Less than 50% of the members shall be state employees or employed by any entity which provides mental health services.

Section 2. Election of Members

(a) No later than October 1st of each year, the Council Development Committee shall notify the Council in writing of the names of Council members whose terms will expire on December 31st. This notice shall include the geographic location
of each Council member whose term will expire, whether that member represents a service provider, persons with a mental illness, family members of persons with mental illness, family members of children or adolescents with a serious emotional disturbance or a specific state agency. The Committee shall solicit nominees from the Council, mental health service providers and organizations representing service providers, organizations which represent or are advocates for persons with mental illness or their relatives.

(b) The Committee shall request that the Division of Mental Health designate a representative to be a member of the Council and that the Division of Mental Health solicit representatives from the Division of Rehabilitation Services, the Department of Corrections, the Housing Development Authority, the Department of Public Aid, and the State Board of Education. The Committee shall request that a union representing persons employed by the Division of Mental Health shall designate a representative.

(c) The Committee shall nominate a slate of proposed new members to be elected during the Fall meeting of the Council. Such slate shall include the persons designated pursuant to paragraph (b) of this Section. The Committee shall ensure that the slate and the membership of the Council as a whole are comprised in a manner so that:

(i) members are chosen in compliance with all applicable federal laws and regulations and these bylaws;
(ii) each region of the state is adequately represented;
(iii) the ratio of parents of children and adolescents with serious emotional disturbances to the other members of the Council is sufficient to provide adequate representation to such parents; and,
(iv) there is diversity in the racial, gender, ethnic and geographic composition of the Council as a whole.

(d) The Council shall vote for the entire slate of proposed new members as a group. Any member of the Council may by motion propose an alternative slate of new members provided such slate complies with the provisions in subsection (c) of this Section and provided such motion is seconded by a member of the Council. The members of the slate which receives the most votes shall be considered elected to the Council.

(e) The Committee may appoint a new member when, during the course of any year, a vacancy occurs. Whenever one or more new members are appointed by the Committee, the Committee shall promptly advise the full Council in writing of the appointment.

Section 3. Terms

Members shall be elected to serve a three-year term. No member shall serve more than three consecutive terms. However, there shall be no limit to the number of terms served
by a representative chosen by the Division of Mental Health, the Division of Rehabilitation Services, the Department of Corrections, the Housing Development Authority, the Department of Public Aid, the State Board of Education or a union representing persons employed by the Division-Office of Mental Health.

Section 4. Compensation

The members of the Council shall serve without pay, but the Council may authorize or recommend the payment of reasonable and necessary expenses incurred by the members in the performance of their duties. By vote of the Council in which consumers shall not participate, the Council may authorize compensation for consumers for their participation in the work of the Council and its committees to the extent that such consumers are not otherwise compensated for this work.

Section 5. Removal of Members

A member may be removed by the Council whenever in its judgment the best interests of the Council would be served thereby. Whenever a member has failed to attend at least 50% of the regularly scheduled meetings in any calendar year, the Council Development Committee shall notify the Council and the member of that fact. If the committee determines that good cause does not exist for the failure of the member to attend Council meetings, the Committee shall move that the member be removed. Removal may occur only at a properly called meeting of the Council, after at least thirty days written notice to the person proposed to be removed and to the Council. No member may be removed unless at least two thirds of the members present vote to remove a member. Any member may resign at any time by giving written notice to the Council.

ARTICLE IV--MEETINGS

Section 1. Timing and location

Regular meetings of the Council shall be held at least four times each year. The dates of the regular meetings shall be determined at the beginning of each year and a written schedule of the meetings shall be provided to each member. The Council may decide to meet more frequently. At least two meetings each year shall be held in Cook County and at least two meetings each year shall be held in Sangamon County. Special meetings of the Council may be called at any time by the co-chairs or by a written request to either of the co-chairs from 25% of the members. Members may participate in Council meetings through video-conferencing or other similar technologies if such technologies are available.

Section 2. Notice

The co-chairs may call for a special meeting of the Council by mailing an agenda to all of the members at least 7 days prior to any such meeting, and not more than 60 days prior to any such meeting.
Section 3. **Quorum**

A quorum of the Council shall exist if one third or more of the total members as of the day prior to the meeting are present. A majority of the members present is required for any action of the Council.

Section 4. **Powers**

The Council shall have all of the powers vested in it by virtue of these Bylaws, together with any other reasonable and necessary powers to carry out the purposes of the Council. The Council may commit the Council, but not the State of Illinois or the Division of Mental Health or any member, concerning any matter within the purpose of the Council.

Section 5. **Open Meetings**

All meetings of the Council shall be open to the public. The Council shall take reasonable steps to insure that persons and organizations with an interest in the mental health system in Illinois are notified of the time and location of all meetings, including, if possible listing such meetings on the websites of relevant government agencies. A reasonable period shall be set aside at all meetings of the Council for members of the public to address the Council. Members of the public shall be permitted to propose “new business” for the next meeting of the Council. Subject to veto by the Council, such new business shall be placed on the next Council meeting agenda.

Section 6. **Alternates; Abstention**

There shall be no proxies for meetings of the Council. A member of the Council may designate an alternative to attend Council meetings when such member is unable to attend, but such an alternative shall not be entitled to vote.

Section 7. **Rules of Order**

In all procedural matters not governed by these Bylaws, the Council shall be bound by the provisions of *Robert’s Rules of Order, Newly Revised* (1990). But the Council may, by the vote of two-thirds of a quorum of the Council present at a meeting of the Council, suspend any provision of these Bylaws or of *Robert’s Rules*, at any time, whether or not such suspension is on the agenda.

Section 8. **Participation of the Division of Mental Health/Youth and Geriatric Advisory Councils**

The co-chairs of the Council shall request that the Division of Mental Health designate such representatives as may be appropriate to attend meetings of the Council and its committees. Whenever issues relating to the delivery of mental health services to aged persons or to children or adolescents are to be discussed, the Division of Mental Health
shall take reasonable steps to obtain the presence at Council meetings of one or more members of the Geriatric Advisory Council or Youth Advisory Council as it deems appropriate.

ARTICLE V - OFFICERS

Section 1. Terms

The officers of the Council shall consist of one co-chair who is a service provider, one co-chair who is a primary or secondary consumer, a secretary and a treasurer. Each officer shall serve for two years unless such person ceases to be qualified to serve as an officer. Each officer shall hold office until his or her successor shall have been duly elected by the Council.

Section 2. Nominations

The Council Development Committee shall solicit nominations for officer positions from the Council and from the Division of Mental Health. The Committee shall choose at least one person for each office. Nominees receiving a plurality vote of the Committee for the available vacancies shall be declared elected. Each position shall be voted on separately.

Section 3. Duties of Co-Chairs

The co-chairs shall be the parliamentary chairs of the Council. It shall be the duty of the co-chairs to preside over all meetings of the Council, and, subject to the control of the Council, to supervise and control all of the business affairs of the Council. The co-chairs shall be ex-officio members of all committees. The co-chairs shall see that all motions and resolutions of the Council are carried into effect.

Section 4. Duties of Treasurer

The Treasurer shall be responsible for accounting for any funds allocated or obtained for the use of the Council, subject to the oversight of the Finance Committee.

Section 5. Duties of Secretary

The Secretary shall be responsible for insuring that minutes of each Council meeting are prepared and provided to the Council and for maintaining such other Council records as the Council or the co-chairs may direct.

Section 6. Removal

An officer may be removed by the Council whenever in its judgment the best interests of the Council would be served thereby, but such removal shall be without prejudice to such officer’s position as a member. Removal may occur only at a properly called meeting of the Council, after at least thirty days notice to the person proposed to be removed. Any
officer may resign at any time by giving written notice to the Council.

Section 7.  Vacancy

A vacancy shall exist whenever an officer is removed, resigns, dies, or ceases to be a member of the Council.

Section 8.  Agenda

After consultation with the Associate Director of the Division of Mental Health and the members of the Executive Committee, to the extent feasible, the co-chairs shall set the agenda for meetings of the Council and recommend action to the Council and shall insure that a copy of the agenda is mailed to the members of the Council at least seven days prior to any meeting of the Council.

ARTICLE VI - COMMITTEES

Section 1.  Appointments

Except for the Council Development Committee and the Executive Committee, the co-chairs, in consultation with the Council, shall appoint all chairs and members of all committees of the Council. The co-chairs may include an additional consumer to maintain a balance of representation on the executive committee. Every member of the Council shall serve on at least one committee, except as may be determined by the co-chairs. Persons who are not members of the Council, including employees of the Division of Mental Health, may serve as members of any standing committee except for the Council Development and Executive Committees. The co-chairs may appoint one or more adolescent consumers to committees of the Council other than the Council Development and Executive Committee. The majority of the members of each committee shall be members of the Council.

Section 2.  Executive Committee

There shall be an Executive Committee comprised of the co-chairs of the Council, the treasurer, the secretary and the chair of each standing committee. The Executive Committee may make any decision concerning the affairs of the Council in the interim between properly called meetings of the Council. However, any such action shall be reported to the Council at the next meeting thereof. The Executive Committee shall develop an annual budget for the Council and shall monitor the expenditure of Council funds.

Section 3.  Standing Committees

The standing committees shall be as follows:
(a)  **Council Development:** This committee shall be comprised of 5 members. One member of the Committee shall be the member of the Council representing the Division of Mental Health. The other members of this committee shall be elected by a vote of the Council at a meeting of the Council to be held prior to June 1st of each year. At least one of the members of the committee elected by the Council shall be a primary consumer. The Executive Committee shall determine the procedures for the conduct of this election and provide written notice of those procedures and of the election itself to the members of the Council at least 30 days prior to the election. This committee shall be responsible for receiving and reviewing applications and nominating members to be members and officers of the Council. This committee shall be responsible: (i) for nominating persons to serve on the council; (ii) for selecting persons to serve as officers of the Council; (iii) for drafting such amendments to the Bylaws as may be needed; (iv) recommending to the Council the removal of any officer or member who is not longer qualified to serve, and, (v) for orienting new Council members. This committee shall also work with the Division of Mental Health to identify state funds to support the work of the Council, may identify and seek other sources of funds, public or private, to support the work of the Council.

(b)  **Planning.** This committee shall review plans provided to the Council by the State pursuant to 42 USC §300x-4(a) and make recommendations to the Council and the Division of Mental Health for modifications to the plans.

(c)  **Substantive Committees.** The council shall establish committees relating to the specific areas of services for persons with mental illnesses. There committees shall be responsible for devising a monitoring plan for their area of oversight; interacting with and advising the relevant state, county and municipal entities which provide services within their area of oversight; and, recommending to the Council advocacy priorities within their area of oversight. The substantive committees shall include:

(i) Adult inpatient mental health services  
(ii) Adult community mental health services  
(iii) Children and adolescent mental health services  
(iv) Persons with mental illnesses in the criminal justice system  
(v) Any other substantive committees as determined by the Council to be necessary or expedient to carry on the mission of the Council.

Section 4.  **Powers**

The Committees shall have the power and authority to make decisions only as may be specifically assigned by a majority of a quorum of the Council at a properly called meeting of the Council. Chairs shall be responsible for keeping minutes of committee meetings and for reporting activities to the Council.
Section 5. **Other Committees**

Other committees may be appointed by the co-chairs as the Council deems necessary or expedient to carry on the business of the Council.

Section 6. **Removal**

The chair or any member of any committee may be removed for willful misconduct by a majority of a quorum of the Council at any time at a properly called meeting of the Council.

ARTICLE VII--ANTI-DISCRIMINATION

The Council shall not discriminate in any regard with respect to race, creed, color, sex, sexual orientation, marital status, religion, national origin, ancestry, pregnancy, parenthood, custody of a minor child or physical or mental disability.

ARTICLE VIII--AMENDMENT OF BYLAWS

Any member of the Council may propose amendments to these bylaws. These bylaws may be amended by the Council at any time, provided that written notice of such proposed amendment is provided to the Council at least 30 days prior to the meeting at which such amendment is approved and that any amendment is approved by a majority of a quorum of the Council present at such meeting.
The Role Of The Illinois Mental Health Planning And Advisory Council IMHPAC) In Improving Mental Health Services Within The State

Charge, Role and Activities
The Illinois Mental Health Planning and Advisory Council (IMHPAC) advises the DMH on mental health issues. The Advisory Council is a body of 53 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 which were revised in FY2005.

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.

The Advisory Council currently has several sub-committees including an Executive Committee, Planning Advisory 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.

Evidence of Advisory Council Activities
- As an advocate for adults with SMI and children with SED, and
- Monitoring, reviewing and evaluating the allocation and adequacy of mental health services within the state.
A major focus this year has been the need to generate more revenue for community services and the related project to increase billing Medicaid for services provided by community mental health centers. Members of the MHPAC, including the co-chair, have been closely involved with DMH and other stakeholder groups in developing this process. The President’s New Freedom Commission Report and the Surgeon General’s Report on Mental Health have been recognized as foundational documents in this ongoing effort.

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 Planning Committee of the Advisory Council met with DMH staff to develop and review the state plan, as indicated by the letter from the Chairpersons, Daniel B. Martinez, MD., and Cathy St.Clair, which are included in this application. A copy of the letter from the MHPAC co-chairs endorsing the FY2010 Illinois Mental Health Block Grant Application is included in this section.

**Transformational Activities**

**of the Illinois Mental Health Planning and Advisory Council**

In FY2008, the IMHPAC Planning Committee identified its transformation goals. A retreat for members of the MHPAC was held in September 2007. The purpose of the retreat was: (1) to engage in a planning process to identify priorities on which the Council will focus over the next two to three years; (2) to develop strategies and action steps to address the priorities, and (3) to clarify the organizational structure and communication structure for the MHPAC as a means of improving on-going planning efforts. Work on these issues is continuing.

A second goal is to conduct a thoughtful and careful review with regard to how Mental Health Block Grant dollars are currently spent and the impact of the services which are purchased with block grant dollars. This process will position the Council to be more effective in advocating for improvements to the public mental health service system.

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: recovery, implementation of evidence-based practices, permanent supportive housing, children’s mental health issues and mental health and justice system involvement.

**State Mental Health Planning Council Comments and Recommendations**

The comments and recommendations of the IMHPAC are reflected in the following letters of support that have been submitted.
Illinois

Adult - Overview of State's Mental Health System

Adult - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.
FY 2010 ADULT PLAN

ADULT-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.

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 quality of recovery-oriented and evidence-based treatment and care possible.

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 regional administrators. The Central Office is responsible for oversight of the system, policy formulation and review, the operation of nine state hospitals, planning, services 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. There are approximately 77 FTE positions in Central Office available to accomplish the manifold tasks required of it.

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 organized into five Comprehensive Community Service Regions (CCSRs). Through these Regions, the DMH operates nine state hospitals, contracts with 27 local hospitals and 151 community-based outpatient/rehabilitation agencies across the state. Comprehensive Community 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 CCSRs carrying the responsibility for the development of congruent local systems of care. CCSR Strategic Plans reflect the overall goal of the development of a recovery-oriented service system that is informed and driven by the vision of the President’s New Freedom Commission. Ongoing strategic thinking and planning efforts with Regional stakeholders are designed to uniquely meet local area needs within each Region. 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 CCSRs 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.

The CCSRs are also responsible for integration of a comprehensive care system which includes mental health, rehabilitation, substance abuse, social services, criminal justice, and education. Each CCSR has assigned staff specially designated to address child and adolescent and Forensic services. Being part of IDHS 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), integration of vocational and psychiatric rehabilitation services, coordination and development of Mental Illness and Substance Abuse (MISA) services and, through the coordinated intake process, an opportunity to enhance case finding, early identification, and outreach efforts.

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 30 years the locus of treatment for persons with mental illness has shifted from institutions to community-based settings. In FY1973, 8% of the DMH’s budget was allocated for community services. Today more than 70% of DMH expenditures are allocated for community-based services. In FY2008, the DMH purchased community based services for more than 185,000 individuals and provided state hospital services for over 10,200 individuals.

The Illinois Mental Health Collaborative for Access and Choice

In Fall 2007 a national behavioral health company was selected to assist DHS/DMH in
implementing a number of contractual objectives. This Administrative Services Organization, called the Illinois Mental Health Collaborative for Access and Choice (Collaborative), began operations in December 2007. The Collaborative established their offices in Chicago and in Springfield and named their Illinois CEO in March 2008. The role and function of the Collaborative in the management of the public mental health system in Illinois is far-reaching and encompasses a broad spectrum of administrative activity.

Most prominent among the goals for the Collaborative is to assist the DMH in continued efforts to transition the mental health system to a consumer/ family-centered recovery and resilience-oriented service system, and to assist in the transition from a pre-payment (grant-in-aid) financing system to a post-payment/fee-for-service (FFS) system. Other key objectives include: a) advancement of evidence-based practices, b) prior authorization for priority services, c) precise accountability mechanisms for providers, d) provider network development to insure provider viability and consumer access, e) efficient and effective claims processing/payment mechanisms and post-payment review that insures that the State is receiving what it is paying for, f) and a state-of-the-art information technology (IT) system capable of supporting implementation of these goals and objectives.
Illinois

Adult - New Developments and Issues

Adult - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.
ADULT-NEW DEVELOPMENTS AND ISSUES

Impact of the Economic Recession

Illinois is facing a $9 billion deficit this year. The General Assembly has rejected the Governor’s proposal for a 50% increase in the state income tax. The current budget, which was passed on July 15, 2009, calls for downsizing of state government and reductions in spending General Revenue Funds, a process which is slowly unfolding. The outlook for any new funding for mental health services is bleak. DHS/ DMH recently (mid-August) announced an 8% reduction ($42,000,000) in FY2010 from the FY2009 budget for community mental health services. In this environment, DMH is making every effort to maintain core mental health services and to provide a consistent level of access to them.

We have learned that several programs previously described in the block grant such as , Qualified Mental Health Professional (QMHP) liaisons to DHS/DHCD Family Community Resource Centers, Screening Assessment and Support Service Flexible Funds, (discretionary funding for non-traditional support services such as special programming components of Wrap Around planning), the Multi-disciplinary Specialty Assessment program that funded specialty assessments such neurological testing and learning disability assessments, five of the ten Mental Health Transition pilot programs and five of the ten Mental Health Early Intervention pilots (See the Child-System of Integrated Services Section for further detail) will not be funded in FY2010.

The Warm Line

In the past year, the Collaborative established a statewide “warm line”. The warm line is a cutting edge source of peer and family support. Staffed by five Peer and Family support specialists, the toll-free number has received 60 to 120 calls per week. These professionals are persons in recovery, or family members of persons in recovery, who are trained to effectively support recovery in other individuals’ lives. They reaffirm, reconnect, and renew hope, and provide practical assistance for overcoming mental illnesses to persons who are striving to live, learn, work, and participate fully in their communities. Warm Line Peer and Family Support Specialists offer emotional support by listening and understanding; recovery education by providing and linking persons to new mental health recovery information; self-advocacy guidance by helping individuals learn to communicate effectively to ensure that their needs are met; and mentoring, through boosting the confidence of individuals as they progress toward their recovery goals. The warm line has already become a successful DHS/DMH investment by assuring the accessibility of a human connection at a time when it is needed now more than ever. Although warm lines are found throughout the U.S., Illinois and Maine reportedly are the only states known to operate statewide Warm Lines.

The Consumer and Family Care Line

In addition to the Warm Line, consumers and family members may contact the Collaborative’s toll-free Consumer and Family Care Line with compliments and
complaints about the mental health services they receive. While the staff of the Collaborative can offer support and coaching if the individual wants to pursue the complaint directly, each complaint is reviewed by the staff, referred to the appropriate agency or authority for investigation or resolution, and followed up. Feedback is provided to consumers and family members in writing on the progress and resolution of their complaints and assistance is offered to obtain further review or to appeal a decision.

**Mental Health Services to Veterans**

The Illinois Warrior Assistance Program provides confidential assistance to Illinois Veterans as they transition back to their everyday lives after serving our country. The goal of the program is to help service members and their families deal with the emotional and psychological challenges they may be facing. A 24-hour, toll free helpline is staffed by health professionals to assist veterans day or night, with any of the symptoms associated with Post Traumatic Stress Disorder (PTSD). Traumatic Brain Injury (TBI) screenings are provided to all interested veterans. TBI screenings are mandatory for all returning members of the Illinois Army National Guard and Air National Guard.

**Veterans Reintegration Initiative (VRI)**

Veterans in the criminal justice system with mental illness and combat-related trauma disorders represent a growing population with unique service needs. Critical barriers to successful reintegration for this population include lack of interface between veteran, justice, and treatment systems and lack of access to dedicated services such as mental health and substance abuse treatment, housing, and trauma-informed treatment. In Illinois, the paucity of military base communities amplifies the need for community and systems-level responses to support this population. The significant number of returning veterans to Illinois also underscores the importance of adapting current training and treatment strategies to meet the needs of returning soldiers and their families. Without these services, veterans with mental health disorders or co-morbid substance abuse may lack the supports necessary to achieve successful reintegration, and find themselves caught in a cycle of homelessness, hospitalization, and incarceration.

The State of Illinois was one of six states awarded the Substance Abuse and Mental Health Services Administration Jail Diversion – Trauma Recovery (Priority to veterans). This grant, for approximately $2 million over 5 years has enabled the Illinois Department of Human Services, Division of Mental Health (IDHS/DMH) to establish the Illinois Veterans Reintegration Initiative (VRI) to increase diversion for criminal justice-involved veterans with trauma histories in Cook and Rock Island counties. The VRI is expected to result in the delivery of trauma-informed, evidence-based treatment to 120 consumers per year over a 5-year program period, as well as specialized training for 1,000 police officers in street-level responses to veterans demonstrating mental illness. The VRI is a collaborative effort of stakeholders from the veterans, justice and treatment systems. The planning phase of the project has included the participation of key stakeholders in Cook County and Rock Island County and will culminate with a comprehensive strategic plan that establishes a formal link between veterans services and justice/treatment
interventions in each of the project sites. IDHS/DMH believes the evaluation of the VRI will support the need for ongoing systems collaboration, and the belief that with appropriate supports, justice-involved veterans with mental illness can achieve successful community reintegration. VRI is expected to strengthen partnerships among justice agencies and service providers, expand diversion opportunities, and establish an infrastructure for intervention and service delivery that can be replicated across the State.

**Mental Health Transformation**

DMH and other state entities continue to work toward envisioning and organizing the Illinois transformation effort to meet New Freedom Commission goals. The DMH has convened meetings in which all agencies purchasing or providing mental health services have participated. The meetings were well attended by a wide range of stakeholders, including consumers, family members, advocacy organizations such as NAMI, the Mental Health Association in Illinois, the Illinois Federation of Families, members of the Illinois Children's Mental Health Partnership, and others. Several workgroups were convened in FY2008 to address key components in transformation that were identified in the meetings. In July, 2008 a leadership staff retreat on Strategic Transformation was attended by the Director of DMH, the Chief of Staff, DMH administrative staff, and more than thirty clinical, community, and hospital administrative staff from Chicago and Springfield offices and each DHS region. The purpose of the retreat was to further advance the transformation of DMH’s services to adhere and align with the vision of *Recovery as the Expectation* for consumers of mental health services in Illinois.

**Community Support Teams**

Community Support Teams were established by DMH in FY2008 as a core service to support recovery/resilience. Community Support Team services are therapeutic interventions delivered by a team that facilitate illness self-management, skill building, the identification and use of natural supports, and the use of community resources to decrease crisis episodes and hospitalizations, to increase community functioning, and to assist the client to achieve rehabilitative, resiliency and recovery goals. The Community Support Model is based on a set of recovery supportive activities and interventions that may be delivered in a highly flexible range of intensity of service, frequency, and modalities including individual, group, and team. Interventions and activities are delivered in natural settings and are targeted toward the management and reduction of symptoms as well as the promotion of stability and independence. The aim of Community Support is to build capacity by assisting the individual to do for self. Reimbursement is based on medical necessity requiring documentation of psychiatric disability (diagnosis), currently assessed need, an existing service plan with allowable interventions, and continuing assessment of progress toward achieving recovery and resilience goals.

**Permanent Supportive Housing**

Permanent Supportive Housing (PSH) refers to integrated permanent housing (typically rental apartments) linked with flexible community-based mental health services that are available to tenants/consumers when they need them, but are not mandated as a condition.
of occupancy. The PSH model is based on a philosophy that supports consumer choice and empowerment, rights and responsibilities of tenancy, and appropriate, flexible, accessible, and available support services that meet each consumer’s changing needs. A growing body of knowledge has documented the effectiveness of PSH and helped generate the systems changes needed to create it. The Division of Mental Health is committed to develop an array of Permanent Supportive Housing consistent with the flexible needs of consumers and associated with other new initiatives, i.e., Money Follows the Person (MFP) demonstration project and supportive employment. A concerted redirection of energy and resources is necessary to ensure that consumers have choice on housing alternatives and that this choice has a foundation based on principles of recovery thereby expanding options for consumers to live independently.

The PSH array will include new construction or acquisition/rehabilitation of units through new partnerships with housing developers, IHDA, and other housing stakeholders, as well as assisting consumers to lease scattered site rental housing, including studio/efficiency units, one bedroom units, and two bedroom, two-person shared apartments. By increasing the supply of safe, decent, and affordable PSH units, DMH will significantly improve its capacity to help consumers obtain permanent housing that meets their preferences and needs. Consumer choice is important because (1) certain housing features/amenities may support a consumer’s recovery goals; and (2) choice in housing correlates with housing and community tenure. PSH can either be tenant based or site based models, with consumers holding leasing rights outlined in a lease agreement. Support services are flexible and by choice, and are not a requirement to maintain occupancy. In most cases and for most individuals the support services necessary to assure successful tenancy are already reimbursable by Medicaid under the Community Support service definition or under other Medicaid plan services (e.g., medication management, psychiatry, outpatient counseling). DMH has provided extensive training to DMH staff members who will serve as Regional Housing Support Facilitators (one for each Region), as well as all DMH community mental health providers, and participating subsidy administrators.

The Bridge Subsidy Initiative is the cornerstone to the success of PSH. Bridge Subsidy funding has been identified to subsidize rental costs for a targeted population of eligible consumers approved for PSH. Consumers will be required to commit up to 30% of their income for rent, in accordance with HUD standards. The Bridge Subsidy will pay the remaining rental cost. The Bridge Subsidy Initiative also includes one-time transitional funding to address move expenses. These Transition Assistance Funds pay for items such as application fees, security deposits, utility deposits, and household needs like furniture, small appliances and home making supplies.

DMH continues to retain national experts from the Technical Assistance Collaborative, Inc. (TAC), and the Corporation for Supportive Housing (CSH), both nationally recognized organizations in developing and funding PSH housing models. Currently DMH has been allocated funding from an Illinois Hospital Tax Initiative to provide PSH to a targeted estimated 600 consumers of mental health services over a three-year period. Additionally, DMH funds have been utilized for the development of a web-based housing
stock database to identify available housing stock in Illinois. This real time web-based housing search website (Ilhousingsearch.org) will be active as of 6/15/09 open to everyone in Illinois to search for housing opportunities.

Public Awareness (Anti-Stigma) Campaign

In FY2008 and FY2009, DMH established and implemented its public awareness initiative targeting adults and children by launching the Say It Out Loud campaign which is continuing. Say It Out Loud is a groundbreaking statewide campaign to promote good mental health. It is co-sponsored by IDHS/DMH and the Illinois Children's Mental Health Partnership. Research tells us that the best way to reduce the biases associated with mental illness is by sharing experiences. This can be accomplished specifically through interaction with family, employers, colleagues, neighbors and friends, as well as medical and mental health professionals. Based on current research, the campaign seeks to address the misperceptions associated with mental illnesses by giving people the opportunity to engage with one another on the subject in a meaningful way and to share their experiences and knowledge. Thus, the campaign has used the stories of real people in advertisements distributed to newspapers and radio stations in every county of the state, and through videos featured on the campaign’s new Web site: www.mentalhealthillinois.org.

The expectation is that this effort will go a long way towards presenting accurate and positive representations about mental illness and diminishing the barriers that prevent people from seeking or offering help and support. The campaign emphasizes a strength-based approach that presents mental health as a critical component of overall health and well being. It creates both “virtual” and real contact opportunities—with people who have mental illnesses, as well as medical and mental health professionals, family, employers, colleagues, neighbors or friends. It transmits reliable and valued information through the media, the Internet, advertising, word-of-mouth, and through the “stories” that are the essence of the campaign. Visually, the campaign is represented by photographs of people wearing t-shirts emblazoned with their stories of mental health promotion or recovery. The campaign addresses the importance of promoting healthy social and emotional development in children and providing early intervention to keep developmental delays or mental health stresses from becoming serious problems. DMH has viewed the campaign as a means of building a larger and stronger base of community support in order to ensure an effective network of programs and services to meet the needs of people living with mental health challenges.

As part of the overall campaign and in order to review the effects of this campaign on the public, DMH developed a comprehensive outcome survey and engaged an independent vendor to complete the survey with a pool of Internet users. Initial survey data indicates that the campaign's strategy and messaging were effective in motivating changes in the knowledge and awareness about mental health issues and in the perceptions of persons with mental illnesses and their families. In addition, individuals who saw and heard the campaign's ads were more likely to express an intention to engage in behaviors consistent with the campaign's explicit calls to action.
Illinois

Adult - Legislative Initiatives and Changes

Adult - Legislative initiatives and changes, if any.
ADULT-LEGISLATIVE INITIATIVES AND CHANGES

Recently several legislative initiatives were passed that will have some impact on the landscape of mental health service delivery in Illinois.

The Governor signed legislation in July 2007 that allows Illinoisans living in rural communities increased access to psychiatric care. Public Act 95-16 permits rural Medicaid patients to receive treatment through telepsychiatry—primarily videoconferencing—to provide psychiatric care despite the distance. This addresses the shortage of psychiatrists working in rural communities, a problem that affects not only Illinois, but the nation. Many persons with mental illness live a long distance from a mental health facility and have limited access to transportation, making it difficult to obtain adequate mental healthcare. The new law requires the Illinois Department of Healthcare and Family Services to reimburse psychiatrists and federally qualified health centers (FQHCs) for mental health services provided via tele-psychiatry. Illinois has joined at least ten other states that have similar regulations in place.

Public Act 96-0093, signed on July 27, 2009, creates a Military and Veterans Court Task Force to study the creation of veterans’ courts for veterans and active duty service personnel with substance abuse or other problems.
Illinois

Adult - Description of State Agency's Leadership

Adult - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.
ADULT-DESCRIPTION OF STATE AGENCY’S LEADERSHIP

DMH exerts ongoing leadership through system integration initiatives, competence development, consumer development and continuous quality improvement. Emphasis is on developing systems integration at the statewide level that parallels the relationships that community mental health centers develop at the local level. The DMH provides leadership by integrating mental health services with other IDHS divisions and working closely at the state level with Illinois departments and organizations.

DMH and IDHS Service Areas

The Illinois Department of Human Services (IDHS) is the cabinet level state agency which manages human service systems in the State, including management of the public mental health system through the Division of Mental Health. The mission of the IDHS is to assist Illinois residents in achieving self-sufficiency, independence and health to the maximum extent possible by providing integrated family-oriented services, promoting prevention, and establishing measurable outcomes in partnership with communities. The IDHS is able to connect eligible clients to a wide range of human services at one location because it administers community health and prevention programs, oversees programs for persons with developmental disabilities, mental health and substance abuse problems, provides rehabilitation services, and helps low-income persons with financial support, employment, training, child care, and other necessary family services. Local office staff use a family-centered approach to identify client needs; determine eligibility for benefits; link clients to appropriate programs, and refer them to services in their community. Increasing systems integration among the divisions and offices of IDHS improves the accessibility of support services for the mental health service system and enhances service delivery for individuals coping with mental illness.

Division of Human Capital Development (DHCD) The DHCD oversees programs that help clients to achieve self-sufficiency including employment and training services, child care and family services, and financial support services. This Division serves over one million DHS customers each month through income supports such as: cash assistance, food stamps, medical programs, employment and training programs, help with child care, emergency assistance, refugee and immigration services, homeless services, and specialized social services. DHCD has six regional and 115 local Family Community Resource Centers that serve as the first point of contact for many IDHS clients. These offices offer direct transitional services and a link to employers and key community organizations.

In an ongoing effort to address issues that may provide barriers to work readiness, the DMH and the DHCD have worked together in establishing and managing liaison relationships between local community mental health centers and local IDHS offices. The aim was to identify customers of IDHS who may be in need of mental health services (screening, assessment, and treatment). Through provider agencies, DMH has funded eleven full or half time Qualified Mental Health Professional (QMHP) staff positions onsite at twelve designated IDHS Family Community Resource Centers. Of these, five DHCD offices located in the Metro Chicago area have had a full-time QMHP, two have had a part-time QMHP, and five offices in Greater Illinois have had the presence of a part-time QMHP. Paralleling this co-location, a statewide collaborative effort involving 97 DMH-funded mental health centers, have had liaison relationships with the remaining
local DHCD offices with a presence in IDHS offices for a minimum of four hours a month. Each DHCD office assigned a liaison to interface with the mental health center administration. This collaboration has lost its funding in FY2010.

**Alcoholism and Substance Abuse** The Division of Alcoholism and Substance Abuse (DASA) administers and monitors funding to a network of community-based substance abuse treatment programs. These programs provide a full continuum of treatment including outpatient and residential programs for persons addicted to alcohol and other drugs.

DMH and the Division of Alcoholism and Substance Abuse (DASA) have collaborated for many years to address services for individuals with co-occurring disorders. Initiatives have included the establishment of consortiums comprised of mental health and substance abuse providers to collaborate on treatment provision, cross-training of providers from both service systems focusing on integrated treatment, and the funding of an institute to provide training to service providers across the state. Additionally DMH and DASA have participated in the SAMHSA National Policy Academy on co-occurring disorders. Staff members of both Divisions are actively working together to implement integrated treatment. Currently DASA funds more than 20 agencies statewide to provide both mental health and substance abuse services to persons with co-morbidity. The DMH and DASA jointly applied for and received, a SAMHSA grant for training providers and evaluation of the implementation of Integrated Dual Diagnosis Treatment (IDDT).

**Developmental Disabilities Services** The Division of Developmental Disabilities (DDD) provides respite care, developmental training, and family support services to help individuals with developmental disabilities to become independent. Services are provided through residential facilities and programs that help disabled individuals live at home or in a community living center. Joint efforts are ongoing to resolve service issues for those consumers who have been dually diagnosed with a developmental disability and a mental disorder.

Both divisions share leadership tasks in addressing the needs of persons with Autistic Spectrum disorders (ASD). In FY 2004, a multi-agency Autism Task Force was established. The momentum and energy engendered by the Task Force dovetailed into complementary action by the Illinois legislature. Public Act 093-0773, An Act in Relation to Persons with Disabilities, directed the IDHS to convene a special task force to study and assess the service needs of persons with ASD. In FY 2005, the Division of Developmental Disabilities (DDD) and the DMH co-convened the Autism Task Force that continues to meet.

**Rehabilitation Services.** The Division of Rehabilitation Services (DRS) oversees programs serving persons with disabilities that include vocational training, home services, educational services, advocacy, information and referral. Also provided are a variety of services for persons who are blind, visually impaired, deaf or hard of hearing.

DMH and DRS actively collaborate to increase the access of persons with serious mental illnesses to vocational rehabilitation services and to improve the coordination of psychiatric and vocational services. Since FY 2004, the DMH and DRS have expanded their efforts in developing and establishing Certified Recovery Support Specialist training...
for consumers and in the development of employment opportunities that are integrated with appropriate support services. DMH, DRS, and DASA worked collaboratively with the Illinois Certification Board (ICB) during FY2007 to develop the Illinois Model for Certified Recovery Support Specialist (CRSS) that defines baseline criteria for CRSS professionals and provides a professional certification that is competency based. This credential became available in FY2008. DMH and DRS continue to jointly assess their service systems to determine what gaps exist locally and emphasize technical assistance for needed program modifications.

Moving from Institution to Community: DHS Olmstead Activities
Since the Supreme Court ruling in the case of Olmstead vs. L.C. issued in June, 1999, which stated that the unjustified institutionalization of people with disabilities is a form of discrimination under the Americans with Disabilities Act (ADA), Illinois, as other states, has been working on a state Olmstead Plan. DHS was assigned the lead role in developing the State’s Olmstead Plan and organized the Disabilities Services Advisory Committee (DSAC) which is comprised of a wide-range of stakeholders and has been established by statute. In FY 2006, DSAC developed a strategic plan, which was submitted to and approved by the Governor and the Legislature. The Plan and updates are available on the DHS Website at http://www.dhs.state.il.us/projectsInitiatives/dsac/.

Relationship of the DMH to the Illinois Departments and Organizations

Illinois Housing Development Authority
Activities Related to Housing
The availability of safe, decent, and affordable housing is a necessary component of a comprehensive community support system. DMH, through its Comprehensive Community Service Regions, is committed to pro-active involvement in expanding the pool of affordable, supported housing for persons with psychiatric disabilities. DMH has worked at forging dialogue and partnerships with the Illinois Housing Development Authority (IHDA), a group with a legislative mandate to oversee and advise on Housing in Illinois, which includes the broader spectrum of state government in its membership, as well as local housing authorities, housing developers and other finance entities. Many DMH local contracted community mental health vendors have worked with HUD to develop housing opportunities for individuals who are homeless through the Shelter Plus Care Project and the 811 Project to pave the way for local housing development. DMH Regions continue to encourage local vendors to explore avenues for capital development for new construction and rehabilitation, as well as the availability of existing resources, such as public housing. DMH staff also work closely with all Department of Human Services Divisions, and the Attorney General to support the needs and rights of mental health consumers when there is community resistance to develop housing for persons with a history of mental illness.

Illinois Department on Aging
The DMH works closely with the Illinois Department on Aging (DOA) to increase training opportunities in the geriatric field, to improve the quality and accessibility of services for elderly persons with mental illness, and to enhance networking, collaboration and coordination of programs and services in provider networks. The DMH continues to
jointly coordinate an Advisory Committee on Geriatric Services with the DOA. The Advisory Committee focuses its efforts on the assessment of the mental health needs of the elderly, as well as identifying model programs, best practices and staff competencies to serve this population. The committee has provided training, consultation and technical assistance in the area of mental health and aging and has promoted public awareness of geriatric mental health concerns. In FY2009, the DMH, in coordination with the DOA, successfully convened its annual Mental Health and Aging Conference. The DMH also continues to fund a Geropsychiatric Specialist Initiative that provides support for the development of local mental health and aging coalitions, education and training on older adult mental health issues, and consultation to DMH case managers and aging personnel.

**Illinois Department of Public Health**

**Suicide Prevention**

In Illinois, more than 1,000 persons die by suicide each year 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. The committee was charged with the development and implementation of a state Suicide Prevention Strategic Plan and with convening a statewide conference on suicide prevention, conducting media and public awareness campaigns, formulating education initiatives, and contingent upon funding, setting up five pilot programs to provide training and direct service. As interest and advocacy grew, an alliance was formed between a coalition of stakeholders and the strategic planning committee which was recognized in law by the General assembly in 2008. The mission of 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.” DMH is a member of the Alliance and has actively participated in the development of the 2007 Illinois Suicide Prevention Strategic Plan. The Plan may be found at: [http://www.idph.state.il.us/about/chronic/Suicide_Prevention_Plan_Jan-08.pdf](http://www.idph.state.il.us/about/chronic/Suicide_Prevention_Plan_Jan-08.pdf)

**Illinois Department of Public Health and Illinois Department of Healthcare and Family Services**

**Mental Health Issues in 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 illness, and others require it for functional limitations associated with both mental illness and medical needs. 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 and the long term care service options that are available.

The “Money Follows The Person” Federal Demonstration

Illinois is to receive $55.7 million dollars in federal Medicaid reimbursement over five years to assist individuals who have serious mental illnesses and who are living in non-IMD nursing facilities with seamless transition to community residential alternatives (non-group home settings) and necessary support services. The “Money Follows the Person” (MFP) demonstration will facilitate the transition of approximately 3500 persons, between the involved state Departments, into their home communities over the course of five years. Six hundred and eighty five individuals to be transitioned will fall within DMH’s identified priority population. The Department of Healthcare and Family Services, the lead agency for the initiative, is working closely with the IDHS divisions of Developmental Disabilities (DDD), Rehabilitation Services (DORS) and DMH, the Department on Aging, and the Illinois Housing Development Authority (IHDA) on the project. IDHS is committed to maximizing this funding in support of the goals of consumer self-direction, independence and community reintegration. Programs under the MFP are designed to: (1) Eliminate barriers or mechanisms that prevent Medicaid-eligible individuals from receiving support for appropriate and necessary long-term services in the setting of their choice; (2) Increase the ability of the state Medicaid program to assure continued provision of home and community-based long term care services to eligible individuals who choose to move from an institutional to a community setting; and (3) Ensure that procedures are in place to provide for continuous quality improvement in these services for individuals receiving Medicaid home and community-based long-term care. Illinois has completed its federally required operational protocol that was accepted in May 2008. DMH is currently participating in the identification of appropriate candidates for transition to the community and is identifying and contracting with provider agencies for the provision of services. As DMH moves forward into shared implementation of the initiative, policies and procedures are being developed to facilitate the provision of mental health clinical and support services.

Mental Health and the Justice System

In addition to oversight and management of inpatient hospital services for persons with mental illnesses who have been declared unfit to stand trial (UST) or not guilty by reason of insanity (NGRI), the DMH Forensic Services collaborates with a range of agencies in the Criminal Justice System including:

- Illinois Department of Corrections
- Illinois Department of Juvenile Justice (Established in FY2006)
- Administrative Offices of the Illinois Courts
- Illinois Criminal Justice Authority
- Illinois State Police
- Illinois Sheriff’s Association
- Cook County Department of Corrections
- County Jails and Juvenile Detention Centers (statewide)
- Local law enforcement agencies and organizations (statewide)

IDHS/DMH has taken a leadership role in developing significant statewide initiatives for justice-involved individuals with mental illness at every stage, including street-level
intervention, jail diversion, correctional programming, and offender reentry. IDHS/DMH has been instrumental in developing integrated processes of identification, reentry linkage, and service delivery between the criminal justice, mental health and substance abuse networks, and recovery support services, such as housing and employment. These efforts have laid the groundwork for a more comprehensive and effective diversion approach based on leveraging existing successful intervention models, enhancement of capacity, and increased availability of clinically appropriate services.

The following initiatives are highlighted as these clearly demonstrate leadership and an increasing clinical role in serving individuals with mental illnesses who have been adjudicated in the criminal courts:

**The Jail Data Link Project**
A pilot program between the Cook County Department of Corrections (CCDOC) and the mental health system begun in FY2000 has now expanded to other sites around the state. The initial program effort was implemented through Thresholds, a community mental health center, and was designed to serve adults diagnosed with serious mental illnesses who are detained at CCDOC (pre-trial). The project received a Gold Award from the American Psychiatric Association. A key aspect of this project was the development of a database for the daily exchange of information between Cook County Jail and the community mental health provider. The learning experienced from this project, which is referred to as the Jail Data Link Project, was used to expand the project to Will, Peoria and Jefferson counties. This initiative is more fully described in Section III (under Adult Establishment of a System of Care).

**Rockford Crisis Services Collaborative**
In the Rockford area, a collaboration between DMH Forensic services staff, Janet Wattles Community Mental Health Center, Singer Mental Health Center, and Rockford Jail liaisons developed strategies for providing post release and emergency mental health services to detainees of the Rockford Jail. The emphasis of services is on detainees with misdemeanors who are known to local mental health providers. As a result, a mental health court was established that provides for diversion, discharge planning, and service linkage to Janet Wattles Community Mental Health Center. This program began initial operations during FY 2005.

**Law Enforcement and Crisis Intervention Training**
The DMH regularly collaborates with law enforcement agencies and emergency services at general hospitals to facilitate appropriate and effective psychiatric intervention to persons who are in crisis. Each DMH Region is committed to working on improving relationships through cross-training events for law enforcement officers and mental health staff of community agencies. DMH has worked collaboratively with a number of law enforcement agencies to provide training targeting police officers that interface with individuals with mental illnesses. Topics have included mental illness crisis and police response. DMH has also provided partial funding, and worked with the Illinois Law Enforcement Training and Standards Board (LETSB) to develop a one day training program targeted for experienced police officers on working with individuals who have
mental illness and are in a behavioral crisis. On-going training in the curriculum has been implemented in 16 Mobile Training Units (MTU) covering the state. The DMH has also worked with the Illinois Sheriff’s Association to examine the issue of the persons with mental illness in county jails and to develop model protocols for mental health screening, suicide, and referral to mental health providers.

DMH and Disaster Response Activities

The Robert T. Stafford Act of 1974 (Public Law 93-288) created the system in place today by which a Presidential Declaration of an emergency triggers financial and physical assistance through the Federal Emergency Management Agency (FEMA) thereby initiating an orderly and systemic means of federal natural disaster assistance for state and local governments in carrying out their responsibilities to aid citizens. The Governor has designated the DMH as the State agency to lead disaster resource coordination and recovery functions related to mental health. Working in the context of the overall State-wide Disaster Plan and the Illinois Emergency Management Administration (IEMA) as well as the State Emergency Operations Center (SEOC), DMH coordinates Illinois’ disaster preparedness for state operated and state funded psychiatric service providers. Through the Comprehensive Community Service Regions, DMH assists in the development of local response capability for issues of Mental Health. The operational focus includes collaboration with other state agencies, monitoring, and facilitating ongoing concordance with National Incident Command Systems (NIMS). DMH participates in Substance Abuse and Mental Health Services (SAMHSA) Grant applications and collaborates with qualified partners in providing training. DMH also develops plans and mechanisms to coordinate surge deployment of mental health services in response to disasters, be they natural or caused by terrorists.

A Statewide Mental Health Disaster Preparedness Plan has been developed which recognizes the concept of local response to disaster mental health needs of Illinois communities and which builds on the strengths of the communities. Each Region has a designated Disaster Resource Coordinator to identify lead providers for each Region (generally by county for most of the state).

In recognition of the potential for natural or terrorist caused disasters in the State, emphasis in disaster planning has been on developing and/or maintaining a local response capacity. This includes educational offerings and the availability of trained mental health professional and paraprofessional volunteers to respond to the needs of their community in time of crisis. A central list of Illinois mental health professionals who were willing to be deployed on an urgent (surge) basis is continually updated as a resource in the event of future terrorist aggression or disaster requiring a mental health response. As necessary, the Red Cross may draw down the volunteers in groups. DMH continues to provide training on disaster response in conjunction with other state agencies and entities.
Illinois

Child - Overview of State's Mental Health System

Child - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.
CHILD AND ADOLESCENT SERVICE PLAN

CHILD-OVERVIEW OF STATE’S MENTAL HEALTH SYSTEM

Organizational Structure of the Illinois System of Care
Illinois has made substantive progress in developing a comprehensive mental health service system for youth with serious emotional disturbances (SED) and their families. 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.

Central Office Structure
The Child and Adolescent Services office is led by a board certified Child and Adolescent Psychiatrist and consists of approximately 20 FTE Statewide C&A Staff who are geographically located in each of five regions of the state. Contracting responsibilities have shifted to the Regional staff who are often accompanied by and/or receive consultation from C&A staff. The model appears to be working well, reducing duplicated effort and allowing the Regions to draw upon C&A staff expertise to support their contract and monitoring role.

The CCSRs
The five geographic Comprehensive Community Service Regions (CCSRs) are responsible for contracting activities with 151 community-based outpatient/rehabilitation agencies which include 124 child serving agencies which are either specialized or are community mental health centers with children’s programming. They also contract with local hospitals that provide psychiatric programs for youth. The localized integration of a comprehensive care system including mental health, substance abuse, child welfare, juvenile justice, and education is within their purview. Child and Adolescent Service expertise is provided to Regional staff by statewide C&A Services staff. Each CCSR has assigned staff specially designated to address child and adolescent and juvenile forensic services.

The Illinois Department of Human Services (DHS)
Being part of DHS has provided an opportunity for the DMH to address a number of challenges within the shared mission of one Department such as: prevention, early intervention, integration of vocational and educational services, coordination and development of Mental Illness and Substance Abuse (MISA) services and, through the coordinated intake process, an opportunity to enhance case finding, early identification, and outreach efforts.

Mental Health Services Provided for Youth Through Other State Agencies
An overview of mental health services to youth and families in Illinois would be incomplete without the acknowledgement of the programs provided through state departments other than DHS. Screening Assessment and Support Services (SASS) are services provided by the Department of Children & Family Services (DCFS) for children
who are under the guardianship of the Department. The Department of Health and Family Services (DHFS) funds SASS services for those eligible for Medicaid. The Illinois Children’s Mental Health Partnership (ICMHP) partners with DMH in providing a range of pilot projects affording services including early intervention, for youth transitioning from DMH funded C&A services to adult services and for any youth with mental health needs and/or social/emotional impairment who is transitioning from correctional services to the community. ICMHP directly manages a mental health consultation program or children under the age of 5. The Illinois State Board of Education (ISBE) provides mental health services through school districts for children who need them in the school setting. The Department of Juvenile Justice (DJJJ) employs mental health professionals who provide services in that Department’s Youth Centers. Within DHS, the Comprehensive Community-Based Youth Services Program (CCBYS) provides mental health services to youth ages 10-17 who are at risk of involvement in the child welfare and/or juvenile justice system. The program has a statutory mandate to provide short-term crisis intervention services to youth who have run away from home; whose parents will not allow them to return to their home; or who are generally beyond the control of their parents. By law, the program must be available in every area of the state, 24 hours a day.
Illinois

Child - New Developments and Issues

Child - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.
CHILD/ADOLESCENT -NEW DEVELOPMENTS AND ISSUES

See the ADULT- NEW DEVELOPMENTS AND ISSUES section for information on the impact of the economic recession, the Warm Line, the Consumer and Family Care Line, Mental Health Transformation, and the Public Awareness Initiative which are relevant to both adults and children.

Family Driven Care
Illinois was one of six states to receive a limited award to develop an initiative addressing family driven care. Family Driven Care as defined by the Federation of Families for Children’s Mental Health, means that families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes:
- Choosing culturally and linguistically competent supports, services, and providers;
- Setting goals;
- Designing, implementing and evaluating programs;
- Monitoring outcomes; and
- Partnering in funding decisions.

Members of the C&A Statewide staff attended a policy academy in which planning and implementation approaches were discussed. The award covered travel expenses and technical assistance costs over a period of six months. So far, a commission on Family Driven Care has been established and efforts are underway to conduct regional surveys of mental health needs and to assess family and provider satisfaction with the services currently available and the extent to which the system is responsive to the needs and issues encountered by families of youth with serious emotional disturbances.

Public Awareness Campaign
In FY2008 and FY2009, DMH established and implemented its public awareness initiative targeting adults and children by launching the Say It Out Loud campaign which is continuing. Say It Out Loud is a groundbreaking statewide campaign to promote good mental health. It is co-sponsored by IDHS/DMH and the Illinois Children’s Mental Health Partnership. (See ADULT-NEW DEVELOPMENTS)

Initiatives of the Illinois Department of Healthcare and Family Services (DHFS)
DHFS, the Illinois Medicaid Agency, is implementing initiatives that impact mental health service delivery. One initiative is the All Kids insurance program that significantly expands medical and mental health services to children across the state. A second initiative is Disease Management, which seeks to manage and coordinate services across service systems for individuals with targeted diagnoses.
Illinois

Child - Legislative Initiatives and Changes

Child - Legislative initiatives and changes, if any.
CHILD-LEGISLATIVE INITIATIVES AND CHANGES

A recent law clarifying the definition of “children with disabilities” establishes uniformity in the School Code making students statewide eligible to receive special education services up until the day of their 22\textsuperscript{nd} birthday. It helps assure that students with disabilities are able to continue to receive the educational services they need to become productive adults. It provides Illinois schools with clear guidance on their responsibilities in this area and provides these students with a stronger foundation for life after graduation.
Illinois

Child - Description of State Agency's Leadership

Child - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.
CHILD-DESCRIPTION OF STATE AGENCY’S LEADERSHIP

Collaboration with the IDHS Division of Community Health and Prevention

The Division of Community Health and Prevention (DCHP) encompasses community health services, family and youth development, violence prevention and intervention and addiction prevention. The DCHP includes: Maternal and Child Health Services, Comprehensive Services for Youth, Substance Abuse Prevention, the Teen REACH Program and Violence Prevention and Education Services.

Collaboration, cross training, and consultation between DMH and Division of Community Health and Prevention (DCHP) has continued:

- A statewide perinatal mental health consultation service has been established for providers to use when a screening indicates that a pregnant or postpartum woman may be suffering from depression. This service is accessed by a toll free number and provides consultation with psychiatrists, information about medications that may be used in the management of perinatal depression during and/or after pregnancy, and referral and linkage to available mental health resources.

- Early Intervention Services provided through DCHP for children under three years of age who are experiencing delays in one or more of the following areas: cognitive development; physical development; language and speech development; psycho-social development; and self-help skills. Evaluations and assessments are provided at no cost to families. Families with eligible children receive an Individualized Family Service Plan (IFSP) which lists the services and supports which must be made available to the family.

The Mental Health Juvenile Justice Initiative

The DMH has a Juvenile Forensic Program that develops treatment programs for forensic youth who are court-ordered into mental health care (i.e. unfit to stand trial or not guilty by reason of insanity). The Juvenile Forensic Program oversees the DMH Mental Health Juvenile Justice Initiative (MHJJ), which links minors in juvenile detention centers who have a major mental illness and sometimes co-occurring substance abuse problems to comprehensive community-based care. MHJJ began as a pilot program in FY2000 and expanded statewide by the end of FY2002. Funding is provided to support local agencies in employing a Masters level clinician who serves as a liaison and works with the minor, the minor's family, the court, the detention center, and local community agencies to develop a community wraparound plan that is intensive, integrated and specialized. Participants in the MHJJ program have been found to exhibit significant clinical improvement within three months. These youth have also been found to have better school attendance and a lower re-arrest rate. MHJJ is available at all the detention centers in Illinois.

Schools - Illinois State Board of Education and the Chicago Public Schools

The DMH has pursued the Positive Behavioral Interventions and Supports (PBIS) model of collaboration between education and mental health primarily through work on the System of Care Grant and through collaborative efforts with the Children's’ Mental
Health Partnership. Work is continuing to expand the education/mental health partnership and to utilize existing expertise to produce a replicable model for this collaboration. Discussions have been held with the Office of the Mayor of Chicago, the Chicago Public Schools, and child-serving state agencies to identify the needs of students and their families for a range of mental health services. A work group has been established which includes university researchers, mental health providers, educators and technical advisors who have designed universal, selected and targeted interventions to meet student and school needs.

Child Welfare
DMH continues to work closely with DCFS, the child welfare agency, on a number of initiatives including Screening, Assessment, and Support Services (SASS) and a training initiative for child welfare staff and service providers to examine and respond to the trauma children and families have experienced as a result of physical abuse, neglect, sexual abuse and domestic violence and its effect on their behavior, performance and adjustment, especially in foster care and other supportive environments.

Pilot Programs for Transitional Youth, Young Children, and Early Intervention
The Children's Mental Health (CMH) Act of 2003 created the Illinois Children's Mental Health Partnership (ICMHP). The Partnership is charged with developing a Children's Mental Health Plan containing short-term and long-term recommendations for providing comprehensive, coordinated mental health prevention, early intervention and treatment services for children from birth to 18. The ICMHP is comprised of members of child-serving agencies and other mental health system stakeholders including parents of children with emotional and serious emotional disturbances. The ICMHP has been successful in garnering state funds for children’s mental health needs. DMH Child and Adolescent Service System staff members actively participate in the ICMHP, are active partners in promoting its vision, and work closely with the ICMHP in planning how the funds are to be used and implementing those plans. In FY2008, ICMHP obtained a $6.5 million budget which included funding for the expansion of pilot programs in services to transitioning youth, early childhood consultation, early intervention and the initiation of clinical pilot programs for children ages 0-5. The programs continued successfully through FY2009, but, as funding was limited to a three year period, programs funded in FY2007 have been discontinued due to the lack of any additional funds for their continuation. See Section III- System Integration (Criterion 3) for a discussion of these pilot programs.
Illinois

Adult - Service System's Strengths and Weaknesses

Adult - A discussion of the strengths and weaknesses of the service system.
ADULT SERVICES PLAN:

ADULT SERVICE SYSTEM’S STRENGTHS AND WEAKNESSES

Important strengths of Illinois’ community-based mental health system in relation to each of the four criteria for adults are described below. It is important to note that while we aptly describe our strengths, significant challenges continue to confront the public mental health service system. Fiscal constraint in the past few years has resulted in limited growth and implementation of a number of the initiatives described below and in Section III of this plan. With the creativity and innovation of the past several years, there has also been increasing awareness of the lack of sufficient resources with which to actualize and transform the service system to fully and rapidly achieve the vision articulated below. In FY2010, the system is facing significant fiscal challenges and is anticipating further reduction instead of growth. DMH efforts are currently geared towards finding practical solutions to challenges and sustaining gradual and incremental progress where possible.

Criterion I: The Comprehensive Community Based Mental Health System:
✓ The array of core services available to adults with serious mental illnesses.
✓ Commitment to a recovery orientation by mental health system stakeholders.
✓ The focus on consumer and family driven care to actualize key goals identified by the President’s New Freedom Commission.
✓ Commitment to the implementation of evidence-based practices.
✓ Involvement of consumers in planning, implementing and evaluating the initiatives and ongoing activities of the public mental health system.
✓ Successful efforts to reduce hospitalization. Screening and crisis services that contribute to this success remain a high priority for DMH, as well as extensive case management services, community support and ACT.
✓ Collaborations with other divisions of the IDHS and with other state agencies have been a successful strategy for improving and enhancing services throughout the system.

Criterion 2: Mental Health System Data Epidemiology
✓ Joint work with the Illinois Mental Health Collaborative towards implementing a new Management Information System (MIS) and establishing a data warehouse to provide improved and expanded access to data which is vital to support decision making.
✓ Through external resources, such as the Data Infrastructure Grant, federally funded studies, and DMH initiatives, our databases and analytic capabilities have steadily grown to an extensive array of computerized information that provides an important resource for analyzing service provision and service needs

Criterion 4: Targeted Services To Homeless, Rural, and Elderly Populations.
✓ 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.
Active collaboration and effort to develop and evaluate approaches to improving housing services such as Permanent Supportive Housing (PSH) and successful advocacy for appropriations from the state legislature to support these promising approaches.

The CCSRs serving Greater Illinois are committed to developing and implementing service models for persons with mental illnesses who reside in rural areas. As we have noted, the 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.

The DMH Geropsychiatry program has been nationally recognized. It is targeted toward the needs of older adults with mental illness, especially in rural areas.

**Criterion 5. Management Systems**

- The DMH has made a substantial, successful and sustained commitment toward increasing the portion of the DMH funds allocated to community-based treatment for persons with mental illnesses.
- In recognition of the increasing role played by federal Medicaid funds, the DMH has worked successfully to increase this revenue source.
- The DMH has maintained a strong joint public and academic program which continues to include Departments of Psychiatry, Social Work, Psychology, and Nursing in universities across the State. All state hospitals in Illinois have agreements with universities to serve as training sites for psychiatric residency programs. Similar programs with Departments of Social Work, Psychology, and Nursing in universities across the state provide fertile ground for the recruitment of program graduates who are well grounded in public mental health as a result of their residencies.
- Innovative directions in the use of limited fiscal resources to promote expansion and growth of needed services such as initiating a fee-for-service payment mechanism to purchase services for individuals from community mental health agencies.
Illinois

Adult - Unmet Service Needs

Adult - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.
ADULT - UNMET SERVICE NEEDS

The FY2010 Illinois Mental Health Block Grant Plan has been developed taking into account service needs and critical gaps within the current mental health system. The identification of these needs and tracking of the progress in meeting these needs using both quantitative and qualitative information is detailed in the Adult Plan sections. The need to address issues such as the adoption and implementation of evidence-based practices, to address the needs of individuals (adults and youth) involved with the justice system, to provide access to services to adults and children residing in rural areas of the state are also described in the Adult Plan sections.
Illinois

Adult - Plans to Address Unmet Needs

Adult - A statement of the State's priorities and plans to address unmet needs.
PLANS TO ADDRESS CHALLENGES AND UNMET SERVICE NEEDS

The following are the priorities for enhancing the adult service system in FY2010:

Criterion 1: The Comprehensive Community Based Mental Health System Priorities and Service Needs:

- Maintenance and enhancement of community-based resources for ongoing clinical care and supportive services in a period of fiscal constraint remain an important DMH priority, especially those services and activities that can reduce hospitalization (such as crisis services, face-to-face screening prior to hospital admission, case management services, including the use of ACT and Community Support teams).
- Expansion of the scope of consumer and family involvement continues to be a priority. Efforts to facilitate and improve the quality of consumer participation have been of paramount importance in Illinois and are the source of many strengths.
- Furthering work on the recovery vision in Illinois.
- The advancement of the Certified Recovery Support Specialist (CRSS) credential by expanding educational opportunities to meet the requirements and obtain the credential as well as creating employment opportunities in provider agencies are priority activities for FY2010.
- Increasing the range of housing opportunities is essential as housing is considered the #1 need of consumers transitioning into the community, of those who have found themselves homeless, and of consumers who are living in substandard environments. The viable development and establishment of the Permanent Supportive Housing initiative will be a primary area of interest and effort in FY2010.
- Enhancement and expansion of evidence based practices is required to provide consumers increased access to proven quality services in family psychoeducation, medication management, ACT, supportive employment and permanent supportive housing.
- The expansion of WRAP programs.
- Family involvement in the development and implementation of treatment plans is important.
- Collaborative initiatives which respond to ongoing consumer needs such as work with the criminal justice system, with providers of alcoholism and substance abuse services, with providers of vocational and employment services, and with the Department on Aging on the mental health needs of older persons must continue as a priority.

Criterion 2: Mental Health System Data Epidemiology
• Continuing improvement of DMH management information systems (MIS) to meet the challenges ahead. This work has been valuably supported by the requirements and activities undertaken through the Data Infrastructure Grant.

Criterion 4: Targeted Services To Homeless, Rural, and Elderly Populations.
• Promotion of models of service provision which can best meet the needs of special populations such as integrated service models that can be adapted and utilized for the many homeless persons who have co-occurring mental illnesses and substance abuse problems.
• Bringing mental health services to persons isolated by distance and shortages of clinical professionals through approaches such as video-conferencing and telepsychiatry is a matter of urgent importance.
• Collaboration with IDOA toward expanding the Geropsychiatry program more broadly in rural areas and to develop statewide applications. IDOA has the support of the growing population of aging citizens in the state who want better health services, including mental health services. These individuals can be a rich source of support in expanding the availability of specialized services to meet the needs of this population.

Criterion 5. Management Systems Priorities and Service Needs:
• Increasing revenue from federal Medicaid funds is necessary to offset the fiscal problems Illinois has experienced in recent years that have led to decreases in allocations for human services.
• The development of alternative cost efficient training supports remains a priority. Although the DMH does not have dedicated resources for a training department of its own some of these responsibilities will be picked up the MHAC (the Collaborative).
• Training events that assist in the implementation of the Recovery Vision in Illinois as well as training related to evidence-based practices continue to be a priority of DMH.
• DMH has recognized the urgency of a statewide mental health plan for response to terrorist activities, as well as natural and other disasters.
Illinois

Adult - Recent Significant Achievements

Adult - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.
RECENT SIGNIFICANT ACHIEVEMENTS

Update on Areas Needing Attention in FY 2009 Plan - Significant Achievements

This section provides a brief summary of areas identified as needing attention in FY2009 and notes significant achievements in these areas.

Consumer Participation and Involvement

During FY2009, the DMH continued work on several exciting initiatives aimed at enhancing recovery services. In-service training on the foundational principles of recovery and the implementation of a recovery-oriented system continued to be provided.

DMH has recognized the need for providing consumers with current, accurate and balanced information regarding changes in the service delivery system, empowering them to take an active, participatory role in all aspects of service delivery. In FY2009, nine pre-arranged conference calls were conducted with consumers in all parts of the State with an average of 438 participants per call. These calls provide a forum for discussion of service information, performance data, new developments, and emerging issues to promote consumers’ awareness, knowledge, and the tools they need to cogently and effectively participate in the development and evaluation of the service system.

In collaboration with the Illinois Certification Board (ICB), the Divisions of Mental Health, Rehabilitation, and Alcoholism and Substance Abuse have developed the Illinois Model for Certified Recovery Support Specialist (CRSS). The Model has defined baseline competencies and skills for CRSS professionals. Access to this new credential became available through the ICB beginning in July of 2007 and 173 individuals have achieved their CRSS certification and are in good standing with the ICB. As a means of disseminating information regarding this new credential, training on the conceptual approach to certification has been provided for interested stakeholders at conferences.

Under the leadership of the DMH Director of the Office of Recovery Support Services, the Wellness Recovery Action Plan (WRAP) model has been adopted by Illinois. A statewide WRAP steering committee meets on a monthly basis to plan and review progress on the WRAP initiative. Through the establishment of WRAP classes in community agencies and the introduction of the principles of WRAP at consumer forums and conferences, thousands of consumers throughout the state have benefited from receiving orientation and education in the principles and components of this emerging best practice in recovery-based services. Since the inception of the Wellness Recovery Action Plan (WRAP) Initiative in Illinois in FY2003, over 200 individuals (including consumers currently receiving services) received Certificates as WRAP Facilitators through their completion of a 40-hour intensive course. Refresher/Continuing Education courses are held in each region bi-annually for Certified WRAP Facilitators.

DMH Recovery Support Specialists work with stakeholders to design, plan and convene annual consumer conferences in each DMH region. These conferences typically have a well-known national speaker who delivers the keynote address and who sets the "tone of recovery" for the conference. Consumer education is provided through a variety of
venues in the state. Six regional conferences were held across the state during FY2009 attended by more than 2,000 participants including consumers, family members, providers, DMH staff and other state agency staff.

Evidence-Based Practices
During the year, the DMH continued major initiatives to adopt and implement evidence-based practices in various areas across the state. Significant work has been done to implement Evidence Based Supported Employment (EBSE). Work continues on planning and implementing Family Psychoeducation, Integrated Dual Diagnosis Treatment (IDDT), Medication Algorithms and Wellness Recovery Action Planning. As an early adopter of Assertive Community Treatment (ACT), the DMH continues to work with agencies to ensure that the evidence-based ACT model is utilized within the State.

DMH continues to address SAMHSA’S National Outcome Measure of Implementing Evidence-Based Practices and strives to make EBPs available throughout the state by providing training and technical assistance to mental health agencies, and by involving mental health consumers and families in the expansion of such practices in Illinois. In May 2009, the DMH convened a second annual statewide conference on EBPs, entitled Implementing and Sustaining Evidence-Based Practices For Recovery, Resilience and Hope. Experts on each of the EBPs made presentations on focusing on implementation, organizational and financing issues that should be taken into consideration when planning for implementation. More than 300 individuals (consumers, family members, advocate, providers and state agency staff) attended the two-day conference.

Program Enhancement
The DMH continued work on a SAMHSA funded statewide initiative to move toward a violence-and-coercion-free hospital environment, reducing the need for seclusion and restraint as alternative person-centered interventions are established.

Fee For Service
The DMH has revised Medicaid Rule 132 to support the service system changes that will be necessary in the transition to a Fee-for-Service System. Planning efforts and gradual implementation of this initiative in key program areas has continued in FY2009. DMH also continues to work with consultants to identify technical assistance needs of providers and to provide technical assistance to support the move to the fee-for-service system.

Information Technology
DMH continues its efforts to refine and streamline data collection efforts to provide information that supports decision-making. As noted above, DMH, working with the Mental Health Collaborative for Access and Choice (MHCAC), has redesigned and implemented a new management information system (MIS). This work includes the development of a data warehouse that will house eligibility, registration, billing/services information, a provider database, and service authorization in one place.

Grants
In FY2009, the DMH completed the SAMHSA Targeted Capacity Expansion - Jail Diversion grant called the Community Reintegration Collaborative to support the DMH Jail Data Linkage Program; and the SAMHSA Transformation Transfer Initiative grant for $105,000 to fund a statewide mental health/criminal justice needs assessment and
system mapping initiative. DMH received continuation grants for the following areas: Data Infrastructure for Quality Improvement; Work Incentive and Planning Assistance Services for SSI/SSDI Beneficiaries, and Supported Employment. DMH is partnering with staff of the Illinois Department of Healthcare and Family Services (DHFS) in implementing a federal Medical Emergency Room Diversion (ERD) Grant from CMS. The grant provides $2 million over a two-year period to improve access and the quality of primary health care services. Illinois was one of six states awarded the Substance Abuse and Mental Health Services Administration Jail Diversion – Trauma Recovery (priority to veterans) grant. This grant, for approximately $2 million over 5 years has enabled the establishment of the Illinois Veterans Reintegration Initiative (VRI) to increase diversion for criminal justice-involved veterans with trauma histories in Cook and Rock Island counties.
Illinois

Adult - State's Vision for the Future

Adult - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.
STATE’S VISION FOR THE FUTURE

Illinois has made substantive progress in developing a comprehensive mental health service system for individuals with serious mental illnesses (SMI) and for youth with serious emotional disturbances (SED) and their families. Illinois envisions a well resourced and transformed mental health system that is consumer directed and community driven providing 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 Illinois Vision for Mental Health is that:

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

- The expectation is recovery
- The consumer is central

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.
Illinois

Child - Service System's Strengths and Weaknesses

Child - A discussion of the strengths and weaknesses of the service system.
Important strengths of Illinois’ community-based mental health system in relation to each of the five criteria for children/adolescents are described below. It is important to note that while we aptly describe our strengths, significant challenges continue to confront the public mental health service system. Fiscal constraint in the past few years has resulted in limited growth and implementation of a number of the initiatives described below and in Section III of this plan. With the creativity and innovation of the past several years, there has also been increasing awareness of the lack of sufficient resources with which to actualize and transform the service system to fully and rapidly achieve the vision articulated below. In FY2010, the system is facing significant fiscal challenges and is anticipating further reduction instead of growth. DMH efforts are currently geared towards finding practical solutions to challenges and sustaining gradual and incremental progress where possible.

Criterion I: The Comprehensive Community Based Mental Health System

- The array of core services that is available to youth with serious emotional disturbances and their families.
- The commitment to evidence informed practices and the dissemination of information regarding the implementation of evidence-informed practices that lead to resilience.
- The consistent commitment and ongoing efforts to divert children and adolescents from inpatient and residential treatment to services in their home communities as exemplified by the SASS (Screening, Assessment and Support Services) program and the DMH Individual Care Grant (ICG) Programs. These individualized ICG or SASS services include intensive home-based support, treatment and respite care which allow the child to remain at home.
- Planning for family driven care based on the goals identified by the President’s New Freedom Commission which serves as the foundation for current and future planning efforts.
- Family Resource Developer positions have been created and maintained across the state and have also been an active component of the System of Care initiatives
- Collaborative efforts, pilot projects, and vocational/employment supports to address the needs of youth with serious emotional disturbance transitioning to adulthood, including those transitioning from correctional settings and the child welfare system.
- The Governor’s state health care coverage program that offers comprehensive, affordable health insurance for children in Illinois assures that every uninsured child, regardless of income or medical condition has access to health care, including mental health services. Additionally healthcare coverage is extended to parents living with their children 18 years old or younger and relatives who are caring for children in place of their parents.
**Criterion 2: Mental Health System Data Epidemiology**

- Implementation of a clinical outcomes analysis system for children/adolescents which can generate multi-level data reporting
- Joint work with the MHCAC on a data warehouse will provide improved and expanded access to data to support decision making in children’s services.
- Through external resources, such as the Data Infrastructure Grant, federally funded studies, and DMH initiatives, our databases and analytic capabilities have steadily grown to an extensive array of computerized information that provides an important resource for analyzing service provision and service needs.

**Criterion 3: Children’s Services**

- Collaboration with IDHS Divisions and free-standing state agencies to ensure continuity of care and service integration is a multifold strength of the DMH service delivery system for children and adolescents.
- The on-going collaboration with the Children’s’ Mental Health Partnership has been fruitful in providing the resources needed to advance several vitally needed initiatives including services to youth in transition, early intervention, and the promotion of Evidence Informed Practices.
- The statewide Mental Health Juvenile Justice (MHJJ) program brings services to youth in county detention centers across the State in collaboration with juvenile justice.
- Long-standing collaborations are in place with the DCFS, the ISBE and the DASA. The DMH has partnered with these agencies to implement the wraparound approach to the delivery of children's services as well as to provide or coordinate delivery of mental health services. More recently, a collaboration with DCFS and DHFS have expanded the provision of SASS services.
- The Mental Health in Schools Model, that strives to strengthen inter-agency collaborations using the school as a setting for prevention, early identification, and intervention activities. This approach is being extended in several areas of the state through federal funding from SAMHSA.

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

- The DMH has put in place outreach services for homeless children and youth. Beacon Therapeutic Center's Shelter Outreach Services (S.O.S.) program utilizes a preventive model which focuses on intervention with children and parents in the shelter setting and provides targeted case management and mental health services to women and children in 22 shelters on the south, north, and west sides of Chicago. Services focus on the identification of untreated mental illness, developmental delays, substance abuse, needs assessment, advocacy, coordination services and follow-up supportive services.
- The IDHS Homeless Youth program has existed for many years and provides outreach and a range of services for homeless youth ages 14-21.
- In rural areas, SASS programs continue to work closely with community providers to enhance service delivery for children and adolescents.
Innovative approaches that integrate DMH services with rural schools have been developed.

Public Act 95-16 signed by the Governor in July, 2007 that gives Illinoisans living in rural communities increased access to psychiatric care by requiring the Illinois Department of Healthcare and Family Services to reimburse psychiatrists and federally-qualified health centers (FQHCs) for mental health services provided via telepsychiatry. DMH has moved forward to provide child psychiatry consultation and services through telepsychiatry in Region 4 and Region 5 which are very rural.

Criterion 5. Management Systems
The DMH has made a substantial, successful and sustained commitment to increasing the portion of the DMH funds allocated to community-based treatment for children and adolescents with serious emotional disturbance and their families.

In recognition of the increasing role played by federal Medicaid funds, the DMH has worked successfully to increase this revenue source to benefit children’s services.

The DMH has maintained a strong joint public and academic program which continues to include Departments of Psychiatry, Social Work, Psychology, and Nursing in universities across the State as evidenced by specialization and curricula appropriate to children with SED.

Innovative directions in the use of limited fiscal resources to promote expansion and growth of needed services geared to children and families such as initiating a fee-for-service payment mechanism to purchase services for individuals from community mental health agencies.
Illinois

Child - Unmet Service Needs

Child - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.
CHILD/ADOLESCENT - UNMET SERVICE NEEDS

As stated for Adults, the FY2010 Illinois Mental Health Block Grant Plan has been developed taking into account service needs and critical gaps within the current mental health system. The identification of these needs and tracking of the progress in meeting these needs using both quantitative and qualitative information are detailed in the Child Plan sections. The need to address issues such as the adoption and implementation of evidence-informed practices, to address the needs of youth involved with the justice system, to provide access to services to children residing in rural areas of the state are also described in the Child Plan sections.
Illinois

Child - Plans to Address Unmet Needs

Child - A statement of the State's priorities and plans to address unmet needs.
PLANS TO ADDRESS CHALLENGES AND UNMET SERVICE NEEDS

Criterion 1: The Comprehensive Community Based Mental Health System Priorities and Service Needs:

- Maintenance and enhancement of community-based resources for ongoing clinical care and supportive services to youth and families in a period of fiscal constraint is the most important DMH priority.

- Continued expansion of the scope and quality of parent and youth involvement remains a priority. Family involvement continues to emerge as a gathering strength in the C&A community service system as well as in successful inter-agency collaborations.

- The development of collaborative initiatives for children of all ages is a major priority of the Statewide C&A Services Office and includes early intervention, transitional care, and the promotion and growth of early childhood consultation and programming in the State to strengthen services for very young children and their families.

- The enhancement of family involvement in the development and implementation of individualized treatment plans for children and adolescents who receive mental health services continues to be a primary concern.

- Inter-agency collaborations have been an important support and strategy for the DMH in improving services for children and adolescents. These initiatives respond to ongoing needs and remain a priority.

- Activities aimed at reducing hospitalization and out of state residential treatment have been successful. Screening through the SASS program, crisis services, case management services, Wraparound services, and ICG/MI community services help to reduce hospitalization and residential treatment while providing ongoing clinical care and linkage to supportive services in the community. These services will remain a high priority for DMH.

Criterion 2: Mental Health System Data Epidemiology

- The DMH places a high priority on the maintenance and improvement of its management information systems to meet the challenges ahead. This work has been valuably supported by the requirements and activities undertaken through the Data Infrastructure Grant.

Criterion 3: Children’s Services

- The service system priority continues to be one of collaboration to provide a seamless system of care, given the multiple problems of children and adolescents, as well as their families, who are involved with overlapping service systems. The
expansion of Mental Health in Schools and Systems of Care such as McHenry county’s model is an important need and priority.

- The C&A statewide office is undertaking joint work with DCFS toward the continuing education of mental health providers on addressing trauma issues.
- Collaborative efforts with Children’s Mental Health Partnership, DHFS, and the IDHS Community Health and Prevention Division (CHP) to develop consultation approaches and promote evidence informed practices are an active priority.

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

- One third of the homeless population (which were served by the DHS Emergency Food & Shelter Program were under the age of 18. New and expanded service models and implementation are required to meet the needs of this population. Existing programs and service models such as Beacon Therapeutic School’s Shelter Outreach Service require statewide replication and continuing expansion.
- A broader partnership among state agencies is required to address major concerns across rural counties for transportation and for “one-stop” services shopping.
- Initiatives with universities located in rural areas such as Southern Illinois University (SIU) are aimed at developing strategies to better align service delivery for children and adolescents in rural areas. Other approaches, including video-conferencing and telepsychiatry are assertively advanced and increasingly utilized.

**Criterion 5. Management Systems Priorities and Service Needs:**

- Like many states, funding for mental health services is bleak in Illinois. There is therefore an even greater need to increase revenue from federal Medicaid funds.
- The development of alternative cost efficient training supports remains a priority. Although the DMH does not have dedicated resources for a training department of its own some of these responsibilities will be picked up the MHAC (the Collaborative).
- Training events that assist in the implementation of evidence-informed practices continue to be a priority of DMH.
- In the wake of 9/11, the DMH has recognized the need for a statewide mental health plan for responding to terrorist activities, as well as natural and other disasters.
Illinois

Child - Recent Significant Achievements

Child - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.
CHILD/ADOLESCENT - RECENT SIGNIFICANT ACHIEVEMENTS

C&A Services focused on family participation by increasing the availability of family resource developers (FRDs). There is generally a modest level of turnover in the FRD staff, and at the point that the FY 2008 FRD survey was conducted 84% of the SASS agencies had FRDs employed. It was noted that their support role has expanded as some agencies are using FRDs to assist with Individual Care Grant application processes and service planning. Family Consumer Specialists (FCS) have been hired as C & A staff members of DMH in each region of the state. Four new full time positions were added statewide in FY2008. The fifth FCS staff member was hired for the Southern Region of Illinois in October of 2008. All five of the DMH regions now have a Family Consumer Specialist actively involved.

Systems Integration

The DMH continued collaborations with many system partners including, collaboration with the Education system on the Positive Behavior Interventions and Support Model. The DMH continued its partnership with the Illinois Department of Healthcare and Family Services (the Illinois Medicaid agency) and the Illinois Department of Children and Family Services (the Illinois Child Welfare Agency) on the purchase of Screening, Assessment and Support Services (SASS) for children and adolescents and their families.

Fee For Service

The DMH has revised Medicaid Rule 132 to support the service system changes that will be necessary in the transition to a Fee-for-Service System. Planning efforts and gradual implementation of this initiative in key program areas such as SASS have continued.

Information Technology

DMH continues its efforts to refine and streamline data collection efforts to provide information that supports decision-making in children’s services. DMH, working with the Mental Health Collaborative for Access and Choice (MHCAC), has redesigned and implemented a new management information system (MIS). This work included the development of a data warehouse that houses eligibility, registration, billing/services information, a provider database, and service authorization in one place.

Grants

DMH completed the SAMHSA System of Care-Chicago in FY2009. A second System of Care grant focusing on McHenry County originally awarded by SAMHSA in 2006 is continuing. In McHenry County, Family CARE stands for Child/Adolescent Recovery Experience and is a $9 million, six–year federal grant designed to involve families and youth in decision making related to treatment, goal-setting, designing and implementing programs, monitoring outcomes and determining the effectiveness of efforts that promote the well-being of children and youth. The grant is designed to improve access to services for five underserved populations who present with mental health and substance abuse issues: preschoolers with serious social/emotional problems, youth with mental disorders, youth with co-occurring mental health and substance abuse issues, young adults 18-21 years old, and Latino children.
In 2009 Illinois was one of six states that received a SAMHSA award which paid expenses to participate in a policy academy focused on Family Driven Care. This project has supported collaboration with other child serving systems and supporters (DCFS, ISBE, CHP, DJJ, DASA, IFF, ICMHP) to address the extent to which the system is Family Driven.
Illinois

Child - State's Vision for the Future

Child - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.
CHILD/ADOLESCENT - STATE’S VISION FOR THE FUTURE
Illinois has made substantive progress in developing a comprehensive mental health service system for youth with serious emotional disturbances (SED) and their families. Illinois envisions a well resourced and transformed mental health system that is consumer directed and community driven with a continuum of integrated and effective culturally inclusive programs and services including prevention, early intervention and treatment that promote healthy lifelong development through equal access and support recovery and resilience. 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.
Illinois

Adult - Establishment of System of Care

Adult - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.
SECTION III-A:
ACTION PLANS AND PERFORMANCE GOALS TO IMPROVE THE SERVICE SYSTEM

ADULT SERVICES PLAN

Criterion 1. Comprehensive Community-based Mental Health System

ESTABLISHMENT OF A SYSTEM OF CARE

Consumer Involvement and Participation
The provision of mental health care that is consumer and family driven is an important priority of the Illinois Division of Mental Health. This priority is consistent with the President’s New Freedom Commission recommendations to involve consumers and families in orienting the mental health system towards recovery, and to improve access to, and accountability for mental health services. A variety of initiatives have been implemented to support consumer participation.

Mental Health Planning Advisory Council
A concerted effort has been made to ensure that consumers and family members play an important role in planning for mental health services. Representation by consumers and parents of children with serious emotional disturbances has increased. Consumers and/or family members co-chair the MHPAC, as well as all MHPAC sub-committees.

WRAP Initiative.
Under the leadership of the DMH Director of the Office of Recovery Support Services, the Wellness Recovery Action Plan (WRAP) model has been adopted by Illinois. A statewide WRAP steering committee meets on a monthly basis to plan and review progress on the WRAP initiative. Through the establishment of WRAP classes in community agencies and the introduction of the principles of WRAP at consumer forums and conferences, thousands of consumers throughout the state have benefited from receiving orientation and education in the principles and components of this emerging best practice in recovery-based services. Since the inception of the Wellness Recovery Action Plan (WRAP) Initiative in Illinois more than 200 individuals (including consumers currently receiving services) have received Certificates as WRAP Facilitators through their completion of a 40-hour intensive course. Refresher/Continuing Education courses are held in each region bi-annually for Certified WRAP Facilitators.

In FY2008, a statewide survey of all certified WRAP Facilitators was conducted. The purpose of the survey was to identify the percentage of trained facilitators who were facilitating WRAP classes, and the best means to support them. The preliminary findings of the survey have been utilized to address the stated needs of the facilitators through the ongoing development and delivery of continuing education/refresher courses and by hosting a bi-monthly conference call for facilitators.
Consumer Conferences.

DMH Recovery Support Specialists work with stakeholders to design, plan and convene annual consumer conferences in each DMH region. These conferences often have a well-known and/or national speaker who delivers the keynote address and who sets the "tone of recovery" for the conference. Consumer education is provided through a variety of venues in the state. Six regional conferences were held across the state during FY2009. More than 2,000 consumers, family members, providers, DMH and other state agency staff attended these conferences.

Consumer participation objectives for FY 2010 support the DMH priority for furthering work on the recovery vision in Illinois, by encouraging consumers and family members to participate in decision-making and service planning. Some of these objectives are continuations of efforts initiated in prior fiscal years.

Objective A1.1: Continue enhancement of the statewide system to educate consumers of mental health services in leadership, personal responsibility and self-advocacy through participation in Consumer Conferences, the use of Wellness Recovery Action Plans (WRAP), and through the Consumer Education and Support Initiative.

Indicators:

- Number of Regional consumer conferences held.
- Number of participants in the quarterly regional WRAP continuing education/refresher trainings conducted in FY2010.

Consumer Education and Support.

Dissemination of accurate information regarding services for consumers is the primary focus of the Consumer Education and Support Initiative that began in FY2007 as an outgrowth of the DMH System Restructuring Initiative (SRI). DMH has recognized the need for providing consumers with the tools they need to cogently and effectively participate in the development and evaluation of the service system. The goal of this project is to ensure that consumers of mental health services receive current, accurate and balanced information regarding changes in the service delivery system, empowering them to take an active, participatory role in all aspects of service delivery. In FY2009, nine pre-arranged statewide calls were held for consumers (see list of topics below), with an average of 438 participants per call. These calls provided a forum for discussion of service information, performance data, new developments, and emerging issues to promote consumers’ awareness and knowledge.

FY2009 Consumer Education and Support Teleconferences:

July: Transitioning Into Independent Living
August: The New Consumer & Family Handbook
September: Do You Want to Get a Job?
October: Shared Decision Making
January: Brainstorming Together
February: Systems Advocacy
April: Empower Yourself with Work
May: Empower Yourself with Your Housing
June: Empower Yourself with Your Rights

Objective A1.2: In FY2010, the DMH Office of Recovery Support Services will conduct a series of conference calls designed to disseminate important information to consumers across the State.

Indicators:
- Number of conference calls completed in FY2010.
- Number of participants in Consumer Education / Support teleconferences.

Recovery oriented training

In addition to the statewide consumer education calls, held monthly, 37 recovery oriented training sessions have been held for all interested stakeholders in FY2009. Audiences for these sessions have included diverse stakeholder groups, educating consumers of mental health services, family members of consumers, mental health and addiction professionals, advocates, college students, occupational therapy professionals, and many others. Topics for these sessions have included the foundational principles of mental health recovery, Wellness Recovery Action Planning (WRAP), mentoring, advocacy, crisis planning, recovery support, spirituality, and others.

Certified Recovery Support Specialist (CRSS) credential

As of June 2009, 173 individuals have achieved their CRSS certification and are in good standing with the Illinois Certification Board (ICB). Four additional individuals have applied and are in the midst of completing the requirements for certification. In FY2009, the DHS/DMH worked together with the Mental Health Collaborative for Access and Choice to design a study guide for individuals seeking to obtain their certification. This study guide is set to be completed and published online by the end of the first quarter, FY2010.

Specialized/Targeted Efforts Related to Recovery

Certified Recovery Support Specialist (CRSS).

In collaboration with the Illinois Certification Board (ICB), the Divisions of Mental Health, Rehabilitation, and Alcoholism and Substance Abuse have developed the Illinois Model for Certified Recovery Support Specialist (CRSS). The CRSS, through collaboration with the ICB, is now competency-based rather than curriculum-based. Individuals are certified as having met specific predetermined criteria for essential competencies and skills. The purpose of certification is to assure that individuals who meet the criteria for CRSS provide quality services. The credentials granted through the certification process will: (1) be instrumental in helping guide employers in their selection of competent CRSS professionals, (2) define the unique role of CRSS professionals as health and human service providers and (3) provide CRSS professionals
with validation of, and recognition for their skills and competencies. Access to this new credential became available through the ICB beginning in July of 2007.

As a means of disseminating information regarding this new credential, the DHS/DMH has developed a brochure entitled “Employing Persons with the CRSS Credential.” Additionally, the ICB has provided staff presence at each of the regional consumer conferences, to distribute information and respond to questions. Individuals attending consumer conferences, statewide consumer education and support teleconferences, and regional WRAP Refresher trainings, receive CEU’s toward achieving or maintaining their credential through the ICB.

In FY2010, the Office of Recovery Support Services will continue to work with other system partners, including the ICB and the Mental Health Collaborative for Access and Choice (MHCAC), to develop training and study materials for those seeking to obtain their CRSS. Additional information regarding this cutting edge approach in credentialing for mental health peer specialists can be found at http://www.iaodapca.org/forms/crss/CRSS_Model.pdf

Objective A1.3: In FY2010, continue to provide recovery-oriented training to all interested stakeholders and support the role of Certified Recovery Support Specialists (CRSS).

Indicator:

- Number of recovery oriented training sessions provided to stakeholders.
- Number of individuals obtaining the CRSS credential.

DMH Public Awareness Campaign

The Report of the President's New Freedom Commission on Mental Health noted that the "stigma that surrounds mental illnesses is one of three major obstacles preventing Americans with mental illnesses from getting the excellent care that they deserve”. One way in which to address this issue is to implement strategies geared toward reducing the stigma associated with mental illness. From FY2007 through FY2009, the Division of Mental Health allocated $200,000 every year to implement a public awareness campaign targeting adults. The DMH developed public service brochures, and T-shirts, buttons, and a variety of other items that carry the anti-stigma message and DMH phone and web contact information to access services. The Division also distributes materials developed and supported by SAMHSA for the national “What a Difference a Friend Makes” anti-stigma campaign. DMH contracted with a public relations firm to assist in the ongoing development of the campaign, oversee public service announcements and utilize opportunities to distribute public awareness information at large public entertainment events and through mass media outlets. The Department of Human Services has also expanded exposure of the public awareness message by insuring that the materials are distributed at the conferences and other public activities that are sponsored by other DHS Divisions. Due to severe fiscal constraints in FY2010, funding for the Campaign will be
very limited. However, direct coordination by DMH staff and a Web-based approach will be utilized to maintain the Campaign through this fiscal year.

The campaign was developed through research, testing and analysis of various approaches and input from mental health professionals and focus groups. The two central themes were: (1) How to reach and appropriately respond to common perceptions of the general population and (2) Creating opportunities for integrating already existing family and local community resources to assist persons coping with diagnosable mental health challenges. Campaign themes were discussed by the campaign’s executive steering committee and at 6 statewide (regional) stakeholder meetings attended by over 175 participants including consumers, family members, community providers, and other stakeholders. The contractor conducted 13 distinct focus groups (with an average of six consumers in each group) carefully selected to represent Illinois’ demographic profile to optimize the campaign’s message and to ensure its positive impact with respect to cultural diversity in communities throughout the state. This extensive deliberation resulted in the “Say It Out Loud” Campaign that was officially launched on May 1, 2008 at Navy Pier, one of Chicago’s premier venues. The Launch ceremony was attended by over 400 persons and received broad media coverage. Similar events followed in Springfield, Illinois’ capital, and other larger population centers in the State.

The campaign was targeted to a broad cross section of ‘experts’ or ‘influencers’ (providers) who are in a position to assist consumers and families and provide them with greater information about up-to-date treatment regimens; screening mechanisms for early identification of persons at risk of developing mental illnesses, and listings of available resources with instructions for making referrals to mental health service providers. In FY2009, the campaign expanded the targeted “audiences of influencers” to: Employers, Clergy, Pediatricians, Educators, in addition to the broader 1st and 2nd year audiences of MH providers and the general public. Advertisements, event promotions and printed materials were developed and distributed for each of these segments. Authentic ‘first person stories’ were solicited for each of the target audiences with photo, story and promotional materials developed for each for inclusion on all subsequent distribution, media, venues, or marketing.

As part of the overall campaign and in order to review the effects of the campaign on the public, DMH developed a comprehensive outcome survey and engaged an independent vendor to complete the survey with a pool of Internet users. Initial survey data indicates that the campaign's strategy and messaging were effective in motivating changes in the knowledge and awareness about mental health issues and in the perceptions of persons with mental illnesses and their families. In addition, individuals who saw and heard the campaign's ads were more likely to express an intention to engage in behaviors consistent with the campaign's explicit calls to action.

**Objective A1.4:** In FY2010, continue the public awareness campaign to reduce negative portrayals associated with mental illnesses. Complete an initial evaluation of the effects of the Campaign.

**Indicators:**
Materials developed for dissemination that address resource and access issues.
Completion of a report on the evaluation of the campaign with documented outcomes and lessons learned.
A report of the key achievements of the campaign and the significant public venues utilized to bring the message to all the citizens of Illinois.

Forensic Services and Mental Health and Justice Activities (Adult)

Forensic Services oversees and coordinates all forensic mental health services for the Division of Mental Health. A primary responsibility of Forensic Services is coordinating the inpatient and outpatient placements of adults and juveniles remanded by Illinois County Courts to the Department of Human Services under Statutes finding them Unfit to Stand Trial (UST) (725 ILCS, 104 -16) and Not Guilty by Reason of Insanity (NGRI) (730 ILCS, 5/5-2-4). The DMH has also implemented adult initiatives related to the criminal justice system with key stakeholders in order to address concerns regarding the large number of non-mandated individuals with mental health needs who are involved with the criminal justice system. The key initiatives in this respect are the Jail Data Link Project and the Transformation Transfer Initiative.

Jail Data Link Project: The Division of Mental Health’s Jail Data Link Project’s inception was in 1999 as a result of Bureau of Justice Assistance and other national experts that published findings that 6.1% of male and 15% of female detainees in the Cook County Jail, suffered from mental illness. Phase I of the Project was limited to Cook County and 14 pilot mental health community providers.

The project itself, which blends technological advancements and clinical systems integration, provided any County Jail and their respective community mental health providers with information as to which detainees have a history of mental illness, both inpatient and outpatient as documented by the Division of Mental Health. This cross match, is provided on a automated technology basis and is performed on a daily basis, based on the jail’s current census.

Phase 2, with grant awards provided by the Illinois Criminal Justice Information Authority, the system graduated both technologically (now an SSL Internet based platform) and expanded to the Illinois counties of Will, Jefferson, Peoria and Marion. An additional three (3) community mental health providers were participatory.

Phase 3 was implemented July 1, 2009, with the additions of Winnebago, St Clair and Rock Island counties and four (4) new participating mental health community providers. All of these counties including sheriffs and provider agencies have signed agreements to participate. The Illinois Criminal Justice Information Authority has provided the funding this phase. Specialized case managers hired by participating community mental health providers ensure continuity of care while a detainee is being held by beginning the immediate discharge aftermath planning process which includes, linkage back to their home community agency for mental health services, linkage services for substance abuse,
housing initiatives, and, in Phase 3, the expansion of Supportive Employment and Community Support services. Eight case managers are covering Cook County (Proviso), Will, Peoria, Jefferson, Rock Island, Winnebago, St. Clair, and Marion Counties.

From July 2008 to the end of May 2009, 22,743 individuals were booked into the Will, Peoria, Jefferson and Marion County Jails. Over 10% (2,580) were identified as having a history of mental illness and 525 individuals in this group were provided linkage services and released within 30 days of their booking at the jails. Follow up data on their status 30 days after their release, showed that 348 individuals (66%) were still engaged in services. In FY2010, the current data system will be advanced to include follow up data collection at 60 days after release and to expand collection of data on a range of services (i.e., those referred for substance abuse only etc.).

In conjunction with the above, the platform for the Jail Data Link Project has been expanded to encompass all Mental Health Court data collection initiatives. This expansion, in the early phase of development has been supported the Council of State Governments and the Illinois Mental Health Court Association. The Division is awaiting response on pending grant from the Bureau of Justice Assistance, Mental Health Collaboration submission in order to implement the data collection model and expand the specialized linkage management model to the Cook County Mental Health Courts of West Suburban and Skokie. Numerous partners and stakeholders are included in this submission.

Jail Linkage Evaluation

The final evaluation of this Project, funded by the Illinois Criminal Justice Information Authority and performed by the University of Illinois (Southern) is pending. Initial findings recommend this project should be expanded throughout the State of Illinois. Although not reducing recidivism as anticipated, the Division of Mental Health is working on preliminary data reflecting the reduction of inpatient hospital bed days for the individuals served by this project. Cook County Jail linkage continues to need dedicated case managers. Will, Peoria, Jefferson, Marion County, and Cook-Proviso are continuing to link individuals into community services. Three new counties have been added to data-link and will begin technology aided linkage activities in FY2010.

Additionally, the Cook County Community Re-Integration Initiative (CRC) is sustaining services with reduced emphasis on the use of ACT services and increased use of Community Support Team services. The final progress report for CRC was completed in February of 2009. The CRC met its major goals and service projections. This included expanding jail diversion contacts through the Cook County Mental Health Court (CCMHC) and CIT street deflections to emergency rooms and outpatient providers. Over three years, 256 clients were diverted or participating in mental health court. CRC also met its goals of involving CCMHC participants in evidence based practices including trauma related services, ACT, and IDDT, training 242 new CIT officers, and providing training to project staff and partners on best practices including trauma related services, ACT, and IDDT.
Objective A1.5: In FY2010, evaluate linkage services for individuals with serious mental illness released from Illinois jails.

Indicators:
- Complete an evaluation of the performance and outcome goals of the Data-Link Phase II initiative.

The Transformation Transfer Initiative: In FY2008 DMH was awarded a SAMHSA Transformation Transfer Initiative grant for $105,000. The grant funded a statewide mental health/criminal justice needs assessment and system mapping initiative to help inform the system transformation process in Illinois. The overriding goal of this initiative is to support the efforts of the Criminal Justice Transformation Workgroup led by DMH that was convened to recommend enhancements in the system of care for individuals with mental illness or co-occurring mental health and substance abuse disorders who are involved with the criminal justice system. A Kick-Off meeting, facilitated by the DMH Deputy Director of Forensic Services and consultants from Policy Research Associates (TAPA Center) was held with an advisory group of stakeholders from across Illinois in April of 2008. Noteworthy was the involvement of judiciary from across the state in the planning start-up. Regional planning meetings were completed in September 2008. Results from the mapping and planning efforts included regional workshop summaries and an overall statewide report entitled, Strategic Planning Illinois: Mental Health Substance Abuse and Criminal Justice. Structured according to the Sequential Intercept Model of identifying points for service delivery, these reports provided information on the following areas: 1) Gaps in service delivery for justice involved individuals within the regions based on each intercept point, 2) Cross intercept gaps in service, 3) Quick fixes for problems in service delivery within regions/counties, 4) Analysis of where the Judiciary can impact positive change, and 5) Lists of issues that require state level intervention or legislative change. The overall statewide report was disseminated by Policy Research Associates in Fall 2008 and included the following list of conclusions and recommendations for Mental Health and Justice in Illinois.

- Expand Police Crisis Intervention Teams (CIT)
- Improve coordination with law enforcement and expand crisis stabilization bed capacity if needed.
- Expand Intercept 2 (initial detention/initial court hearings) diversion options and Data Link.
- Improve screening and basic jail mental health services.
- Improve the Unfit to Stand Trial (UST) and the Not Guilty by Reason of Insanity (NGRI) process to reduce jail waiting lists for hospital admission and develop outpatient capacity for examination and competency restoration.
- Improve jail transition planning.
- Improve prison discharge planning.
- Involve field parole staff with community mental health planning and improve parole coordination with mental health service providers.
- Consider multiple funding strategies.
• Continue to develop and expand integration of consumers with histories of justice system involvement into planning and service delivery activities.
• Continue to expand on innovative housing initiatives.
• Expand capacity for integrated dual disorder treatment services.
• Develop trauma-informed systems and implement trauma-specific services.
• The Mental Health and Justice Steering Committee should review the accumulating “legal disabilities” faced by consumers with mental illness.
• Continue to improve collaboration between the mental health systems, Veterans Administration, veterans groups and the criminal justice system.
• Develop a Coordinating Center of Excellence.

Recommendations to the Judiciary:
• Consider a broader range of diversion alternatives.
• Consider a survey of mental health training needs for the judiciary.
• Share current expertise.

Community Monitoring of Persons Adjudicated as NGRI
Forensic Services is mandated by law to monitor the community-based treatment services and status of individuals who have been court-ordered into treatment due to a finding of Not Guilty by Reason of Insanity (NGRI). Currently, two tracking systems are being maintained. One follows those NGRI consumers who have been conditionally released from DHS facilities by court order. The second tracking system monitors those NGRI consumers who are ordered directly into outpatient treatment by the Court.

During FY 2009 a total of 120 NGRI individuals on Conditional Release (CR) status were monitored in the community. Of these, a total of 27 received an initial placement on Conditional Release by jurisdictional courts during FY 2009 and a total of 19 CR NGRI individuals were removed from the monitoring system due to changes in their legal status by the jurisdictional courts. There are currently a total of 91 “active files” maintained in this tracking system. Agency compliance with court reporting and service delivery requirements for this population was 98% for FY2009. This objective is continuing in FY2010:

Objective A1.6. Maintain the tracking system for persons adjudicated Not Guilty by Reason of Insanity (NGRI) who have been conditionally released from DHS inpatient programs to the community.

Indicator:
• Number of persons adjudicated as NGRI who have been released and maintained in the community
• Number of persons adjudicated as NGRI who have completed conditions of release.
• Number of persons adjudicated as NGRI who been subject to revocation of conditional release

Not all individuals with a finding of NGRI are court-ordered for hospitalization. There are those who are directly ordered into outpatient treatment. During FY2009 a total of 48 individuals court–ordered into outpatient treatment (Outpatient NGRI) were monitored in the community. Of these, eight (8)individuals received an initial placement as Outpatient
NGRI by jurisdictional courts during FY2009 and eleven (11) were removed from the monitoring system due to changes in legal status. There are currently a total of 37 “active files” maintained in the tracking system. Agency compliance with timely court reporting and service delivery requirements for this population was 78% for FY2009. This objective is new for FY2010.

Objective A1.7: Maintain the tracking system for persons adjudicated Not Guilty by Reason of Insanity (NGRI) who have been court ordered into Outpatient treatment.

Indicators:
- Number of persons adjudicated as NGRI who have been court ordered into Outpatient treatment.
- Number of persons removed from the monitoring database due to change in legal status.
- Agency compliance with timely reporting

In FY2010, Forensic Services will continue to maintain and refine the tracking systems and application of data to ensure compliance with legal mandates. Emphasis will be placed on continuing to improve the flow of communication between DHS, local providers and the judicial stakeholders.

Outpatient Fitness Restoration Service Monitoring and Expansion.

DHS provides fitness restoration services on an inpatient and outpatient basis. These services are focused on providing treatment that will allow individuals found unfit to stand trial to be restored to fitness and complete their trial process. The service involves psycho-educational and clinical treatments that will assist a person in understanding the legal process of their trial and/or working with their attorney. The goal is to increase the amount of these services in least restrictive community settings and monitor the performance of outpatient providers that agree to provide fitness restoration services.

In FY2009, 85 adult consumers and 64 juveniles received outpatient fitness restoration services. There were 48 new referrals during the year and a total of 53 Outpatient UST were removed from the monitoring system due to changes in legal status by the jurisdictional courts. There are currently a total of 110 “active files” maintained in the tracking system. Agency compliance with timely court reporting and service delivery requirements for this population was 96% for FY 2009 and agency compliance with providing fitness restoration services was 100%. In FY 2010, Forensic services will continue to follow up on Outpatient UST and improve the flow of information between DHS, courts, corrections, law enforcement and local providers in order to continue to maximize Out Patient UST service capacity and beneficial service outcomes.

This objective is continuing in FY 2010.

Objective A1.8. Develop and maintain a tracking system for persons receiving outpatient fitness restoration services.

Indicators:
- Number of adult persons receiving outpatient fitness restoration services in FY 2010.
- Number of juveniles receiving outpatient fitness restoration services in FY2010.
- Number of new cases referred for outpatient fitness restoration.
- Agency compliance with timely court reporting.
- Agency compliance with providing fitness restoration services for UST patients in FY2010.

Monitoring of Persons with UST Status Returning to the Community
Forensic services tracks individuals discharged from DMH hospitals after inpatient fitness restoration services. A total of 373 discharged UST patients were linked to community services in FY 2009. The documented number of discharged UST patients that followed through with appointments as reported by community agencies within thirty days of release from jail custody was 54% (200). In FY2009, 42% (155), of the documented number of discharged UST patients continued with follow up services as confirmed by community providers. In FY2010 Forensic Services will continue to follow up on discharged UST consumers and work collaboratively to improve the flow of information between DHS, courts, corrections, law enforcement and local providers in order to increase the number of discharged UST consumers who follow up on continuity of care referrals.

Objective A1.9: Provide continuity of care for individuals found unfit to stand trial (UST) that are restored to fitness in state operated inpatient forensic programs.
Indicators:
- Number of discharged UST patients linked to community services.
- Number of discharged UST patients that follow-through with appointments in community agencies within thirty days of release from jail custody.
- Number of discharged UST reported in correctional custody.

Monitoring Length of Stay
Monitoring the length of stay for inpatient restoration services in DHS facilities is required in order to maintain an adequate number of inpatient beds specialized to this service and to reduce the amount of time that a consumer with a UST finding needs to remain in this more restrictive level of care. Benchmarking was undertaken in FY2009 in to collect data with which to monitor length of stay. The performance measurements to address the objective below were developed with input from staff from all hospital forensic programs and central office quality management staff. Forensic performance measures have been completed and data collection will be initiated in FY2010.

Objective A1.10. Reduce the length of stay from the time that court orders are received to the discharge of patients referred to DHS/DMH under UST statutes.
Indicators:
- The period of time between DHS receipt of court orders to placement of patients in forensic inpatient programs.
- The period of time from inpatient admission to recommendation for a court hearing based on resolution of fitness issues.
The period of time between recommendation for a court hearing and discharge from the inpatient program.

Services for Individuals with Co-occurring Mental Illnesses and Substance Abuse Disorders

Addressing the treatment needs of individuals with co-occurring disorders requires the collaboration of mental health and substance abuse agencies at the state and local levels. The Division of Mental Health (DMH) and the Division of Alcohol and Substance Abuse (DASA) have worked diligently over the years to collaborate, develop and implement initiatives focusing on consumers with co-occurring disorders. These collaborations included co-location projects that continued through FY2009 at four state hospitals; Elgin, Chicago Read, Madden, and McFarland. Sharing service delivery site resources has 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 are warranted. Sharing facilities has resulted in the development of more hospital staff training and expanded the role of the DASA providers to perform linkage and engagement activities. DMH has initiated data collection on service timelines, major diagnosis and interventions by co-location service providers. In the past year, funding for these efforts has either been significantly reduced or eliminated and the collaborative programming is no longer sustainable.

Assessing Consumer Perception of Care

The DMH uses the National Outcome Measures (NOMS) along with additional system indicators to track mental health system service delivery and outcomes to aid in service planning. A number of the National Outcome Measures (NOMS) are currently collected through the MHSIP Consumer Survey that has been completed annually since FY2007. The measures reported through the survey are: Client Perception of Care, Decreased Criminal Justice Involvement, Increased Social Supports/Social Connectedness, and Improved Level of Functioning.

The Adult Consumer Survey is part of the Mental Health Statistics Improvement Program (MHSIP) Quality Report performance measures. The surveys address two goals of the Division: data-based decision-making in a continuous quality improvement environment and to enhance and expand the involvement of consumers in the review, planning, evaluation and delivery of mental health services. Variables included in the analysis are: severity of emotional disturbance, race/ethnicity, and length of time in treatment. The information compiled in this report can be used for management, planning, quality improvement and feedback to providers, consumers and family members regarding state and federally funded services. The survey will be conducted again in FY2010.

Objective A1.11 (NOM): The percentage of consumers reporting positive outcomes through the Adult Consumer Survey will increase in FY2010.

Indicators:
Percentage of consumers reporting positively about outcomes with reference to the following national outcome measures:
- Client Perception of Care (Outcomes Domain)
- Decreased Criminal Justice Involvement
- Increased Social Supports/Social Connectedness
- Improved Level of Functioning
Illinois

Adult - Available Services

Adult - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing services;
Educational services;
Substance abuse services;
Medical and dental services;
Support services;
Services provided by local school systems under the Individuals with Disabilities Education Act;
Case management services;
Services for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities leading to reduction of hospitalization.
ADULT-AVAILABLE SERVICES

Health, Mental Health and Rehabilitation Services

Health Services

“There is no Health without Mental Health” has been the slogan of the Division of Mental Health for the past several years. The diagnosis and treatment of mental disorders is inextricably woven into the broader context of an individual’s physical health. Physicians in general practice are very likely to be the access and linkage point for psychiatric services, especially for persons suffering with depressive and anxiety disorders. On the other hand, mental health practitioners should be cognizant of the medical issues being faced by the clients they see and be prepared to refer them to the appropriate medical specialties. Individuals with serious mental illnesses who are Medicaid recipients are entitled to the range of health services covered in the Illinois Medicaid plan. DMH continues to emphasize the importance of assisting adult consumers in the completion of an application for Medicaid services as one means of assuring that access to health services are available. The establishment of relationships between Federally Qualified Health Centers (FQHCs) and DMH funded community mental health agencies has also been emphasized. An initiative recently implemented by the Department of Health Care and Family Services (DHFS) follows a Disease Management model. Illinois Health Connect is a statewide Primary Care Case Management (PCCM) Program for most persons covered by DHFS medical programs. People who are enrolled in Illinois Health Connect have a “medical home” through a Primary Care Provider who will coordinates and manages their care. This program can benefit many consumers of public mental health services both children and adults. Additionally, a second program, Your Healthcare Plus, employs health care teams to assist with problems of chronic diseases including mental illness and uses an “action planning” approach to help consumers understand their illness, how to cope with it and work constructively with their doctors. DHFS, in partnership with DMH, applied for and received a $2,000,000 Medical Emergency Room Diversion (ERD) Grant, one of twenty grants to twenty states for two-year projects with the goal of reducing the use of hospital emergency rooms by Medicaid beneficiaries for non-emergent reasons. The anticipated outcomes of these grant-funded projects are improved access to, and quality of, primary healthcare services, improved beneficiary health status and demonstrated program cost savings.

The Array of Core Mental Health Services

The array of core mental health services purchased on behalf of Illinois citizens with mental illnesses are based on the tenets of the Community Support Program (CSP) and Child and Adolescent Support Services (CASSP) models. They are described in the Provider Handbook which has been issued by the Mental Health Collaborative, the administrative services organization which is assisting DMH with the organization and evaluation of service delivery. The following is a brief summary of the core services.

Acute Care.
Acute Care Program services provide a rapid response to individuals in a mental health crisis, to members of the individual’s support system and the community on a 24-hour a day basis. Such services are intensive, short-term and are oriented toward stabilization of the individual’s condition and management of disruptive and life threatening symptoms. Services include crisis-emergency services (e.g. mobile, walk-in and telephone response, crisis residential services and hospital-based services.

Mental Health Treatment - Outpatient

These core services are delivered to consumers who have been determined on the basis of a mental health assessment to have a mental illness or emotional disturbance with significant impairment in role functioning. Outpatient services that are intended to reduce psychiatric symptoms and promote adaptive functioning are based on an evaluation of an individual’s mental health service needs and an individual treatment plan (ITP) that is monitored, reviewed, and modified as needed on an ongoing basis. These services include:

- Assessment, Treatment Planning and Monitoring;
- Counseling and Therapy Services;
- Psychiatric Services*;
- Medication-related Services; and
- PAS/MH Services (Long Term Care screening and assessment service).

Psychiatric Services*

Psychiatric Services are a primary core service in mental health treatment programs. It is noteworthy that block grant dollars allocated to Illinois have largely been directed to improving the quality and availability of this vital clinical service through further infrastructure development. Funds are used in recruitment and retention of qualified psychiatrists, and to further collaboration with medical schools. This initiative was one of the three top priorities to increase access to quality psychiatric services in areas of critical need cited by the Illinois Mental Health and Planning Advisory Council (IMHPAC) for both adults and children.

Rehabilitation Core Services

Rehabilitation core services include:

- Psychosocial Rehabilitation,
- Assertive Community Treatment (ACT).
- Community Support and Case Management
- Client Transitional Subsidy: -a temporary short-term assistance for medication, clothing and housing support in order to facilitate a consumer’s resettlement in the least restrictive, community integrated setting possible.
- Transition to Adult Services.
- Residential Support Services- for promoting community adjustment and long-term recovery and relapse prevention.
• Residential services -including supported residential and supervised residential services.

Additional Support Services Funded and Provided through DMH:

Psychiatric Medication provides resources for psychiatric medications primarily to adults with serious mental illnesses or children/adolescents with serious emotional disturbance who have insufficient insurance coverage or private resources to pay for them. Three ($3) million in General Revenue Funds (GRF) have been budgeted yearly to increase accessibility to psychiatric medications. The program targets persons discharged from hospitals and waiting for Medicaid reinstatement, SSI/SSDI applicants waiting for initial Medicaid or All Kids eligibility determination, or applicants for pharmaceutical indigent programs awaiting access. The priority is to access the medications, which produce the most favorable clinical outcome as determined by the treating psychiatrist.

Community Integrated Living Arrangements provide a funding mechanism for an individually-tailored array of supportive services for individuals residing under the supervision of the service provider which promotes residential stability for an individual who resides in his or her own home or in the natural family home.

Emergency Psychiatric Services are provided through a hospital-based service model and include, emergency room psychiatric consultation and assessment activity, crisis/observation beds, transportation, emergency purchase of medications (short term), partial hospitalization, and inpatient hospitalization.

Community Psychiatric Hospitalization provides inpatient psychiatric hospitalization in a community hospital for persons experiencing acute psychiatric conditions.

Employment Services

Supported Employment Services are based on the financial and service integration of the DHS Division of Rehabilitation Services (DRS) funded vocational services and resources with DMH funded mental health treatment and supportive services. DMH and DRS have collaborated closely in a joint effort -“The Brand New Day Initiative” - to increase access to Individual Placement and Support (IPS) supportive employment for persons with serious mental illnesses and to improve the coordination of psychiatric and vocational services. Locally, services are obtained through joint planning and service efforts by community mental health centers (CMHCs) and local offices of DRS. This collaboration addresses the needs of both adults and youth.

Evidence Based Supported Employment (EBSE)

Supported Employment is an evidence-based practice that has been shown to improve employment rates of persons with serious mental illness by as much as 60%. Two grants have assisted in implementing this model in Illinois: a NIH/SAMHSA Planning grant to address state infrastructure issues (which ended in September, 2007) and a Johnson & Johnson/Dartmouth Community Mental Health Program Grant to support implementation at four pilot sites ended in June 2009. The DMH and the DHS/Division of Rehabilitation Services (DRS) are actively collaborating to implement this evidence-based practice initiative.
In the past year the number of mental health agencies working to implement EBSE increased from 13 to 17. Twelve of these agencies have reached fidelity to standards of EBSE based upon the Individual Placement and Support (IPS) model. One agency provides the service at 8 sites and another at 2 sites. Thus, the total number of locations where fidelity EBSE services can be accessed is 20. There are four additional locations working to reach fidelity.

July 1, 2008 through March 31, 2009 (fidelity agencies only):

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Number of agencies at fidelity</td>
<td>11</td>
<td>11</td>
<td>12</td>
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<tr>
<td>Number of locations at fidelity</td>
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<tr>
<td>Number of consumers receiving supported employment</td>
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<tr>
<td>Number employed in competitive jobs</td>
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<tr>
<td>Number of days persons enrolled in EBSE held competitive jobs</td>
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<td>24,933</td>
<td></td>
</tr>
<tr>
<td>Number of hours worked per week by persons currently enrolled</td>
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<td>8,533</td>
<td></td>
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<tr>
<td>Number of working people transitioned off the IPS Caseload</td>
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<td>241</td>
<td>210</td>
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<tr>
<td>Number of new enrollees</td>
<td>239</td>
<td>239</td>
<td>258</td>
</tr>
</tbody>
</table>

Accomplishments in FY2009 include:
- Four new pilot sites were established after consensus was reached within the agencies to implement EBSE.
- An EBSE (IPS) Section to the DRS Procedure Manual was developed to better align DRS procedures with the evidence-based practice.
- The statewide EBSE steering committee, with large consumer and family member representation as well as a range of other stakeholders, continues to meet regularly.
- A technical assistance model for EBSE was developed and work is continuing on refining the model. Learning is ongoing in identifying technical assistance needs and strategies to guide mental health agencies and their local DRS offices on how to implement EBSE. Varying levels of technical assistance are being provided to the 17 agencies.
- One fourth of the members of the technical assistance/fidelity team are persons who have lived with the experience of serious mental illness.
- Illinois is partnering with the Dartmouth Psychiatric Research Center to develop a Vocational Rehabilitation Fidelity Scale for EBSE to clarify the Vocational Rehabilitation role in implementing the model and increase accountability.
- Illinois was awarded a Johnson & Johnson/Dartmouth Community Mental Health Program Grant to develop an IPS Family Project. Currently 4 local NAMI affiliates are educating membership about IPS, the role of employment in
recovery, and how to access the Work Incentives Planning and Assistance Program (benefits planning).

- Outcomes have not had a major decline despite the poor economic conditions. Programs are, however, beginning to reduce the number of employment specialist positions.
- Extensive Technical Assistance was provided in the past year. So far a total of 74 tele-conferences were conducted. These included employment specialists on job development issues (50); supervisors on their role (12), and IPS providers on various implementation issues, with recent emphasis on planning and implementing job retention supports (12). Assessments of fidelity were done for 25 sites. Over 200 technical assistance sessions were conducted onsite, and one all-day IPS Leadership meeting was held for all DRS and MH IPS Supervisors.

**Objective A1.12: Continue to expand the implementation of Evidence Based Supportive Employment.**

**Indicators:**

- Number of consumers receiving supported employment in FY2010. (National Outcome Measure)
- Number of consumers in supported employment who are employed in competitive jobs in FY2010.
- Number of technical assistance sessions provided to the IPS sites to increase fidelity to the SE model.

**Housing Services for Adults**

Illinois has been consistent in its efforts to develop housing options and support services for consumers of mental health services. Substantial portions of block grant funding have been allocated for the provision of ‘therapeutic’ Supervised and Supportive Residential Services Programs. Community supports range from in-home help for families, to community integrated living arrangements where people share a home with services individually tailored to their needs, or independent apartments with support services. Supported and Supervised Residential programs offer skills training, counseling and other supports to assist our consumers in maintaining a stable living arrangement. The Illinois General Assembly has steadily increased the State’s commitment to housing for persons with mental illnesses since FY2005, when DMH first received an allocation of $4.7 million for "Mentally Ill Supportive Housing". That year the DMH contracted with 34 community-based agencies to serve 1,232 persons with disabilities, who were formerly homeless, to provide affordable housing and supportive services. In FY 2006, the appropriation by the General Assembly brought the total allocation to $6,150,000, which led contracts to another 13 providers for new supportive housing opportunities to an additional 279 individuals. In FY 2007, another $4.3 million was added bringing the total appropriation for that year to $10.5 million funding 11 new supportive housing projects that served another 134 consumers. In FY2008, an additional $3.9 million was allocated bringing this initiative to a projected $14.5 million, adding 12 additional supportive housing projects statewide, and serving 263 new consumers. In FY2009 the Illinois General Assembly added an additional $3.75 million to expand permanent
supportive housing in Illinois for persons with special needs to bring the grand total to $18.25 million. In FY2009 an additional nine DMH permanent supportive housing projects were realized serving an additional 174 new consumers.

**Permanent Supportive Housing**

In FY2009 Illinois has expanded resources in creating the DMH Permanent Supportive Housing (PSH) policy and model. Permanent Supportive Housing (PSH) is a specific Evidence Based program model in which a consumer lives in a house, apartment or similar setting, alone or with others (upon mutual agreement – no more than two consumers within a common unit). The criteria for supportive housing include: housing choice, functional separation of housing from service provision, affordability, integration (with persons who do not have mental illness), and right to tenure, service choice, service individualization and service availability. Housing should be integrated and affordable (consumers pay no more than 30% of their income on rent). Ownership or lease documents are maintained in the name of the consumer, so tenant landlord relationships are maintained.

The goal of this initiative is to promote and stabilize consumer recovery by providing decent, safe, and affordable housing opportunities linked with voluntary DMH-funded community support services. A key component to the success of this effort is the creation of the DMH Bridge Subsidy Initiative to provide tenant-based rental assistance opportunities to eligible consumers who are capable of living in their own housing units within the community. The Bridge rental subsidy is designed to act as a “bridge” between the time the consumer is ready to move into his or her own housing unit until the time he or she can secure a permanent rental subsidy, such as Section 8 Housing Choice Voucher or comparable permanent rental subsidy. To facilitate transition to a permanent voucher from the Bridge Subsidy Program as seamlessly as possible, the requirements and guidelines for the program are consistent with those of the Housing Choice Voucher (HCV) Program and the consumer must either already be on a Public Housing Authority (PHA) waiting list for a Section 8 HCV or agree to register/apply for a HCV or comparable subsidy and to accept the subsidy whenever the opportunity is available. Consumers who have a serious mental illness or a co-occurring mental illness and substance abuse disorder whose household income is at or below 30% of Area Median Income (AMI) as defined by HUD are eligible to apply to the program. DMH is currently targeting a defined population of consumers, including: those in long term care facilities or at risk of being in a nursing facility, long-term patients in state hospitals, young adults aging out of the ICG/MI program or out of DCFS guardianship, residents of DMH funded supported or supervised residential settings, and those who are determined by DMH to be homeless.

In FY2009 DMH utilized approximately $5 million of newly dedicated funding to new Permanent Supportive Housing expansion and 229 eligible consumers were approved for PSH in the Bridge Subsidy Initiative in the first two application rounds opened by DMH. These consumers will be securing PSH opportunities on a statewide basis. DMH has partnerships (contractual as well) with seven (7) service providers for the provision of Subsidy Administration duties. These seven Subsidy Administrators currently cover the
entire state of Illinois. The DMH Permanent Supportive Housing (PSH) Bridge Subsidy Initiative is open and available to all DMH service providers currently under IDHS/DMH contract.

Objective A1.13: By the end of FY2010, through the provision of rental subsidies, implement a statewide permanent supportive housing initiative which targets 300 consumers acquiring decent, safe, and affordable housing and support services in a manner consistent with the national standards for this evidence based practice.

Indicators:
- Number of consumers who acquire appropriate permanent supportive housing in FY2010. (National Outcome Measure)
- Number of DMH-funded providers participating in the program.
- Amount of money expended for the program in FY2010.

Educational Services

Educational services in the form of stipends and scholarships for college, trade school, and vocational training are available through DRS and facilitated by mental health providers. Consumers receive support through Psychosocial Rehabilitation and Care Management in pursuing the completion of basic educational requirements (e.g., GED) and other available educational programs through local public school system. Since FY2005, DMH has continued to emphasize consumer and family education and this will continue in FY2009 through a variety of educational activities. Recent legislation amended the School Code to provide statewide uniformity for students with disabilities who are now eligible to receive special education services up until the day of their 22nd birthday. This is particularly helpful to transitioning youth.

Substance Abuse Services

Services for individuals with substance use problems are provided by community-based substance abuse treatment programs funded through the DHS Division of Alcoholism and Substance Abuse (DASA). These programs provide a full continuum of treatment including outpatient and residential programs for persons addicted to alcohol and other drugs.

Services for Co-Occurring Mental Health Disorder and Substance Abuse

Many adults with serious mental illnesses have co-occurring mental health and substance abuse disorders. In Illinois, substance abuse, particularly, has been a primary presenting problem for nearly half of the individuals admitted for treatment in DMH state hospitals. Although data submitted by providers to the DMH reporting of community services (ROCS) system showed that close to 12% of consumers seeking services having a co-occurring substance abuse diagnosis, research suggests that a much higher proportion of persons with mental illness also have substance use problems. The collaboration of DMH and the DASA to meet the needs of this population were previously described. In respect to service provision, DMH and DASA continue to work with the five geographic MISA consortiums that were established in FY 2003 which meet quarterly at a minimum
to problem-solve and develop strategies to meet the needs of individuals with co-occurring disorders. Collaboration has continued on co-location projects in which DASA funded agencies work on site at DMH state hospitals to assess, consult and transition consumers with co-occurring disorders to appropriate community-based mental health and substance abuse services.

**Medical and Dental Services**

Adults with serious mental illnesses access the same medical and dental care services available to the general population through the service coordination functions provided in case management and therapeutic services. DMH is addressing issues in primary health care with a special emphasis on the relationship between primary health care and mental illness. Adults with mental illnesses often have neither the insurance nor the financial means to cover their healthcare costs. Assistance is usually provided to them in applying for Medicaid. Those who are Medicaid eligible benefit from the medical services and programs provided through the Department of Healthcare and Family Services (DHFS) which were described above. For hospitalized patients, this process is begun as close to admission as possible.

In addition to treating consumers for their acute psychiatric conditions, DMH state hospitals employ primary care physicians who provide basic general health care. All State Hospitals are required to provide dental screening exams and basic dental care to their inpatients. They do so either by directly employing dentists who work at the hospitals or via a contractual arrangement with an independent provider. Metabolic Syndrome screens are provided in state hospitals to identify individuals who may have Diabetes.

Integration of primary medical care and behavioral health care is increasing in importance and is being energized by federal funding initiatives. DMH staff continue to explore options for collaboration with Health Resources and Services Administration (HRSA) funded Federally Qualified Health Centers (FQHCs) in Illinois. Several CMHC’S have participated in this collaboration in the past three years. In FY2008, DMH partnered with staff of the Illinois Department of Healthcare and Family Services (DHFS) in applying for and obtaining a federal Medical Emergency Room Diversion (ERD) Grant from CMS. The grant provides $2 million over a two-year period to improve access to, and quality of, primary health care services through peer-delivered crisis response services. Through the grant, two new Community Health Center (CHC) sites will be located on or near hospital campuses which will partner with behavioral health providers so consumers seeking non-emergent care may be seen in a non-emergent primary care and behavioral health setting. DHFS will seek proposals from CHC/hospital and behavioral health collaborators and will fund two collaborations, one in Chicago and one in an area serving rural citizens.

**Support Services**

Effective mental health services across Illinois require the integration of local community-based services from a variety of sources. The development of local networks
of service providers has been instrumental to improve this integration. Many of the local networks have representatives from local housing, public health, vocational development, and medical care as a part of their memberships.

IDHS provides an extensive range of services that are available to adults with serious mental illnesses. Liaisons have been developed between local community mental health centers and local IDHS offices for the purpose of facilitating consumer entitlements and identifying those IDHS clients who are in need of assistance in accessing mental health services.

The Home-Based Support Services Program, which is legislatively mandated, provides reimbursement for support services to adults with serious mental illnesses (SMI) or developmental disabilities. Requests for services must be approved by a Service Facilitator and by IDHS program staff. The statute requires SSI/SSDI disability status as a condition of application and states that these program resources are not intended for any services that are available through other programs or entitlements. The program currently serves 200 adults with SMI.

GAPS Work Incentive and Planning Assistance Project. To assist mental health consumers and other individuals with disabilities, DMH applied for and received the Work Incentives Planning and Assistance grant funded by the Social Security Administration, which began in October 2006. This cooperative agreement funds benefits planning and assistance for persons with disabilities receiving SSI/SSDI and their beneficiaries. The primary goals of the project are to provide (1) accurate information regarding state and federal benefit and work incentive programs; (2) assistance in interpreting and applying this information so that they can make informed decisions regarding employment; (3) to provide technical assistance on benefit planning strategies to service providers and advocates working with persons with disabilities; and, (4) activities with SSI/SSDI recipients regarding the availability of benefits planning and assistance services presented in "lay terms" that are non-technical and culturally sensitive. DMH Work Incentive Planning Assistance (WIPA) services are being provided to persons in suburban Cook County and more than 40 counties across Illinois.

Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)

Local school systems provide special education and a range of related support services to students with disabilities over the age of 18. Mental health and transitional services include but are not limited to counseling, adapted driver education, parent counseling, psychiatric, psychological and social work services, behavioral intervention planning, transitional services through the STEP program, career and technical education, competitive and supportive employment, interagency linkages for social services, and supports for transition to post-secondary (college) education. Since the same student can use several services, the Illinois State Board of Education (ISBE) uses a point-in-time count to reach an unduplicated total. Based on the data provided by local school districts for the 2005-2006 school year, as of December 1, 2005, at least one of the above services
was provided to 1,517 students in the Emotional Disability category who were over the age of 18 years, 277 such students in the Autism category, and 58 students over 18 in the TBI Disability category.

Case Management Services

In Illinois, Case Management is a required service for adults with serious mental illnesses who receive substantial services through the public mental health system. It is pivotal to hospital-community linkages and in providing continuity of treatment and supportive services in the community. Due to DMH’s early adoption of the Community Support Program and CASSP models, for which Case Management is the critical “hub of the wheel” of services, Case Management services have been continually available in Illinois as a core service, and efforts are made to track service delivery on an on-going basis. Continuity of Care Agreements (COCAs) between community mental health providers and state hospitals outline assurances of coordinated service approaches by clinicians from both settings who are knowledgeable and attuned to the needs, strengths, and weaknesses of the consumer, the consumers' support networks, and the environment. It is required that care management assignments be solidified during the inpatient treatment process, with face-to-face linkage occurring within seven days after discharge. Compliance with the COCA requirements in discharge, linkage, and face-to-face engagement is monitored by CCSRs. Increasing the availability of services to support continuity of care for persons discharged or triaged from state hospitals and increasing the capacity of ACT programming through Medicaid Reimbursements have been priorities in recent years.

Community Support Teams: A Recovery Approach

The Community Support Team (CST) model was established by DMH in FY2008 as a core service to support recovery/resilience. Community Support Team services consist of therapeutic interventions delivered by a team that facilitates illness self-management, skill building, identification and use of natural supports, and use of community resources aimed at decreasing hospitalization and crisis episodes and increasing community functioning in order for the consumer to achieve rehabilitative, resiliency and recovery goals. CST services can be provided face-to-face and by telephone or videoconference, to an individual or family member. Providers are required to deliver 60% of all CST services in natural settings, during times and at locations that reasonably accommodate the consumer's needs, and at hours that do not interfere with the consumer's work, educational and other community activities. Community Support is seen as an active intervention that builds capacity by assisting the individual to do for self. Reimbursement is based on medical necessity requiring documentation of psychiatric disability (diagnosis), currently assessed need, an existing service plan with allowed interventions, and a continuing assessment of progress toward achieving recovery/resilience goals.

Assertive Community Treatment

Illinois was an early adopter of the ACT model beginning implementation in 1992. ACT is the most intensive specialized model of case management in which a team of mental health professionals takes responsibility for a small group of program participants’ day-to-day living and treatment needs. These individuals typically require assertive outreach and support to remain connected with the necessary mental health services to maintain
their stability in the community. Often these consumers have a history of repeated admission to psychiatric inpatient or excessive use of emergency services. Previous efforts to provide linkage to necessary services have failed and the need for multiple services requires extensive coordination. The active participation of nurses, psychiatrists, and specialists trained in substance abuse is crucial to the success of the ACT model.

During FY 2007, the Illinois ACT model was modified as part of the State Medicaid Plan amendment to bring it into line with the National ACT Model and a plan was developed to monitor the fidelity of ACT services. Subsequently, several agencies determined that they did not have the capacity to deliver the evidence-based ACT model, and chose to adopt the step-down model of the Community Support Team (CST) instead. During FY 2009, DMH has continued to provide additional technical assistance to agencies that elect to provide ACT services to help them in meeting the National ACT fidelity requirements. This has included statewide calls with ACT team leaders, as well as break out sessions focused on ACT during the annual Evidence Based Practices Conference held in May 2009. Technical assistance, including statewide calls, will continue in FY2010 as well. As of June 2009 twelve ACT teams meet National fidelity standards, an increase of two since the end of FY2008.

Objective A1.14. Continue provision of Assertive Community Treatment that meets national fidelity model requirements.

Indicators:
- Number of persons with SMI receiving Assertive Community Treatment in FY2010 (National Outcome Measure)
- Number of ACT teams meeting National fidelity standards by the end of FY 2010.

Other Activities Leading To the Reduction of Hospitalization

Historical Reduction of State Hospitals Beds and change in the Utilization of Psychiatric Inpatient Care

Illinois has shared the de-institutionalization experience common throughout the U.S. over the past three decades, including the closure of large state hospitals and the dramatic downsizing of the remaining large older institutions. At the height of the era of institutions in 1940, Illinois state hospitals had a resident population of 55,587. In contrast, the resident population on June 30, 2009 was 1,319. Significant decreases of admissions in state hospitals are the result of attention to the issue of local area utilization of state hospital resources and continuity of care. The statewide reduction of bed utilization is based upon the principle that reduction must occur within a context that assures that clinically effective care remains continuous and that alternative and supportive community services are in place.

A variety of strategies have resulted in a significant reduction in admissions to state hospitals from 21,393 adults in FY1987 to 10,045 in FY2009. The reduction in admissions has allowed a reduction in the size of all facilities and closure of several with the concomitant increase in the provision of services in the community to persons who would otherwise have been hospitalized in state hospitals. Paralleling the downsizing of
state hospitals, and fostering the movement to the community, Illinois has developed a network of community mental health agencies covering all geographic areas of the State. These providers share the goal of providing the necessary basic services to maintain persons with serious mental illness in the least restrictive setting possible. The reduction in admissions and bed utilization since FY1993 has largely been the result of a continuing impact of a succession of new initiatives.

- **Single Point of Responsibility** for screening of admissions to state hospitals has had the broadest impact in significantly reducing the rate of hospitalization. In FY-1993, Illinois developed a re-conceptualized system for Single Point of Responsibility referred to as Pre-Admission Screening, which was implemented across the State and has consistently resulted in over 90% compliance over the past several years.

- **Community Based Programs for High Users:** High users (3+ admissions in a year) of psychiatric hospitalization have been targeted since FY1994 through the implementation of ACT teams in the geographic areas that have the highest concentration of heavy utilization.

- **Building Community Services:** Several initiatives have had a substantial and sustained impact on the public mental health system of care. Each Comprehensive Community Region (CCSR) ensures that a community mental health provider screens consumers prior to admission to state hospitals. When consumers are discharged or triaged from a state hospital they are enrolled with a care management provider to assure linkage to needed treatment and support services. Reductions in state hospital utilization have resulted in funds becoming available for the development of community-based services designed to maintain individuals in the community and to provide inpatient services when required in community hospitals.

- **Entitlements.** A significant factor in avoiding re-hospitalization is assuring the availability of medical and financial support to consumers upon their discharge from the state hospital. DMH has instituted policies to ensure that state hospital staff work with individuals to determine their potential eligibility for Medicaid services and expedite the process to increase consumer access to medical benefits upon discharge from the state hospital. Community mental health agency staff also work with consumers around this issue. There has also been increasing focus on Medicaid eligibility as the DMH payment system transitions from grant-in-aid funding to fee-for-service.

The trend for reduced rates in admissions and census has begun to reverse over the last few years. The number of adults (non-Forensic) admitted to state hospitals in FY2004 was 8,844 and increased slightly each year to 10,770 in FY2006 which was a number not seen since the mid-1990s. Civil adult (non-forensic) admissions for FY2009 were 10,045. The median length of stay for this same population has steadily decreased from 19 days in FY2000 to 11 days in FY2006 and remains steady there. At the present time, all civil state hospitals are quite small, with some having a census of less than 100, and the largest being under 150. For both admissions per 100,000 and beds per 100,000, this places Illinois below the U.S. average.
Decreased Rate of Civil Readmissions
DMH will continue to monitor the number of adults readmitted to state hospitals within 30 days of discharge and the number of adults readmitted to state hospitals within 180 days of discharge with a FY2010 goal of maintaining or decreasing the level of re-hospitalization through the use of community based services that provide alternatives to hospitalization. However, it is to be expected that individuals with serious mental illnesses, may, at times of crisis and relapse, require access to inpatient services for evaluation and stabilization in a safe, structured, and supportive environment. See the Adult-Goals, Targets, and Action Plans section for data and information about these indicators which are a National Outcome Measure (NOM)

Objective A1.15 (NOM): Continue efforts to decrease 30 day and 180 day readmission rates to DMH state hospitals.
Indicators:
- Percentage of adults readmitted to state hospitals within 30 days of being discharged
- Percentage of adults readmitted to state hospitals with 180 days of being discharged.

Services for Persons Involved In the Criminal Justice System
The incarceration of persons with serious mental illness in correctional settings continues to be a matter of increasing concern in Illinois. The DMH serves a forensic population consisting of individuals determined by the court to be unfit to stand trial (UST) or not guilty be reason of insanity (NGRI). According to data reported by DMH community providers, approximately 2% of persons with mental illness seen at intake are forensic outpatients, and about 2% have a correctional history. These figures are fairly low. However, mental health staff has estimated that about 10,000 persons with mental illness are served annually by Creak Hospital at Cook County jail – more than the total number of people served annually by all the Illinois state hospitals combined. This high incidence is part of a continuing and larger national trend for persons with mental illnesses to comprise an increasing proportion of prison inmates and jail detainees. The DMH tracks key system performance indicators related to criminal justice involvement on an on-going basis. The DMH currently operates programs for forensic patients at five state hospitals and contracts with community agencies to provide services to those placed in the community. In an effort to ensure continuity of care when these individuals are discharged from state services, DMH Forensic staff provide consultation to community agencies that provide mental health services. DMH staff monitor the services and activities of conditional releases through contacts with community mental health service providers.

Adoption and Implementation of Evidence-Based Practices
Despite the existence of a wide range of clinical treatments and programs with strong empirical support, research suggests that access to these services in the community is quite limited. In recognition of this issue, the President’s New Freedom Commission on
Mental Health has noted the importance of expanded implementation of evidence-based practices. The DHS Division of Mental Health aims to provide excellent mental health care that maintains and expands access to effective mental health services, and in particular to evidence-based practices (EBPs) and best practices. Efforts are underway to pilot each of the adult EBPs identified by SAMHSA.

DMH continues to address SAMHSA’S National Outcome Measure of Implementing Evidence-Based Practices and strives to make EBPs available throughout the state by providing training and technical assistance to mental health agencies, and by involving mental health consumers and families in the expansion of such practices in Illinois. In May 2009, the DMH convened a second annual statewide conference on EBPs, entitled Implementing and Sustaining Evidence-Based Practices For Recovery, Resilience and Hope. Experts on each of the EBPs made presentations on focusing on implementation, organizational and financing issues that should be taken into consideration when planning for implementation. More than 300 individuals (consumers, family members, advocate, providers and state agency staff) attended the two-day conference.

In addition to ACT, EBSE, and the evidence-based PSH model described above, DMH is active in developing and expanding Medication Algorithms and Family Psychoeducation.

**Medication Algorithms**

The Center for the Implementation of Medication Algorithms (CIMA) is an initiative designed to disseminate empirically informed medication algorithms, patient and family education, and outcomes assessment systems that support the psychopharmacotherapeutic treatment of schizophrenia, major depression, and bipolar disorder, consistent with recommendations of the 2003 report of the President’s New Freedom Commission on Mental Health. Since its inception in July 2004, CIMA has provided education, implementation planning, and clinical training to personnel in mental health treatment agencies across the State using a three-stage training model. Level 1-Education introduces and informs potentially interested service providers about the role of CIMA and how agencies can participate in the project. Level 2-Planning, the second stage of engagement, involves meetings with specific, interested agencies. An assessment is made to determine what changes are required for the conversion of existing service delivery practice to the use of medication algorithms. Level 3-Training is the actual clinical training of agency personnel in the use of the algorithms, outcomes, and education components of treatment. Delivery of Level 1-Education takes multiple forms, including, for example, the dissemination of educational materials, meetings with leadership, or presentations to individuals, an agency or agencies, or several constituencies representing multiple agencies. Levels 2 and 3 are interventions that are aimed more specifically to interested agencies. In addition, CIMA has developed a website that offers materials and other resources that facilitate the use of the algorithms presented at the training sessions ([http://www2.uiucomp.uic.edu/Dept/Psychiatry/CIMA/index.shtml](http://www2.uiucomp.uic.edu/Dept/Psychiatry/CIMA/index.shtml)). Professional personnel at CIMA provide consultation to agencies and agency providers ranging from systemic issues related to implementation to individual patient consultations. CIMA personnel also stay current with research in clinical psychopharmacology and outcomes assessment and update the algorithms as needed.
Agencies engaging in CIMA, Community Mental Health Centers (CMHCs) and State Operated Hospitals (SOHs), have done so to varying degrees, with some completing all three levels of training and others opting out after the first or second levels. Of participating agencies, some have implemented all three algorithms while others have chosen fewer. To date, CIMA has trained 43 agencies at Level 1, 24 agencies at Level 2, and 20 agencies at Level 3. The cumulative numbers of trainings, including multiple training at single sites, are as follows: Level 1: 54; Level 2: 29; and Level 3: 25.

Since its inception, the CIMA project has evolved to the point where agencies interested in providing evidence based psychopharmacology and volunteering to participate have been trained or are currently in the process of training. Agencies that did not volunteer during the initial stages of the project are now being targeted. A major focus of CIMA during this past fiscal year has been to engage these non-volunteer CMHCs and SOHs, particularly those that would work together. Currently, five of seven SOHs have completed Levels 1-3 training in at least one algorithm, with three having received training in more than one. Both nonparticipating SOHs were approached again this past year. One indicated that it was not ready to participate. The other scheduled initial training, but then delayed it to July 2009. In both cases changes in medical leadership, resource limitations, and high clinical workloads were cited as reason for delays. Accordingly, one objective for the coming fiscal year is to revisit these hospitals toward engaging their participation.

Several efforts were made this past year to do Level 1-Education with CMHCs, including meetings with individual leadership and presentations to single or multi-constituency groups. From these efforts, two major CMHCs completed Levels 1-3 training in the Depression algorithm during the year. A third, multi-site CMHC is in the process of scheduling Level 3 training in the schizophrenia algorithm. Of those agencies declining training, lack of financial incentive to switch their current practice to algorithmic treatment was the salient reason cited. Accordingly, continued efforts to engage CMHCs is an objective for the next fiscal year, but addressing the incentive issue is also warranted. CIMA has been working on proposals to motivate agency participation and on the development of a mechanism that allows reviewers from funding agencies to assess accurately and efficiently whether an agency is actually delivering algorithmic treatment.

The past few years have witnessed advances in pharmacotherapy research sufficient to warrant an evaluation of whether any of the algorithms trained through CIMA are eligible to be updated. Accordingly, this determination and any warranted updates are an objective of the project over the next fiscal year. Finally, the process of updating the CIMA website has begun and is planned for completion during the next fiscal year. One of the aims of this update is to expand Non-English versions of the educational and other resource documentation offered on the site in an effort to improve its application and ultimately its dissemination to underserved populations. CIMA is also currently looking into methods for documenting the competence of training participants resulting from the use of the educational approach conducted during the training.
Objective A1.16: (a) Continue and increase training and implementation of medication algorithms as an evidence-based practice. (b): Continue and increase the training of State Operated Hospitals and Community Mental Health Centers. (c) Determine if current algorithms require updating based on recent advances in psychopharmacological research and complete appropriate updates. (d) Update the CIMA Website in a manner that fosters greater public awareness and understanding of medication algorithms and their usage. (e) Introduce documentation and reporting of the competency of participants in the use of medication algorithms.

Indicators:
- Number of training sessions and agencies completing training at each level.
- Number of training sessions and number of State Operated Hospitals, affiliated Community Mental Health Centers, and other Community Mental Health Centers who complete training at each level.
- Number of algorithms updated.
- Evidence of updates on the website.
- An evaluation of the competence attained by participants based on documented findings is completed and disseminated.

Family Psychoeducation

Family Psychoeducation implementation efforts have continued in DMH Region I. This committee has evolved into a public/private Family Psychoeducation (FP) implementation group. The activities of this group have resulted in the formation of a number of family psychoeducation programs. Currently, three agencies in the region are implementing varying models of family psychoeducation. Several other agencies have developed programs in conjunction with these implementation teams. All of them have reported it as a positive experience and have cited the benefits to consumers as a result of family involvement.

Staff members from community agencies, along with DMH Region I and central office staff members, continue to meet and provide mutual consultation on clinical, financial, and implementation issues, and to report on progress in individual program growth. Collaborative efforts to implement Family Psychoeducation in Illinois have resulted in an increased number of providers who have adjusted their treatment focus to extend services to more families when doing so would clearly benefit the consumer. Agencies that have been involved but have not yet implemented an EBP model of family psychoeducation have made decisions to become more family focused, and to try to rectify some of the barriers that have existed in mental health systems to involvement of families. Similarly, productive relationships between some agencies and advocacy groups such as NAMI, who has long been a participant in this project, have emerged.

While the Illinois Medicaid Rule (132 ) now allows agencies to bill for family psychoeducation services in a variety of ways, a specific billing code allowing an enhanced rate has been discussed, but not as yet established. DMH is committed to implementing evidence based practices and is attempting to develop the resources for,
training, technical assistance, fidelity monitoring, and other essential ingredients to major implementation efforts

Other Evidence-Based Practices

DMH staff have discussed implementation of Illness Management and Recovery (IMR) within the state. However, no active planning has as yet occurred. Illinois cannot report data for Medication Management. Although plans were made to collect data on the number of consumers enrolled in algorithm treatment, data collection has not been undertaken because funding is not available to establish a database. The primary focus has been on education and training in the implementation of medication algorithms. (See Objective A1.16 above.) For Integrated Treatment of Co-occurring Disorders, the primary focus has been on developing provider interest and capacity to meet the service challenges posed by this model. In FY2007, the Division of Mental Health completed its work on a three year Training and Evaluation grant funded by SAMHSA/CMHS. Training and evaluation in the IDDT model were provided to nineteen agencies (17 community-based agencies and 2 state hospitals) located in Chicago. The IDDT project used the Integrated Dual Diagnosis Treatment Fidelity Scale; a component of the IDDT Resource Implementation Kit published by SAMHSA and added the Dual Diagnosis Capable in Addiction Treatment (DD-CAT) Scale developed by Mark McGovern from Dartmouth University. Both instruments provided the IDDT project with the opportunity to assess agency capabilities to improve and to provide integrated treatment services. Participating agencies were provided with tailored technical assistance and consultation geared toward strengthening each agency’s ability to move toward providing IDDT. Agencies used the opportunity to assess their capability to commit to implementation of the IDDT model or to move forward with the necessary changes that would enhance their capability to provide IDDT services. The IDDT project emphasized statewide education and leadership to promote IDDT and the project’s advisory committee has continued to meet and provide valued feedback on promoting IDDT and recovery. During the final year of the project, it was established that consultation and technical assistance were the key means of strengthening the ability of agencies to move toward providing Integrated Dual Diagnosis Treatment services. The feasibility of realigning these activities with new funding is continuously being assessed.

Objective A1.17 (NOM): Continue efforts to increase the implementation of Family Psychoeducation and continue to study the feasibility of establishing the following Evidence Based Practices: Integrated Treatment of Co-Occurring Disorders, Illness Self-Management, and Medication Management.

Indicators:

- Number of adults with SMI receiving Family Psychoeducation.
- Number of adults with SMI receiving Integrated Treatment of Co-occurring Disorders.
- Number of adults with SMI receiving Illness Self-Management.
- Number of adults with SMI receiving Medication Management.
Illinois

Adult - Estimate of Prevalence

Adult - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children
ADULTS – CRITERION 2

ESTIMATE OF PREVALENCE

The CMHS definition and methodology for prevalence estimation for adults is 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 FY2009 there were 523,155 adults with serious mental illnesses residing in Illinois.
Illinois

Adult - Quantitative Targets

Adult - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1
Definitions of DMH Eligible and Target Populations

The Eligible Population (Adults and Children/Adolescents):

- Must have a mental illness, defined as “a mental or emotional disorder verified by diagnosis contained in the DSM-IV or ICD9-CM which substantially impairs the person’s cognitive, emotional and/or behavioral functioning, excluding the following unless they co-occur with a diagnosed mental illness: V-codes, organic disorders, psychoactive substance induced organic mental disorders, mental retardation, pervasive developmental disorders associated with mental retardation, and psychoactive substance use disorders.
- Must have significant impairment in an important area of life functioning as a result of the mental disorder identified above and as indicated on the Global Level of Functioning (GAF) for adults and Children’s Global Assessment Scale (CGAS) for children.
- All ages

The Adult Target Population:

- Must be 18 years of age or older.
- Must have a serious mental illness (SMI) defined as, “emotional or behavioral functioning so impaired as to interfere with their capacity to remain in the
community without supportive treatment. The mental impairment is severe and persistent and may result in a limitation of their capacities for primary activities of daily living, interpersonal relationships, homemaking, self-care, employment or recreation. The mental impairment may limit their ability to seek or receive local, state, or federal assistance with housing, medical and dental care, rehabilitation services, income assistance and food stamps, or protective services.”

**Individuals Receiving Services In FY2009**

Information on the number of persons served in FY2009 is derived from Basic Tables 2A and 2B, which is being prepared for the FY 2009 Uniform Reporting System Tables. National Outcome Measures (NOMs)/Performance Indicators with quantitative targets related to increased access to services are described in the Goals, Targets and Action Plans Section.

The number of individuals with Serious Mental Illnesses (DMH eligible population) reported as receiving services from DMH-funded agencies in FY2008 was 130,675, approximately 90% of the total number of adults receiving services (144,485). FY2009 data is currently being gathered.

The definition of the DMH eligible population is somewhat broader than the definition for the target population. In FY 2005, 56.5% of adults receiving services met DMH criteria for the target population and in FY 2006 it was 56.6%. In FY2007, it remained steady at 56.5%, however in FY2008 it increased to 58.8%. (Note: Data for FY2009 will be provided in the implementation report.)

**Quantitative Targets For FY2010.**

The DMH continues efforts to increase access to services by adults with serious mental illnesses (the target population). All DMH objectives described in this Plan are designed to increase access to available services either directly or indirectly. Although DMH aspires to increase access yearly, an increase appears unlikely this fiscal year due to the current economic distress. Therefore the goal of maintaining a percentage of at least 57% will be pursued by DMH in FY2010.

DMH tracks access through three key performance indicators. These are:

**Increased Access to Services (NOM)**

**Indicator:**
- Number of persons served.

**Increased Access to Services by the DMH Target Population**

**Indicator:**
- Percentage of the DMH adult target population receiving services

**Increased Access to Services by the DMH Eligible Population.**

**Indicator:**
- Percentage of the DMH adult Eligible Population receiving services
Demographic Factors

In Illinois, three major ethnic and racial minority groups represent over 30% of the total population – 15.1% African Americans; 12.3% Hispanic Americans; and 3.4 % Asian American/Pacific Islanders. The DMH Bureau of Decision Support, Evaluation and Research continues to evaluate access and utilization of mental health services by specific ethnic groups using data such as that generated for URS Tables 2A and 2B. In recent years, the IDHS has also focused on the segment of the state’s population, which remains uninsured or under insured without sufficient resources to purchase needed mental health services. An increasingly accepted guide for identifying this segment is the utilization of the 200% poverty level which provides census-based demographic data which assists in targeting service delivery and developing cost models which support a system of care for the neediest persons in the State.

Progress In Performance Measurement

The DMH has established reporting requirements and standards for data submission and has incorporated them in all DMH-funded agency contracts. In FY2008 and FY2009, DMH has been working with the Illinois Mental Health Collaborative for Access and Choice (Collaborative), to redesign and implement a new management information system (MIS). This work included the development of a data warehouse that houses eligibility, registration, billing/services information, a provider database, and service authorization in one place. DMH has unprecedented access to this data. One of the updates to the MIS is the requirement to update key clinical and demographic fields that will be used to track consumer outcomes over time.

Data is submitted to the information system developed jointly with the Collaborative. DMH has made several modifications to enhance data collection requirements and to permit collection of data that is compatible with Uniform Reporting System requirements as developed under the State Infrastructure Grants (DIGs). DMH reporting standards require full reporting of consumer and service data by community providers. Data for consumers receiving treatment in DMH state hospitals are also reported electronically to the DMH Clinical Information System (CIS). Data reported to the community reporting system and the CIS are used as the basis for computing performance indicators that have been established by DMH to monitor system performance. Information is disseminated to a wide variety of entities in different formats that have been designed to be user-friendly. Through the use of quantitative measures of organizational functioning, comparisons can be made against a standard over extended time or between organizational units. Target levels for the performance indicators provide focus for evaluation and planning.

DMH staff have successfully participated in federally funded studies and activities related to performance measurement, including the Data Infrastructure Grant opportunities over the years. This included piloting the implementation of MHSIP Consumer Oriented Mental Health Report Card performance measures, the Five State Feasibility Study of Performance Measurement, the Sixteen State Pilot Indicator Study on Mental Health Performance Measures, the State Data Infrastructure Grants, and the current State Data Infrastructure Grants for Quality Improvement.
Unduplication of Consumers for Reporting
Since FY2006 all individuals seeking mental health services have been assigned unique ID numbers referred to as RINS. RINS are also being assigned to consumers who access services under other Divisions within DHS, as well as to individuals receiving services through the Child Welfare System and Corrections. The use of RINS will improve tracking of services received by consumers across state systems, as well as increase accuracy in the unduplication of consumers receiving services in the mental health system.
Illinois

Adult - Outreach to Homeless

Adult - Describe State's outreach to and services for individuals who are homeless
OUTREACH TO HOMELESS

The Homeless Population in Illinois

Emergency Food and Shelter (EF&S) Services Annual Report

The most reliable source, though not complete, for descriptive data of the homeless population is the IDHS Division of Human Capitol Development, Office of Family Support Services, which administers the Emergency Food and Shelter (EF&S) program. This program was developed to provide immediate food and shelter to homeless persons and families or to persons and families at imminent risk of becoming homeless. It provides meals, beds and supportive services through not-for-profit organizations to homeless individuals and families to assist them to return to self-sufficiency. The General Revenue Fund (GRF) allocation for the EF&S Program in FY2008 totaled approximately $9.3 million. Between July 1, 2007 and June 30, 2008 there were 45,418 individuals that received shelter, food, and services to meet their emergency needs and help them regain self-sufficiency. During the year, organizations funded through the EF&S Program provided 2,004,407 nights of shelter, served 3,266,922 meals and delivered 2,780,570 units of supportive services.

The IDHS Emergency Food and Shelter (EF&S) program issues an annual report that reviews trends in services provided to homeless persons in Illinois. The data should not be construed to represent the total homeless population in Illinois, because not all homeless persons are served by the EF&S program. Several trends in the characteristics of the population have been noted within recent years. Homelessness is affecting fewer people, becoming more rural, occurring in a younger population, and there is a significant percentage of homeless individuals who have a disability.

The FY2008 Report

The most recent report by EF&S (FY2008) provides an interesting profile of the homeless population receiving services.* The number of participants in the program decreased from 47,697 in FY2007 to 45,418 in FY2008. Males made up the majority of the homeless population statewide at 58.7%. There were 31,787 total households (the measurable unit of family composition) and, of these, single males comprised 19,145 households and single females, 6,112. The other households were: couples with no

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* For services in Chicago, the IDHS contracts with the Chicago Department of Human Services (CDHS). The CDHS uses non-profit organizations to provide food, shelter, and supportive services to homeless individuals and families within the city. The CDHS has oversight for organizations, monitors services, vouchers funds, reports to the Department and operates an emergency call system. The appropriation for EF&S is divided between Chicago (54%) and the remainder of the state (46%). CDHS combines EF&S funds with federal and municipal money. The EF&S program funded 37 projects in Chicago through 23 providers in FY2008. Data submitted by CDHS is included in the annual report. However, CDHS does not report on length of stay in shelters for all entrants and shelters’ refusal and referral data.
In FY2008, the racial composition of the homeless population served by EF&S consisted of 60.4 percent African American and 31 percent European-American. The other categories tracked: Hispanic or Latino (3,358), American Indian/Alaskan Native/Pacific Islander/Asian (697), and Other Race (3,203) accounted for the remaining 8.5%.

The 6,280 households with children noted above accounted for 12,559 participants under the age of 18 (27.6% of the total served) of which 51.5% (6,458) ranged from newborn infants through five years of age. Combined with the 18 through 21 year old group (2,914) 34% of the homeless persons served by the EF&S program were under the age of 22. In comparison, only 1.8% of those served (836) were over the age of 62 while those 41-61 (33%) and those 22-40 (31%) were similar in numbers which dispels the myth that homelessness is predominantly an issue for older adults.

This is consistent with the finding that the major causes of homelessness are identified as income and family/neighborhood issues that have the most impact on households with children. Of the 31,787 households served by EF&S in FY2008, the largest group, almost 39 percent (12,383) cited income as the primary cause of their homelessness. Insufficient income, loss of job, loss of public assistance, and mismanagement of money were reasons given on this category. Almost 22 percent (6,946) gave reasons related to family and neighborhood such as overcrowded conditions, domestic violence, gang violence, and disputes with neighbors and landlords. The remaining 39% cited the lack of affordable and decent housing, alcohol and substance abuse, medical problems, release from correctional facilities, and relocation as primary reasons for being homeless.

Outreach and Services to Homeless Adults

Homeless adults with serious mental illnesses require linkage to outpatient and inpatient mental health services and to housing, employment, and other support services. The DMH has encouraged providers to develop working relationships and working agreements with neighboring shelters, soup kitchens and pantries in order to identify where outreach and engagement service needs were to be focused and to develop co-affiliation services for this population.

Project for Assistance in Transition from Homelessness (PATH)

The State of Illinois has an extensive history of working with individuals and families who are experiencing homelessness. Since 1988, Illinois has been a recipient of federal funds provided by the Stewart B. McKinney Act, which was enacted into legislation to
address the crisis of homelessness among the nation’s population of individuals who are homeless or at imminent risk of homelessness with a serious mental illness who may have a co-occurring substance abuse disorder. In 1991, this block grant evolved into a federal formula funding award titled Projects for Assistance in Transition from Homelessness (PATH). The funds are governed by the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), and the Center for Mental Health Services (CMHS). Illinois providers have developed an array of services that include in vivo case management, crisis intervention services, a day center/drop-in-program, and two (2) mobile assessment units in the City of Chicago.

Allocations for the PATH program have fluctuated in recent years, and providers have diligently continued to use funds to expand and enhance services to homeless persons with mental illness. In FY 2006, the funding increased from $2,192,000 to $2,441,000. In FY 2007, funds decreased from $2,441,000 to $2,414,000, and in FY 2008, funds decreased from $2,414,000 to $2,366,000—a loss of $49,000—which was reconciled by a pro-rated percentage per provider. However, in FY 2009, the PATH allocation increased to $2,686,000.

During FY 2008, due to the closing of a transitional-residential program, the Illinois PATH Program was able to restructure $236,000 in funds within the same geographic community:

- Two (2) new agencies were added to the Illinois PATH Providers’ roster,
- There were adjustments in allocations and increases in the case management services of two current providers, and
- 8.0 FTE staff were hired to serve an estimated additional 185 individuals who met PATH-eligible criteria. Four (4) consumers: were hired in half-time positions—three in Rockford and one in Chicago. The PATH program continues to work on hiring consumers as staff in PATH-funded agencies.

Currently, all PATH funding is used for the provision of case management services with the exception of $53,000 for a drop-in center (Rockford) and $653,000 in two Mobile Assessment Units (Chicago) operated by Thresholds - which do in vivo outreach and engagement. In the past three years the number of individuals served has steadily increased from 2,763 in FY2007, 2,830 in FY2008, and as of the end of April, 2009, 3,077 individuals have been served.

The State of Illinois’ Federal PATH allocation was increased from $2,366,000 to $2,686,000. The additional funds are being utilized in FY2010 to increase the allocations and numbers of people served by two (2) programs: Beacon Therapeutic Diagnostic and Treatment Center (Chicago) - which serves homeless families, and Shelter Care Ministries (Rockford) - which provides a drop-in center for individuals who are homeless, and to collaborate with IDOC/OMH to develop two (2) FTE positions to work in conjunction with existing PATH programs in Rockford and Chicago; targeting ex-offenders returning to the communities who are homeless with serious mental illness and increasing the availability of much-needed services.
Objective A4.1: Utilizing an increase of $320,000 in the Illinois Federal PATH allocation, (1) increase the number of persons served in two key PATH funded programs, one in Chicago and one in Rockford and, (2) by the end of FY2010, with the collaboration of the Illinois Department of Corrections, establish two FTE positions targeted to the provision of services to sixty ex-offenders who are homeless with serious mental illness returning to their communities in Rockford and Chicago. Indicators:

- Number of persons receiving case management services under the PATH initiative by the end of FY2010.
- Establishment of the two full-time positions to serve ex-offenders who are homeless with serious mental illness in Rockford and Chicago.
- Number of ex-offenders who are homeless with serious mental illness served through this initiative by the end of FY2010.

The first Illinois PATH Providers Conference was held in Bloomington, September 18-19, 2008. There were more than sixty persons in attendance including 12 consumers and 10 attendees representing mental health and homeless interests outside the PATH service system. The Conference objectives included trainings on innovative strategies, opportunities for cross-pollination of ideas and techniques, and the initiation of an expanded network which will be beneficial to consumers. The following sessions were provided to attendees: (a) Psychopharmacology, (b) Outreach and Engagement to PATH-eligible individuals: Chicago-Style, (c) Dual Diagnosis: Translating Science to Practice, (d) Diagnostic Training for Staff without Clinical Backgrounds, (e) Working with Individuals who have a history of Incarceration, (f) Recovery and Wellness for the Homeless Services Team and Consumers, and (g) Practical Approaches to Helping Homeless and at-risk persons with Mental Illness secure SSI/SSDI Benefits. Nine out of every ten participants who submitted an evaluation rated the event as very successful. A second PATH Providers Conference is planned in FY2010, contingent upon funds being available.

DMH and Continuums of Care

The U.S. Department of Housing and Urban Development (HUD) initiated the Continuum of Care process in 1994 to encourage a coordinated, strategic approach to planning for programs that assist homeless individuals and families. To apply for federal funding, jurisdictions must submit a continuum of care plan that demonstrates the broad participation of community stakeholders and that identifies the resources and gaps in the community’s approach to providing a range of homeless services. Community stakeholders determine local priorities for funding. The fundamental components of a comprehensive Continuum of Care system are:

- Outreach, intake, and assessment to identify the individual’s or family’s service and housing needs and link them to appropriate housing/service resources.
- Emergency shelters and safe, decent alternatives to living on the streets.
- Transitional housing with supportive services to help people develop the skills necessary to permanent housing.
- Permanent housing and permanent supportive housing.
Significant progress has been reported in the collaboration between homeless service providers and mental health service providers through Continuums of Care. The Division of Mental Health (DMH) is represented on Continuums of Care statewide throughout its Comprehensive Community Service Regions (CCSRs), and its funded Community Mental Health Centers (CMHC’s) who are members. In this capacity, DMH and PATH-funded programs are members of the Chicago Alliance to End Homelessness, the Homeless Action Committee – Chicago, and the Alliance to End Homelessness in Suburban Cook County. As a large percentage of persons who are homeless in the Chicago area have diagnosable mental illnesses, HUD funding is vital to support the provision of mental health services and the development of permanent supportive housing. In suburban Cook County, HUD funds support Project WIN (Wellness Initiative Network), which is a multi-agency, multi-service collaboration to provide coordinated care in the areas of mental health, medical health, and substance abuse treatment. To engage persons who are homeless in these critical services, a team of clinicians provides on-site assessments and linkage to mental health services at the emergency shelters.

In Greater Illinois, PATH funded mental health providers are actively involved in Continuums of Care located across the State. Mental Health Centers of Central Illinois (MHCCI) - Springfield, is a member of the Heartland Continuum of Care, Delta Center, Inc. – Cairo (the southern-most tip of the state) and Southern Illinois Regional Social Services (SIRSS) – Carbondale, are members of the Southern Illinois Continuum of Care Network, CBHC of St. Clair County - East St. Louis, is a member of the Homeless Action Council, the Supportive Housing Providers’ Association, and the Homeless Action Coalition in St. Clair County. Janet Wattles Center and Shelter Care Ministries - Rockford (northwestern Illinois) are both founding, active members of the Rockford Area (HUD) Continuum of Care under the auspices of the Winnebago/Boone Counties Mayors’ Task Force on Homelessness; (established in Rockford, 1988).

**Number of Homeless Persons Receiving Services**

A System Performance Indicator was created in FY1999 to track the number of homeless adults entering community-based services funded by public mental health dollars. This indicator permits an initial evaluation of the ability to provide access to mental health services for those individuals who are homeless and have mental illnesses. DMH plans to maintain or expand access to community mental health services by persons with mental illness who are homeless. This indicator can be found in the Goals, Targets, and Action Plans section and is now named **Increased Stability in Housing (a National Outcome Measure)**. The indicator provides the number of individuals being served by DMH-funded community-based providers who are reported as homeless or living in shelters at the time of entry into service. In FY2008, 7,121 homeless adults received DMH funded services.
Illinois

Adult - Rural Area Services

Adult - Describes how community-based services will be provided to individuals in rural areas
RURAL AREA SERVICES

Definition of “rural localities” in the State

In Illinois, the definition of rural has been based upon the U.S. Bureau of the Census designation of Metropolitan Statistical Areas (MSA) which are assigned to counties that contain a central city or twin cities having a population of 50,000 or more. The classification of counties into MSA (metro) and non-MSA (non-metro) categories has been found to be the best and most common way to define urban and rural. Thus, the term "rural" in Illinois is used to refer to residents in 76 non-MSA counties and residents not in municipalities of 25,000 or larger. (Rural Revitalization: The Comprehensive State Policy For the Future, Governor's Rural Affairs Council, April, 1990 pp. 2-4) Based on Illinois' definition of rural areas, 76 non-metropolitan counties are being targeted for assessment of the mental health needs of residents, evaluation of current services and programs, and the identification and eventual resolution of problems in service delivery unique to rural environments.

The DMH is a member of the Governor’s Rural Affairs Council and provides the mental health perspective on rural issues. The Council provides an opportunity to network with a variety of state government agencies and community institutions, which can support mental health services in rural areas.

Mental Health Services in Rural Areas

Mental health services for persons with serious mental illnesses are available in rural Illinois through hospital programs and community mental health centers. The DMH provides grant funding to community mental health centers, certifies mental health centers for Medicaid Clinic, Rehabilitation, and Case Management options and provides Emergency Psychiatric Services funds, which can purchase emergency services through a community clinic or private psychiatric hospital. DMH providers offer crisis/emergency services and an array of outpatient services including psychiatric services, community support, psychosocial rehabilitation, and residential services in rural areas across the state.

Comprehensive Community Service Regions (CCSR) serving Greater Illinois have worked on enhancing and developing core mental health services for adults with serious mental illness residing in rural areas. CCSR staff work closely with mental health providers serving the more sparsely populated rural areas to design a range of services that are as accessible as possible to meet the treatment and support needs of rural residents.

The Stark County Rural Mental Health Initiative

The Stark County Rural Mental Health Initiative is a unique development in rural mental health for Illinois. It demonstrates the resolve of persons residing in sparsely populated rural areas to access the mental health services they require. The grass roots beginning of this initiative, the enthusiasm it engendered, and the regional and state support it has received reflect the nature of rural settings and are evidence of the significant system change that can occur when stakeholders with a common interest work together.
Stark County is a rural county located in north central Illinois, not far from Peoria. The total population of the county is 6,300. A series of mental health related deaths prompted several citizens to become concerned and, in 2004 the Stark County Citizens Mental Health Task Force was formed with a collaboration of citizens, ministers, law enforcement, and a mental health provider. A survey of the county revealed that less than ten individuals in the county were receiving mental health and substance abuse services and that distances to providers in other counties were prohibitive. The Task Force subsequently developed a rural mental health initiative based on the collaboration between the Stark County Citizens’ Mental Health Task Force, DMH, and participating regional and local service providers including the Henry-Stark County Health Department, the school district, and the local office of the Illinois Violence Prevention Authority. A CMHC has assigned a full time mental health clinician to the Stark county initiative who now oversees a caseload of sixty persons receiving needed mental health services in the county. The Stark County Rural Mental Health Initiative provides access, education, and advocacy services to the citizens of Stark County. The mission of the initiative is community-based, family-focused and recovery-oriented for persons with mental health and substance abuse problems. Access services provided by the initiative include: mental health and substance abuse screening and treatment; counseling services at school, in the home, or at the DHS Office in the county seat; an on-line community resource directory; and a crisis hotline available 24 hours a day. Educational activities include: training in suicide prevention skills; promoting awareness and understanding of mental health and mental illnesses; and family support. Advocacy occurs at several levels including support to individuals and families as they attempt to access services, collaborative work to improve communication and cut out “red tape”, and local and regional interagency collaboration and planning. Sustainability of the initiative is planned through local fundraising efforts and a variety of modest grants.

Use of Communication Technology as a Basis for Service Delivery

In FY2010, as resources allow, advanced telecommunication systems will be used to improve access to expertise from professionals located in urban areas to persons residing in rural areas. Internet access, video conferencing, and other applications provide an opportunity to enhance the quality of care in rural mental health services. These approaches also provide substantial support for better integration of mental health and primary healthcare programming in rural areas and assist in addressing the shortage of psychiatrists working in rural communities. Public Act 95-16 signed by the Governor in July, 2007 gives Illinoisans living in rural communities increased access to psychiatric care by requiring the Illinois Department of Healthcare and Family Services to reimburse psychiatrists and federally-qualified health centers (FQHCs) for mental health services provided via tele-psychiatry approaches, such as videoconferencing.

Tracking Mental Health Services to Residents of Rural Areas.

DMH continues to track the number of residents residing in rural areas that receive DMH funded services. Seventy-six counties have been identified as rural in Illinois with an adult population of 1,509,159 according to 2000 census figures, yielding a prevalence estimate of 81,494 (at 5.4%). In FY1999, when this system indicator was first established, 25,127 individuals who lived in the 76 rural counties were reported as...
receiving services. By the end of FY2008, the number had increased substantially (by 40%) to 35,146.
Illinois

Adult - Older Adults

Adult - Describes how community-based services are provided to older adults
OLDER ADULTS

More than 1.9 million persons over the age of 60 reside in Illinois, representing nearly 20% of the state population. It is conservatively estimated that 15-25% of individuals over age 60 experience symptoms of mental disorders as they are considered to have a higher incidence than other age groups due to increasing number of life stressors. In Mental Health: A Report of the Surgeon General, (U.S. Department of Health and Human Services. Rockville, MD, 1999), an entire chapter is devoted to mental health issues faced by older adults. The Report states that: “a substantial proportion of the population 55 and older –almost 20 percent of this age group-experience specific mental disorders that are not part of “normal” aging.” (Page335) Estimated prevalence rates for this population were cited: Anxiety Disorder-11.4%; Mood Disorder-4.4%; Schizophrenia-0.6%; Somatization-0.3%; Severe Cognitive Impairment-6.6% and, Any Disorder-19.8%. While older adults may be more vulnerable to experiencing mental health problems, they often do not seek, or are not successful, at linking with needed mental health services. In FY2008, a total of 6,712 individuals over the age of 65 were served, accounting for only 4.6% of the total number of adults served. Several systems of care play a role in the delivery of mental health services to the older adult including mental health, aging, primary medical care, and public health. In recognition of the importance of coordinating services for this population, DMH jointly coordinates an Advisory Committee on Geriatric Services that represent a variety of mental health older adult provider services and advises the Department on delivery of services to older adults.

Geropsychiatry Services

This mental health and aging systems initiative establishes a geropsychiatric specialist in a comprehensive community mental health center with access to a psychiatrist, board certified in Geropsychiatry, to improve access, availability and quality of mental health services for older adults (age 60 and older) with mental health needs. The program strives to positively enhance integration of mental health, aging, primary medical care and public health systems to enhance the effectiveness of mental health service delivery to this population. The Geropsychiatric Initiative focuses on three key areas: systems integration, mental health services/consultation and training/education. In FY 2007 there were five funded positions for Geriatric Specialists that cover 27 counties throughout the southern part of the state. However, Geriatric Specialists provided treatment and education resources for mental health services to the aging throughout the state. The GeroPsychiatry Initiative has received national recognition. In 2005, it received the American Society on Aging/Pfizer Award of Excellence---the only mental health program which ever received this award. In 2006, it was recognized as an exemplary program by the National Technical Assistance Center for Older Adult, Mental Health, and Substance Abuse Services. Statewide expansion of the program has been proposed by the Illinois Department on Aging, but acquisition of sufficient funding continues to be an obstacle to further development of this valuable resource.
Expansion of Services for Older Persons Residing in Rural Areas

In rural areas, the older population often experiences the most difficulty in obtaining services that are geared to their needs. The Geropsychiatric Initiative, initiated by the DOA and DMH in FY 2001, is designed to meet that need and was piloted in the rural areas in DMH Southern and Metro-East Regions. Local coordinating councils have been established for all 27 counties in the pilot project service area. The primary purpose of these councils is to educate key stakeholders regarding services available, the process for accessing services, and identifying strategies for improving services. The councils include representatives from primary health care, consumers, aging area offices, mental health agencies, and senior citizen centers. Each Community Mental Health Center has a case manager assigned specifically to focus on service provision for older adults.

The Geriatric Advisory Council

The Division of Mental Health convenes an Advisory Committee on Geriatric Services jointly with the Illinois Department on Aging (DOA). This Advisory Committee has focused its efforts on the assessment of the mental health needs of the elderly, identification of model programs, best practices and staff competencies, and increased awareness of geriatric mental health concerns. Training, consultation, and technical assistance in the area of mental health and aging continue to be provided through the efforts of the Advisory Committee. The Council promotes increased awareness of geriatric mental health concerns and has developed a position paper on issues of Self-Neglect that was used widely throughout the state including a Self-Neglect Forum and the Self-Neglect Task Force. The Division of Mental Health contributes staff to participate in the Self-Neglect Task Force, and the “Grandparents raising Grandchildren Task Force” project convened by the Illinois Department on Aging. The DMH also serves in an advisory capacity to the statewide, Northern and Southern Mental Health and Aging Coalition. The Division of Mental Health and the Illinois Department of Aging also collaborated with resources and expertise to develop, market and present three conferences. The Annual Statewide Mental Health and Aging Conference which was held in April, 2009 was attended by well over 300 people –setting a record for the highest attendance for this yearly conference. The keynote theme of the conference was suicide prevention for older persons. Additionally, a Behavioral Health, Aging and Wellness Conference; and a Central Illinois Mental Health and Aging Conference are planned for Fall 2009. The Illinois Department on Aging has developed a proposal to fund a statewide expansion of the Gero-Psychiatric Project through the Division of Mental Health.

Objective A4.2. In collaboration with the Illinois Department On Aging (IDOA), convene meetings with stakeholders to improve access to treatment by older adults.

Indicator:

- Number of meetings convened in FY 2010.
Illinois

Adult - Resources for Providers

Adult - Describes financial resources, staffing and training for mental health services providers necessary for the plan;
RESOURCES FOR PROVIDERS

The DMH continues to work towards an integrated system of care that includes both state hospitals and community-based providers, including those responsible for emergency health services regarding mental health. In this section, initiatives to enhance financial resources and human resources including significant achievements are described.

ENHANCING FINANCIAL RESOURCES

Increased Financial Resources For Community Services

With the increased emphasis on community-based treatment in the last twenty years came an increase in the proportion of budget spending on community mental health services. Compared to 8% of the DMH’s budget in FY1973, more than 70% of the mental health budget in FY2009 was allotted to fund community programs.

Since FY1999 the DMH has created a transition line for each state hospital. This funding line can be used for continued state hospital operations if needed, or can be used for expanding community services as census reductions free up resources. In FY2007 $12,071,107 was allocated in transition funding to the Regions and $20,180,848 was allocated in FY2009.

Service Enhancement Using Block Grant Funds

Despite the fact that the allocation of Mental Health Block grant funds to Illinois by SAMHSA has been reduced over the past four years, the DMH continues its efforts to utilize these funds to enhance service provision within the state. Block Grant funds continue to support such initiatives as the provision of wellness, recovery and action planning (WRAP), community consumer support, crisis care and psychiatric leadership services.

Grant Development

The DMH continues to undertake efforts to increase the flow of Federal and other grant dollars to the state. Some of the grants awarded to DMH over the past few years include the SAMHSA CMHS System of Care Grants (one in Chicago and one in McHenry County), a SAMHSA CMHS evidence-based practices implementation grant for Integrated Dual Diagnosis Treatment, a Data Infrastructure Grant, a SAMHSA Disaster Response grant, a Johnson and Johnson/Dartmouth Grant focusing on Supported Employment, a NIMH Planning Grant to implement Supported Employment, a SAMHSA grant focusing on alternatives to restraint and seclusion, a social security grant related to work incentive planning and a grant funded by the Federal Anti-Drug Abuse Act administered by the Illinois Criminal Justice Authority for the DMH jail data-link project. In FY 2007, the DMH worked with Healthcare and Family Services (HFS) to submit a “Money Follows the Person” grant to the Centers for Medicare and Medicaid Services (CMS). This grant was funded and planning has begun to implement the grant. In FY2008, DMH partnered with staff of the Illinois Department of Healthcare and Family Services (DHFS) in applying for and obtaining a federal Medical Emergency
Room Diversion (ERD) Grant from CMS. The grant provides $2 million over a two year period to improve access to, and quality of, primary health care services. DMH was also awarded a SAMHSA Transformation Transfer Initiative grant for $105,000 which is funding a statewide needs assessment of mental health/criminal justice and system mapping initiative.

**Increased Financial Resources For The Adult Population**

Financial resources for the adult, as well as the children and adolescent populations come from the General Revenue Funds (GRF) appropriated by the Legislature, Block Grant funds, and the redirection of dollars accrued from the reduced utilization of state hospital services and annualized income from previous initiatives. Through careful planning, previously established initiatives have proven to be beneficial to mental health consumers both in quality of care and increased financial resources.

The Department has requested and received appropriations of General Revenue Funds (GRF) for the continuing expansion and development of Care Management and Crisis Intervention services designed to aggressively promote continuity of care for persons discharged or triaged from state hospitals, Psychosocial Rehabilitation Services (PSR), and to increase service capacity and staff expertise in programs serving persons with dual diagnosis (mental illness and substance abuse). Since FY 2005, the DMH has received allocations for housing to support persons with mental illnesses. Starting with $4.7 million in FY2005 additional supportive housing funding has been appropriated by the Legislature annually bringing the total for this initiative to $14.5 million in FY2008. These dollars led to the addition of 36 new supportive housing projects statewide, and in the last two years, 397 new consumers were served through these appropriations.

**Increasing Federal Financial Participation (FFP)**

*The content of this section is the same for both the Adult and the Child Plan.*

Since FY1996 DMH has implemented procedures to increase enrollment and billing of persons leaving state hospitals, and modification of certain technical aspects of the billing process. These activities permitted greater flexibility in generating Medicaid funds for community mental health programs. As a result, there has been a steady increase in the amount of FFP generated to support adult and child and adolescent mental health services in Illinois. In contrast to FY1991, when Medicaid community billing for adult services was $130,000, Medicaid billing had risen to $129,028,640 in FY2005.

Over the past seven years, the DMH has worked closely with community agencies on an aggressive plan to increase the claiming of Federal Medicaid funds to support community based mental health services. In FY2003, DMH was able to support efforts to increase Medicaid Funding for the Illinois Mental Health Service System by simplifying and clarifying Medicaid policies and procedures (making necessary changes in the State Medicaid Plan, 59 Ill. Admin. Rule 132, the DMH Medicaid Handbook, and the DMH Program Book). Also during FY2003, the structure for utilization of the Medicaid Trust Fund was established and implemented. The distinction and importance of this fund is that it is a federal trust fund based exclusively upon the anticipated federal revenues from Medicaid payments for community mental health services. As billing for Medicaid services increases, so do the resources in the fund. Medicaid reimbursement through the
Trust Fund continues to increase across time. In FY2003 Medicaid reimbursement through the Trust Fund was $59 million; in FY2006 it had risen to $79,689,964. In FY2007, $84.4 million was deposited in the Trust Fund, and $85.4 million in deposits was anticipated for FY 2008. The FY 2009 amount is not yet available. The focus on increasing Medicaid capture will continue in FY2010.

Medicaid Billing For The Adult Population
Medicaid billing has risen substantially over the years. In FY2005 Medicaid billing for adults had risen to $129,028,640 and in the following year it was $149,599,641. By FY2007 it rose to $164,742,868 and was maintained in FY2008 at $164,407,968. Final reporting with regard to Medicaid billing for FY 2009 is not yet available. This information will be reported in the FY 2009 Implementation Report.

Accomplishments in FY2009 include:

✓ Revisions to the state’s Mental Health Medicaid Rule (Rule 132) were implemented in FY2009. These revisions clarify and enhance standards for services and other provisions of the Rule. Additional revisions are anticipated in future years in an effort to keep the Rule as current as possible and minimize exceptionally large changes and revisions in the Rule.
✓ In collaboration with the Department of Healthcare and Family Services, the state’s Medicaid agency, DMH has initiated a project to automate the Medicaid “spend down” provisions for eligible individuals with serious mental illness.
✓ Through the Medicaid Rule revision, DMH has improved and clarified the documentation requirements to enhance providers’ and states compliance with federal and state Medicaid regulations and expectations.

ENHANCING HUMAN RESOURCES

Staff Recruitment and Retention
Human resource development is a critical aspect of community-based services for both adults with serious mental illnesses and children with serious emotional disturbances and their families. It is important to ensure that persons providing mental health services have the required knowledge, skills, competencies and attitudes. In addition, the mental health service system must be able to recruit and retain skilled staff.

There have been several efforts to impact these issues. The continued support of public/academic linkages is one such effort of focus by DMH. All state hospitals in Illinois have agreements with universities to serve as training sites for psychiatric residency programs. These sites provide an opportunity for psychiatric residents to work with patients with serious and persistent mental illnesses, as well as children and adolescents with SED, and to learn how the publicly funded mental health system operates. There are also similar programs with Departments of Social Work, Psychology, and Nursing in universities across the state. These programs provide fertile ground for the recruitment of program graduates who are well grounded in public mental health as a result of their residencies.
The DHS Division of Mental Health continues to work towards an integrated system of care that includes both state hospitals and community-based providers, including those that are responsible for emergency health services regarding mental health.

### Human Resource Development Relevant To Adult Services

DMH continues to support human resource development through the following activities:

- Providing training events that assist in the implementation of the Recovery Vision in Illinois continues to be a priority. This training is offered statewide through DMH Regions and other venues to DMH staff, providers, consumers, family members and other interested stakeholders.
- Continued funding of the Illinois Nursing Institute which addresses competencies needed by DMH psychiatric nurses. The DMH contracts with the University of Illinois in Peoria to fund the Nursing Institute that provides targeted training and develops targeted deliverables such as the development of a web-based application to provide training to psychiatric nurses on the competencies required to perform their job and responsibilities.
- Recruiting and training consumers to become Recovery Specialists.
- Establishment of the Certified Recovery Support Specialist credentialing process.
- Recruiting and training consumers as WRAP facilitators.
- Providing training and consultation to community providers around the implementation of medication algorithms with the DMH/University of Illinois Center for the Implementation of Medication Algorithms (CIMA).
- Tele-psychiatry initiatives in which psychiatric consultation is provided to community mental health providers in remote and rural areas in the state.
- Mental Health and Law Enforcement Training - The DMH regularly collaborates with law enforcement agencies and emergency services at general hospitals to facilitate appropriate and effective psychiatric intervention to persons in crisis.
- Provision of technical assistance and training to agencies to improve the efficiency of billing and agency operation.
Illinois

Adult - Emergency Service Provider Training

Adult - Provides for training of providers of emergency health services regarding mental health;
EMERGENCY SERVICE PROVIDER TRAINING

Mental Health and Law Enforcement Training
The DMH regularly collaborates with law enforcement agencies and emergency services at general hospitals to facilitate appropriate and effective psychiatric intervention to persons in crisis. DMH, in conjunction with the U.S. Attorney’s Office of the Central and Northern Districts of Illinois, has developed initiatives aimed at improving the attitudes of law enforcement and mental health professionals towards each other’s views, duties, roles, and skills. DMH has also worked with the Illinois Law Enforcement Training and Standards Board (LETSB) to develop a one-day training program targeted for experienced police officers on dealing with individuals who are mentally ill and in a behavioral crisis. An annual forensic conference that attracts a large audience of law enforcement, mental health, and other first responder personnel was extensively planned in FY2008 and occurred on July 15-17, 2008 (in FY2009).

Emergency and crisis service providers have also participated in a DMH training event focused on legal changes in the Illinois Mental Health Code which impact service provision. Clinical and legal experiences and insights are provided on how to implement changes in civil commitment standards and procedures while safeguarding the rights of recipients and families. Emergency service providers attending have received up-to-date information on statutes regarding court-ordered medication, outpatient involuntary treatment, requirements and the clinical justification required for involuntary civil commitment to state hospitals, and guidelines for mental health providers and the rights of recipients under the Illinois Firearms Act. In 2008, the one-day training event successfully attracted nearly a thousand participants in the Northern Illinois in May and 175 participants in the Southern Illinois in November.

CIT Training
The Cook County Community Re-Integration Initiative (CRC) involved project staff, partners, and CCMHC participants in training on trauma related services. As of February 2009, when it ended, the CRC provided training and certification to 242 new CIT officers. The Chicago Police Department trained over 1100 officers in Cook County to date and has extended training to some police departments in Suburban Cook County as well as in other counties such as Rock Island (a CIT project addressing veterans) in Northwest Illinois and McClean County in Central Illinois.

Training and Coordination of Providers of Emergency and Disaster Services
The Governor has designated DMH as the lead State agency for disaster resource coordination, training and recovery functions related to mental health. Working in the collaborative context of the overall Statewide Disaster Plan, DMH is coordinating Illinois’ disaster preparedness for state operated and state funded psychiatric service entities. The operational focus includes collaboration and training with other State agencies, monitoring and facilitating ongoing concordance with NIMS (National Incident Management Systems), and assisting State funded agencies in the development of local response capability for issues of Mental Health.
In recognition of the potential for natural or terrorist caused disasters in the State, emphasis in disaster planning has been on developing and/or maintaining a local response capacity. This includes educational offerings and the availability of trained mental health professional and paraprofessional volunteers to respond to the needs of their community in time of crisis. A central list of Illinois mental health professionals who were willing to be deployed on an urgent (surge) basis is continually updated as a resource in the event of future terrorist aggression or disaster requiring a mental health response. As necessary, the Red Cross may draw down the volunteers in groups. DMH continues to provide training on disaster response in conjunction with other state agencies and entities. Training in team managed intensive case management has been ongoing in FY2008 with the introduction of the Community Support Teams (CST) and fidelity-related training in ACT.
Illinois

Adult - Grant Expenditure Manner

Adult - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved
ADULT- GRANT EXPENDITURE MANNER

Allocation Of Block Grant Dollars In FY2010

Allocations of Block Grant dollars to specific agencies for service provision are displayed in Table 10 which is appended. The Illinois plan for the expenditure of the FY2010 Community Mental Health Services Block Grant is directed at providing services in community settings for adults with serious mental illness and children and adolescents with serious emotional disturbances. The Illinois block grant fund amount for FY2010, based on projections from FY2009 is $16,023,807. Please note however that the grant awards to community providers represent the best known information available as per their issuance in July of 2009. The state budget as appropriated and approved reflects the FY 2009 level of award continuing to be provided. Administrative expenses, which are capped at 5%, amount to $801,190. In FY2009, block grant dollars were allocated (for adults and children combined) as follows:

- Community Consumer Support - $3,373,678
- Psychiatrist Services In Mental Health Centers (Psychiatric Leadership)- $11,566,916.00
- Special Projects - $180,000.00

A table detailing allocation of dollars to agencies providing services to adults and children has been included in the appendix.

Block Grant Allocation - Adult Population

For adults, dollars will continue to be directed toward psychiatric leadership, community consumer support which is a component of psychosocial rehabilitation, and crisis care to serve individuals with serious mental illnesses. These programs are designed to provide the necessary intermediate and ongoing support and supervision for individuals who are transitioning from a state hospital to the community. The adult service funding allocation is consistent with the State Mental Health Plan, especially the need to provide community-based services as alternatives to hospitalization so that the need for state hospitals is reduced.
| GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health | Yes |  |  |
| GOAL 2: Mental Health Care is Consumer and Family Driven | Yes |  |  |
| GOAL 3: Disparities in Mental Health Services are Eliminated | Yes |  |  |
| GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice | Yes |  |  |
| GOAL 5: Excellent Mental Health Care Is Delivered and Programs are Evaluated* | Yes |  |  |
| GOAL 6: Technology Is Used to Access Mental Health Care and Information | Yes |  |  |

**Total MHBG Funds**

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*Goal 5 of the Final Report of the President’s New Freedom Commission on Mental Health states: Excellent Mental Health Care is Delivered and Research is Accelerated. However, Section XX of the MHBG statute provides that research … Therefore, States are asked to report expected MHBG expenditures related to program evaluation, rather than research.
Illinois

Table C - Description of Transformation Activities

For each mental health transformation goal provided in Table C, briefly describe transformation activities that are supported by the MHBG. You may combine goals in a single description if appropriate. If your State’s transformation activities are described elsewhere in this application, you may simply refer to that section(s).
DESCRIPTION OF TRANSFORMATION

Background: Illinois Transformation Agenda

The Division of Mental Health (DMH), in collaboration with state agencies and stakeholders, has moved forward with a comprehensive cross-system planning approach for public mental health services which emphasizes effective coordination of services, cohesiveness, and the principles of the Recovery Model for the provision of clinical and supportive mental health services. Since the President’s New Freedom Commission on Mental Health released its final report, the Division of Mental Health has focused its efforts at reforms and improvements in the Illinois public mental health system in accordance with the six principal goals of a transformed system of care which were articulated by the Commission:

1) Americans understand that mental health is essential to overall health.
2) Mental health care is consumer and family driven.
3) Disparities in mental health services are eliminated.
4) Early mental health screening, assessment, and referral to services are common practice.
5) Excellent mental health care is delivered and research is accelerated.
6) Technology is used to access mental health care and information.

The Commission’s goals and recommendations were based on the key principle that public mental health systems should be altered to make recovery from mental illness the expected outcome from a transformed system of care:

“We envision a future when everyone with a mental illness will recover, mental illnesses can be prevented or cured, mental illnesses are detected early, everyone with a mental illness at any stage of life has access to effective treatment and supports – essentials for living, working, learning, and participating fully in the community”

A Strategic Vision Report based on feedback from planning retreats with state agency staffers and from more than 200 stakeholders through the use of focus groups was completed in May 2005. The report identified the need to increase DMH’s leadership role (consistent with state statute) with respect to the policies and allocation of resources to serve people diagnosed with mental illnesses and to invite greater collaboration across agencies and service systems utilizing DMH as the locus of mental health expertise and direction. The ideal system of care in Illinois was characterized as:

1) A focus on recovery as the goal of service delivery, emphasizing outcomes rather than the services themselves;

2) Data-driven policy and program decisions based upon an improved capacity to analyze and disseminate relevant information;
3) Individualized service planning with the active participation of the consumer with emphasis on his/her choice of what services are most needed at any particular point; and,

4) An increased role for mental health consumers and advocates in shaping mental health policy, including more influence in the allocation of scarce health and human services resources.

For consumers and their families, mental health services needed to be integrated with other health and human services so as to appear seamless in access when needed. Subsequently, a series of informant group activities set the stage for two comprehensive state planning meetings that occurred in FY2007. The agendas of these meetings were aimed toward renewing collective commitment to collaborating in the interest of the system; reaching consensus regarding the vision/values that underlie mental health service delivery (establishment of recovery as a unifying principle); and prioritizing cross-cutting goals for quality mental health services that span multiple agencies.

After extensive discussion, the current mission and vision statements were developed and established:

**Mission Statement:**
“Illinois envisions a well resourced and transformed mental health system that is consumer directed and community driven with a continuum of integrated and effective culturally inclusive programs, services (prevention, early intervention and treatment) and supports that promote healthy lifelong development through equal access, and that supports recovery and resilience.”

**Vision Statement**
The Illinois Vision for Mental Health is "The Expectation of Resilience and Recovery through Treatment, Accountability and Equal Access"

Several workgroups were convened in FY2008 to address key components in transformation that were identified in the meetings. In July, 2008 a leadership staff retreat on Strategic Transformation was attended by the Director of DMH, the Chief of Staff, DMH administrative staff, and more than thirty clinical, community, and hospital administrative staff from Chicago and Springfield offices and each DHS region. The purpose of the retreat was to further advance the transformation of DMH’s services to adhere and align with the vision of *Recovery as the Expectation* for consumers of mental health services in Illinois.

**Adult Plan**

**Transformation Activities in FY2010: Achieving the Promise**
Overall, the DMH vision for the community mental health system is one that is oriented towards fostering resilience and recovery, and one that is consumer and family driven. It
is our belief that system transformation, as all constructive endeavors, must be based on an assessment of needs, available strengths from which to build and change, and a set of priorities that provide clear direction and lend structure to the process and the activities aimed toward positive results. The Report of the President’s New Freedom Commission on Mental Health provides an important foundation for on-going planning efforts in this regard. Transformation activities identified in this Plan address the following New Freedom Commission goals:

**Americans understand that mental health is essential to overall health.**

- Affirming the state’s vision of Recovery is an essential feature of this goal. DMH will do this by actively providing recovery oriented training to all interested stakeholders and supporting the role and credentialing of Certified Recovery Support Specialists (CRSS). (See Objective A1.3)
- DMH is now making the coordination of primary care with mental health care an area of focus and practice shaping among the CMHCs it funds and has also partnered with staff of the Illinois Department of Healthcare and Family Services (DHFS) in implementing a federal Medical Emergency Room Diversion (ERD) Grant from CMS.
- DMH is maintaining a public awareness campaign to reduce the stigma experienced by children/adolescents and their families associated with mental illnesses. Funding has been obtained through collaboration with the Illinois Children’s Mental Health Partnership (See Objective C1.5.).

**Mental health care is consumer and family driven.**

- The DMH Office of Recovery Services will continue enhancement of the statewide system to educate consumers of mental health services in leadership, personal responsibility and self-advocacy through participation in Consumer Conferences, the use of Wellness Recovery Action Plans (WRAP), and through the Consumer Education and Support Initiative which includes consumer education/support teleconferencing. (See Objectives A1.1 and A1.2)
- DMH C&A Services has established a Family Driven Care initiative in Illinois which includes a Family Driven Care Commission and the establishment of “Family Advisory Councils” in each DMH Region to facilitate family friendly services and provide input toward improving the quality of care. DMH is also continuing to work with parents and parent-led organizations to facilitate parent-to-parent support through the use of Family Resource Developers (FRD’s), to increase the number of FRD’s employed in child-serving mental health agencies, and to encourage substantive feedback from parents and parent led organization on enhancing the quality of services at all levels of care. (See Objectives C1.1 and C1.2)

**Disparities in mental health services are eliminated.**

- Consistent with this important NFC goal, the DMH continues to track data on
gender, race/ethnicity, and age as a means discovering, analyzing, and solving disparity issues.

- The DMH continues to pursue the goal of increasing access to services by adults with serious mental illnesses and, in this period of economic crisis, every effort is being made to at least maintain the current level of access to community-based services.

- The DMH continues efforts to increase access to services by children and adolescents with serious emotional disturbance.

- The Mental Health Juvenile Justice (MHJJ) initiative will continue work to increase the number of juvenile detainees with serious mental illnesses who are identified, screened, and linked with appropriate community-based services. (See Objective C3.1) Evaluation of the MHJJ program has found that these services result in overall clinical improvement, decreased functional impairment and reduced rates of recidivism for youths enrolled in the program. Based upon evaluation findings, the program will work on increasing the clinical services that have been found to be most strongly associated with positive outcomes.

- Increasing access by homeless adults to DMH-funded services has been a priority. In FY 2008, there were 7,121 homeless adults receiving DMH funded services. This information is being gathered for FY2009 and will be tracked in FY2010.

- DMH continues to track the number of homeless youth entering community-based services. In FY200, 293 youth were reported as undomiciled. (See the NOM Performance Indicator for Increased Stability in Housing)

- The number of adults living in the 76 rural counties of Illinois who receive DMH–funded services is tracked on an ongoing basis and an increase in number has been evident. Tracking and efforts to increase the number of adults in rural areas receiving services will continue to be a priority.

- The DMH also continues to track the number of rural youth served in the public mental health system. There appears to be a trend toward increased access of services by this population.

- The DMH collaborates closely with the Illinois Department On Aging (IDOA) to improve access to mental health services by older adults. In FY2010, the DMH and the IDOA continue to convene meetings with stakeholders to plan services for older adults and expand treatment options such as the GeroPsychiatry program. (See Objective A4.3)

**Early mental health screening, assessment, and referral to services are common practice.**

- DMH Forensic Services will continue to expedite, facilitate, monitor and coordinate services to persons with serious mental illnesses in the criminal justice system. Those found unfit to stand trial or not guilty by reason of insanity and treated in state operated mental health facilities require timely restoration of fitness to conclude court involvement and reentry to community services at the earliest possible time. Case finding, data coordination, planned linkages and services through Mental Health Courts are being advanced to meet the mental
health needs of persons detained in county jails and incarcerated in the Illinois Department of Corrections.

- An increase in federal Project for Assistance in the Transition from Homelessness (PATH) funding is being directed to expand case management services to more adults who are homeless and who are PATH eligible. The increase in case management is being targeted to homeless persons with mental illnesses being released from jail. (See Objective A4.1)
- During FY2008 DMH, in collaboration with ICMHP, awarded $100,000 to one provider in each of the five DHS regions to develop and provide Mental Health Early Intervention Services for Children and Adolescents. A major goal of this initiative has been to identify and engage children and adolescents with mental illness or social/emotional problems who are untreated, and those at risk of serious emotional disturbance or social/emotional problems. The overall objectives of this initiative are to implement a statewide system of early intervention services and to develop a network of providers who will be able to identify best practice models through their experience. (See Objective C3.3)
- During FY2008, DMH, in collaboration with ICMHP, awarded $100,000 to one successful bidder in each of the five DHS regions to develop and provide mental health services that address the unique and special needs of older adolescents (16-17 years old) with SED who are transitioning from C&A services to adult services and for any youth with SED who is transitioning from correctional services to the community. In addition to providing an array of mental health services the projects are expected to build community infrastructure that will facilitate and support expansion of transition services for youth and the effectiveness of services, as well as development of a system of care for transitioning youth. (See Objective C3.2).
- The DMH will continue to emphasize Mental Health and Law Enforcement Training by collaborating with law enforcement agencies and emergency services at general hospitals to facilitate appropriate and effective psychiatric intervention to persons in crisis.

**Excellent mental health care is delivered and research is accelerated.**

- The DMH is continuing its work on advancing evidence-based practice in Illinois
  - DMH is implementing a statewide permanent supportive housing initiative that targets 600 consumers over three years to acquire decent, safe, and affordable housing and support services in a manner consistent with the national standards for this evidence based practice.
  - Training and implementation in the use of medication algorithms will be increased and expanded to additional agencies. Coordination of medication algorithms between Community Mental Health Centers and State Operated Hospitals for the purpose of continuity of care is continuing. Consistency in medication management practices can improve
patient outcomes in the continuum of treatment that begins in state operated facilities and continues with community mental health providers.

- An effort has been made to strengthen fidelity and support the provision of ACT services.
- DMH and DRS are committed to implementing and expanding supported employment.
- Planning to implement family psychoeducation continues.
- Joint planning with DASA for services to persons with co-occurring disorders will build upon the lessons learned from the Integrated Dual Diagnosis Treatment (IDDT) project.
- DMH staff are engaged in planning the development and implementation of Illness Management and Recovery (IMR) within the state.

- DMH is committed to advancing the implementation of evidence-informed practices in the child and adolescent service system through training events and a clearly laid out curriculum based upon research and practice experience. (See Objective C1.3).

- Training in trauma-informed service provision is being provided to child mental health providers, child welfare, and juvenile justice staff through a collaborative effort with DCFS and ICMHP.

- Early Childhood Mental Health assessment and treatment services for children ages 0-5 and their families is being prioritized in FY2010 with the establishment and continuing support of five pilot sites across the State and collaboration with the ICMHP to provide early childhood consultation statewide. (See Objective C3.4)

**Technology is used to access mental health care and information.**

- A state-of-the-art management information system (MIS) currently supports a range of data related functions including consumer enrollment, service utilization, provider claims submission, validation, processing, adjudication, and payment through reliable, valid, and expeditious data transmission among all appropriate federal, state, and local entities. Access to this data was achieved by developing a data warehouse that is accessible to DMH staff.

DMH is moving forward to develop and solidify the infrastructure and introduce the technology necessary for the successful use of tele-psychiatry, particularly in rural areas in which there is a shortage of psychiatrists and other needed mental health clinicians. Internet access, video conferencing, and other applications provide an opportunity to enhance the quality of care in rural mental health services. DMH C&A Services is implementing a telepsychiatry pilot project in seven rural sites in Illinois and assessing service utilization and the need for further enhancement and expansion in FY2010. (See Objective C4.)
The Child and Adolescent Outcomes Analysis system, a Web-based system that will feature the ability to generate immediate feedback at the individual, agency, and statewide levels, is being enhanced in FY2010. (See Objective C2.1)

Table C: Mental Health Block Grant Funding for Transformation

Although the above section describes transformation activities undertaken by the DMH, and Table C identifies how these activities relate to the President’s New Freedom Commission goals, please note that we have not identified specific block grant dollar amounts allocated for these activities. At this time we can not break out the specific dollar amounts.
Name of Performance Indicator: Increased Access to Services (Number)

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</table>

Table Descriptors:

Goal: To monitor access to services.

Target: Maintain access to services for adults with mental illnesses at the FY 2008 and projected FY 2009 level.

Population: Adults with mental illnesses.

Criterion: 2: Mental Health System Data Epidemiology

3: Children's Services

Indicator: Number of adults served.

Measure: Number of adults receiving services from DMH-funded community-based providers.

Sources of Information: DMH ASO Community Reporting System. This indicator is generated from URS Tables 2A and 2B.

Special Issues: The DMH Fiscal Year 2010 community mental health services budget has been cut by 8% or approximately 42 million dollars. The impact on programs/services was described in the mental health block grant plan narrative. Because of the draconian nature of these cuts, DMH is not projecting an increase in access to programs.

Significance: Adults with mental illnesses should have access to treatment.

Action Plan: DMH will continue to track the number of persons receiving services from DMH-funded community-based providers in FY 2010 using the methodology described below. The data will be submitted via the URS and will continue to be partitioned by gender, age and race/ethnicity. DMH community funded providers by contract must submit registration and claims data for all individuals receiving services funded using DMH dollars. Data is submitted daily or weekly to the Community Reporting System maintained by the DMH’s Administrative Services Organization (ASO), the Illinois Mental Health Collaborative for Access and Choice. Once this data is processed, it is then transferred to the DMH Data Warehouse for storage. This information is then used to develop reports. FY 2009 data will be reported in the FY 2009 Implementation Report.
### Transformation Activities:

**Name of Performance Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

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**Table Descriptors:**

**Goal:** To decrease readmissions of individuals to state hospitals within 30 days by providing treatment that results in sufficient clinical stabilization such that subsequent treatment is provided in the least restrictive setting.

**Target:** Decrease readmissions within 30 days to state hospitals by 1% based on actual FY2008 value (FY 2009 data not currently available).

**Population:** Adults with serious mental illnesses.

**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

**Indicator:** Decreased Rate of Civil Readmissions to State Psychiatric Hospitals within 30 days.

**Measure:**
- Numerator: Number of civil readmissions to any state hospital within 30 days.
- Denominator: Total number of civil discharges in the year.

**Sources of Information:** DMH Inpatient Clinical Information System (CIS). This indicator is generated from URS Table 20A.

**Special Issues:** There are no special issues that impact this indicator.

**Significance:** Individuals with mental illnesses should receive services in the least restrictive settings possible. However, there are times when access to inpatient services is required. Treatment provided in these settings however should not result in an individuals return to the inpatient setting within a short period of time.

**Action Plan:** This data is generated by DMH on an annual basis for evaluation and monitoring purposes. DMH will continue to monitor the number of adults readmitted to state hospitals within 30 days of discharge with a FY 2010 goal of decreasing the level of re-hospitalization by providing services in the community that provide alternatives to re-hospitalization.
Transformation Activities:

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

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Table Descriptors:

Goal: To decrease readmissions of individuals to state hospitals within 180 days by providing treatment that results in sufficient clinical stabilization such that subsequent treatment is provided in the least restrictive setting.

Target: Decrease the percentage of 180 day readmissions to DMH State Hospitals by 2% (based on FY08 indicator value.

Population: Adults with Serious mental illnesses.

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

Indicator: Decreased Rate of Civil Readmissions to State Psychiatric Hospitals within 180 days.

Measure: Numerator: Number of civil readmissions to any state hospital within 180 days.
Denominator: Total number of civil discharges in the year.

Sources of Information: Inpatient Clinical Information System. This indicator is generated from URS Table 20A.

Special Issues: Note that an incorrect value of 11.43 was reported for FY 2007. The FY 08 actual value of 23.37 is however correct and FY 09 and FY 10 projections are based on this value.

Significance: Individuals with mental illnesses should receive services in the least restrictive settings possible. However, there are times when access to inpatient services is required. Treatment provided in these settings however should not result in individuals return to the inpatient setting within a short period of time.

Action Plan: DMH will continue to monitor the number of adults readmitted to state hospitals within 180 days of discharge with a FY 2009 goal of decreasing the level of re-hospitalization by providing services in the community that provide alternatives to re-hospitalization.
Name of Performance Indicator: Evidence Based - Number of Practices (Number)

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</table>

Table Descriptors:
Goal: To maintain the availability of EBPs within the state
Target: Maintain the number of EBPs available within the state.
Population: Adults with serious mental illnesses.
Criterion: 1: Comprehensive Community-Based Mental Health Service Systems
3: Children’s Services
Indicator: Number of EBPs Implemented in Illinois
Measure: Number of EBPs Implemented in Illinois
Sources of Information: Structured program reports collected by DMH staff from community agencies and data generated from DMH ASO Community Reporting System.
Special Issues: EBPs are very difficult to implement requiring the dedication of many resources. As noted previously, the DMH community services budget has been cut by 8% this year. It is unlikely that there will be an increase in the number of EBPs implemented in FY10. As a general note, many EBPs take multiple years to implement especially without additional or targeted funding to do so.

DMH has a goal of increasing the number and type of EBPs provided within the state. During the past few years, the DMH has focused on Supported Employment (SE), Assertive Community Treatment (ACT) and Permanent Supported Housing. Grant funding from SAMHSA and other sources has been largely used for SE related implementation efforts. Although there is much discussion with regard to Integrated Dual Diagnosis Treatment, Illness-Self-Management, and Medication Algorithms there is still much work to do in this arena. DMH has made a concerted effort to implement Supportive Housing as noted in the narrative. However, we will not be reporting on this effort for FY 2010.

Significance: Adults with serious mental illnesses should have access to evidence-based practices.
Action Plan: As discussed in the narrative, DMH worked with its ASO to implement a new Community Services Reporting System in FY 2009. DMH community funded providers by contract must submit registration and claims data for all individuals receiving services funded using DMH dollars. Data is submitted daily or weekly to the Community Reporting System maintained by the DMH’s Administrative Services Organization (ASO), the Illinois Mental Health Collaborative for Access and Choice. Once this data is processed, it is then transferred to the DMH Data Warehouse for storage. This information is then used to develop reports. The DMH has created special codes for reporting of ACT and to some extent SE. Once all data is received for FY 2009, the indicator will be calculated and the values will be reported in the FY 2009 Implementation Report.
ADULT - GOALS TARGETS AND ACTION PLANS

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Supported Housing (Percentage)

<table>
<thead>
<tr>
<th>(1) Fiscal Year</th>
<th>(2) FY 2007 Actual</th>
<th>(3) FY 2008 Actual</th>
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**Table Descriptors:**

- **Goal:** Provide Permanent Supported Housing to adults needing these services
- **Target:** Increase the number of individuals with SMI receiving permanent supportive housing by 150 in FY 2009
- **Population:** Adults with serious mental illnesses
- **Criterion:**
  - 1: Comprehensive Community-Based Mental Health Service Systems
  - 3: Children's Services
- **Indicator:** Number of adults with SMI receiving Supported Housing
- **Measure:** Number of adults with SMI receiving permanent supported housing.
- **Sources of Information:** This data will be generated from a web-based database created especially for this initiative.
- **Special Issues:** Individuals receiving permanent supported housing are not required to be registered for mental health treatment services. Therefore, it was necessary to create a special database to track access to and receipt of permanent supported housing for individuals with SMI.
- **Significance:** Adults with serious mental illnesses who are in need of supported permanent housing should have access to it.
- **Action Plan:** The DMH has implemented permanent supportive housing. DMH staff work with the ASO to receive and evaluate applications for permanent supportive housing. A web-based database is in the process of being created to accept this data. The expected completion date is January 2010. Once implemented, DMH funded community providers working with individuals with an interest in residing in permanent supported housing will submit electronic applications on behalf of consumers. The database that will retain the applications will also collect information with regard to the outcome of the submitted application. This information will then be aggregated and used to provide data for this indicator.
Transformation Activities:

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Supported Employment (Percentage)

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<tr>
<th>Fiscal Year</th>
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Table Descriptors:

Goal: Provide Supported Employment to individuals with SMI who want to receive this service. Please note that I had to insert a 1 as the denominator for FY 2007--Otherwise webbgas application would not accept the update. This needs to be fixed.

Target: Increase availability of supported employment to those individuals who want to receive this service. (Please note that the target for FY 2009 was based on FY 2008 Data--thus the discrepancy between 08 target and actual. FY 2010 target is based on FY 08 actual data.

Population: Adults with serious mental illnesses

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of persons with SMI receiving supported employment.

Measure: Number of adults with SMI receiving supported employment

Sources of Information: Reports submitted to the DMH central office coordinator of supported employment by agencies providing this service. The indicator will be generated from URS Table 16.

Special Issues: All SE data has not yet integrated into DMH ASO Community Reporting System; Data is being collected through a database designed for this purpose.

Significance: Adults with serious mental illnesses who want competitively employment should be able to attain this goal; Supported employment supports adults with SMI in their recovery.

Action Plan: DMH staff have been working with DMH funded community providers to streamline reporting of data and to report in a more consistent manner. Data regarding some key services has been integrated into the DMH ASO Community Reporting System, however data for key indicators related to fidelity and outcomes has not. This data is being reported through excel spreadsheets developed for this purpose. DMH Decision Support staff are working to develop a web-based reporting system to collect this data. It is expected that the design will be complete and available for data submission by late FY 2010.
**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Assertive Community Treatment (Percentage)

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</table>

**Table Descriptors:**

**Goal:** Provide access to assertive community treatment (Please note that the number of persons receiving ACT in FY 2007 was 2,904. The webbgas application would not accept this update)

**Target:** No target was projected for FY 2009 due to the fact that ACT was revamped to ensure that the EBP is meeting fidelity to the national model. We will consider establishing a target for FY10 once data is generated for FY 2009.

**Population:** Adults with serious mental illnesses with multiple psychiatric hospitalizations

**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

**Indicator:** Numerator: Number of adults with SMI receiving ACT

**Measure:** Number of adults with SMI receiving ACT

**Sources of Information:** DMH ASO Community Reporting System. This indicator will be generated from URS Table 16.

**Special Issues:** During FY 09. The DMH Undertook an effort to ensure that evidence-based assertive community treatment is being provided. All teams underwent a fidelity assessment this year. Fidelity assessments will also be undertaken in FY 2010.

**Significance:** ACT should be available to individuals who will benefit from this service

**Action Plan:** DMH community funded providers by contract must submit registration and claims data for all individuals receiving services funded using DMH dollars. Data is submitted daily or weekly to the Community Reporting System maintained by the DMH’s Administrative Services Organization (ASO), the Illinois Mental Health Collaborative for Access and Choice. Once this data is processed, it is then transferred to the DMH Data Warehouse for storage. This information is then used to develop reports. This system will be utilized to obtain data for FY 10. FY 2009 data will be reported in the FY 2009 Implementation Report.
Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Family Psychoeducation (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1) FY 2007 Actual</th>
<th>(2) FY 2008 Actual</th>
<th>(3) FY 2009 Projected</th>
<th>(4) FY 2010 Target</th>
<th>(5) FY 2011 Target</th>
</tr>
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<tbody>
<tr>
<td>Performance Indicator</td>
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<td>Numerator</td>
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</tr>
<tr>
<td>Denominator</td>
<td>N/A</td>
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</tbody>
</table>

Table Descriptors:
Goal: Indicator Not Applicable: The DMH is not currently implementing this EBP
Target: No target; planning underway to implement
Population: Adults with serious mental illnesses.
Criterion: 1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services
Indicator: Number of adults with SMI receiving family psychoeducation
Measure: Number of adults with SMI receiving family psychoeducation
Sources of Information: Not currently collected.
Special Issues: Although DMH continues to have a discussion with a small group of providers regarding implementation of this EBP, DMH is not currently implementing it.
Significance:
Action Plan: No current plans to implement in FY10.
ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: [ ] Indicator Data Not Applicable

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders (MISA) (Percentage)

<table>
<thead>
<tr>
<th></th>
<th>(1) Fiscal Year FY 2007 Actual</th>
<th>(2) FY 2008 Actual</th>
<th>(3) FY 2009 Projected</th>
<th>(4) FY 2010 Target</th>
<th>(5) FY 2011 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Indicator</td>
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<td>Numerator</td>
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</tr>
<tr>
<td>Denominator</td>
<td>N/A</td>
<td>N/A</td>
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</tr>
</tbody>
</table>

Table Descriptors:
Goal: Not Currently Applicable; DMH is undertaking planning to continue implementation of IDDT.
Target: Not Applicable--Zero; still in process of implementing
Population: Adults with co-occurring serious mental illnesses and substance use disorders
Criterion: 1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services
Indicator: Numerator: Number of Individuals receiving IDDT services
Measure: Number of Individuals receiving IDDT/MISA
Sources of Information: Not available
Special Issues: IDDT/MISA is one of the more difficult EBPs to implement. Although the DMH worked on a pilot project with community agencies to implement this EBP, implementation has not occurred.
Significance: It has been estimated that 50% or more of individuals with serious mental illnesses have co-occurring substance abuse disorders. Integrated treatment is the most effective means of treating these disorders.
Action Plan: The DMH will continue its efforts to implement IDDT/MISA during FY 2010.
## ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: □ Indicator Data Not Applicable

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Illness Self-Management (Percentage)

<table>
<thead>
<tr>
<th></th>
<th>(1)</th>
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<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
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</thead>
<tbody>
<tr>
<td>Fiscal Year</td>
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</tr>
<tr>
<td>Performance Indicator</td>
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<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Numerator</td>
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</tr>
<tr>
<td>Denominator</td>
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<td>N/A</td>
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</tr>
</tbody>
</table>

### Table Descriptors:

**Goal:** Availability of Illness Self Management - Not Applicable

**Target:** Not Applicable. Continuing efforts to implement this EBP

**Population:** Adults with SMI

**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

**Indicator:** Numerator: Number of individuals receiving Illness Self Management.

**Measure:** Number of individuals receiving Illness Self Management

**Sources of Information:** Not implemented; No data currently collected

**Special Issues:**

**Significance:** Illness self-management should be accessible to individuals with serious mental illnesses

**Action Plan:** The DMH will continue its work on planning for implementation of this service.
**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:** [ ] Indicator Data Not Applicable

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Medication Management (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Performance Indicator</th>
<th>Numerator</th>
<th>Denominator</th>
<th>(1) FY 2007 Actual</th>
<th>(2) FY 2008 Actual</th>
<th>(3) FY 2009 Projected</th>
<th>(4) FY 2010 Target</th>
<th>(5) FY 2011 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Actual</strong></td>
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<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td><strong>Projected</strong></td>
<td>FY 2009 Projected</td>
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</tr>
<tr>
<td><strong>Target</strong></td>
<td>FY 2010 Target</td>
<td>FY 2011 Target</td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Actual</strong></td>
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</tr>
</tbody>
</table>

**Table Descriptors:**

**Goal:** NOT APPLICABLE--Availability of medication managment

**Target:** Not Applicable The DMH will continue working on efforts to strengthen its work in this area.

**Population:** Individuals with serious mental illnesses with specified diagnoses receiving psychotropic medication

**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

**Indicator:** Numerator: Number of individuals receiving medication management.

**Measure:** Number of individuals receiving medication management

**Sources of Information:** None currently -- not applicable as EBP has not been implemented.

**Special Issues:**

**Significance:** Medication management is a key to the provision of service resulting in positive outcomes for certain diagnoses

**Action Plan:** The DMH will continue its work with the University of Illinois to implement medication algorithms in state hospitals and community agencies during FY 2010 by providing training and support. However, this EBP has not yet been implemented.
ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Client Perception of Care (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1) FY 2007 Actual</th>
<th>(2) FY 2008 Actual</th>
<th>(3) FY 2009 Projected</th>
<th>(4) FY 2010 Target</th>
<th>(5) FY 2011 Target</th>
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<tbody>
<tr>
<td>Performance Indicator</td>
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<td>Numerator</td>
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</tr>
<tr>
<td>Denominator</td>
<td>476</td>
<td>427</td>
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</tr>
</tbody>
</table>

Table Descriptors:
Goal: Provide services which increase consumer perception of positive treatment outcomes
Target: Increase perception of positive treatment outcomes by 1% (over that reported in FY 2008)
Population: Adults with mental illnesses receiving mental health treatment
Criterion: 1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services
Indicator: Percentage of adult consumers reporting positively about outcomes.
Measure: Numerator: Number of adult consumers reporting positively about outcomes using the MHSIP Adult Survey
Denominator: Total number of adult consumer responses regarding perceptions of outcomes completing the MHSIP Adult Survey
Sources of Information: MHSIP Adult Consumer Survey - Reported in Table 11 URS Tables
Special Issues: Significance: Mental health services should result in positive outcomes as reported by consumers
Action Plan: As in previous fiscal years, DMH will select a random stratified sample of individuals receiving treatment in June 2009. This sample will be the basis for the survey which will be disseminated in October 2009 with a goal of all data collected by early November. DMH staff will strive to complete the analysis by the implementation report due date, however data may not be readily available until January 2010.
ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Adult - Increase/Retained Employment (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1) FY 2007 Actual</th>
<th>(2) FY 2008 Actual</th>
<th>(3) FY 2009 Projected</th>
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<tr>
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<td>120,058</td>
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</tr>
</tbody>
</table>

Table Descriptors:

**Goal:** Increase in competitive employment status by adults with mental illnesses receiving treatment

**Target:** Maintain or increase competitive employment rate (Currently this data is only collected at intake prior to treatment, therefore there is no expectation that there will be an increase. Such a target will be set when we begin collecting data at T1 and T2.

**Population:** Adults with mental illnesses receiving treatment

**Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems

**Indicator:** Percent of adult clients who are competitively employed.

**Measure:** Numerator: Number of adult consumers competitively employed full or part-time (includes supported employment). Denominator: Number of adult consumers competitively employed full or part-time (includes Supported Employment) plus number of persons unemployed plus number of persons not in labor force (includes retired, sheltered employment, sheltered workshops, and other) This does not include persons whose employment status is "not Available".

**Sources of Information:** DMH ASO Community Reporting System. Employment Status is currently reported at case opening or admission.

**Special Issues:** Change in status requires the ability to collect data at multiple points in time. These issues are still being discussed by the states, NRI and CMHS.

**Significance:** Employment is an important variable contributing to recovery

**Action Plan:** Although the states, CMHS and the DIG State Data Infrastructure Coordinating Center are still working to define measures for change in Employment status for individuals receiving treatment, the Illinois DMH has developed a policy to require 6 month updates of employment status for consumers. This new requirement will be instrumental in helping to track this important variable across time. Once the quality of data is ascertained through a data integrity plan which is in the process of being implemented, DMH will be able to report change in employment status. Employment status will continue to be reported on URS Table 4.
ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Adult - Decreased Criminal Justice Involvement (Percentage)

<table>
<thead>
<tr>
<th></th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
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</tr>
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</tbody>
</table>

Table Descriptors:

Goal: Decreased involvement with the justice system by adults with serious mental illnesses

Target: No target established as this measure is a developmental measure.

Population: Adults with serious mental illnesses who have had involvement with the justice system

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems
          3: Children's Services

Indicator: Percent of adult consumers arrested in Year 1 who were not rearrested in Year 2.

Measure: Numerator: Number of adult consumers arrested in T1 who were not rearrested in T2 (new and continuing clients combined).
          Denominator: Number of adult consumers arrested in T1 (new and continuing clients combined).

Sources of Information: This indicator was collected using the MHSIP Survey in FY 2008 and will be collected again by this method in FY 2009.

Special Issues: The states, CMHS and the DIG State Data Infrastructure Coordinating Center (NRI) are still working to define a measure for decreased criminal justice involvement.

Significance: There is an expectation that adults receiving mental health services who have been involved with the justice system will decrease this involvement, however questions remain regarding the appropriate measure.

Action Plan: Illinois will collect this data using the MHSIP Consumer Survey in 2009; however, due to the small response rate and the developmental nature of the measure NO target has been established for FY 2009.
Name of Performance Indicator: Adult - Increased Stability in Housing (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1) FY 2007 Actual</th>
<th>(2) FY 2008 Actual</th>
<th>(3) FY 2009 Projected</th>
<th>(4) FY 2010 Target</th>
<th>(5) FY 2011 Target</th>
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</thead>
<tbody>
<tr>
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<td>134,288</td>
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</table>

Table Descriptors:

Goal: Improve stability of housing for adults with serious mental illnesses

Target: Track number of individuals who are homeless; this data is collected at intake prior to treatment so we do not expect change to occur. Once we begin to track data at T1 and T2 we will specify a target.

Population: Adults with serious mental illnesses

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems 3: Children's Services

Indicator: Percent of adult consumers who are homeless or living in shelters.

Measure: Numerator: Number of adult consumers who are homeless or living in shelters. Denominator: All adult consumers with living situation excluding persons with Living Situation Not Available.

Sources of Information: DMH ASO Community Reporting System.

Special Issues: Although the states, CMHS and the DIG State Data Infrastructure Coordinating Center are still working to define measures for increased stability in housing, the Illinois DMH has developed a policy to require 6 month updates of living status for consumers. This new requirement will be instrumental in supporting DMH in its quest to measure change across time in this NOM. Once the quality of data is ascertained through a data integrity plan which is in the process of being implemented, DMH will be able to report change in employment status.

Significance: Adults with serious mental illnesses should have access to stable living environments.

Action Plan: DMH community funded providers by contract must submit registration and claims data for all individuals receiving services funded using DMH dollars. Data is submitted daily or weekly to the Community Reporting System maintained by the DMH’s Administrative Services Organization (ASO), the Illinois Mental Health Collaborative for Access and Choice. Once this data is processed, it is then transferred to the DMH Data Warehouse for storage. This information is then used to develop reports. As noted above, DMH has established a policy requiring providers to update this information on a bi-annual basis. Once it has been determined that the quality of the data is good, DMH will begin to report change data for this variable.
**Transformation Activities:**

**Name of Performance Indicator:** Adult - Increased Social Supports/Social Connectedness (Percentage)

<table>
<thead>
<tr>
<th>(1) Fiscal Year</th>
<th>(2) FY 2007 Actual</th>
<th>(3) FY 2008 Actual</th>
<th>(4) FY 2009 Projected</th>
<th>(5) FY 2010 Target</th>
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<tr>
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</tr>
</tbody>
</table>

**Table Descriptors:**

**Goal:** Increased perception of social support/connectedness for individuals participating in treatment

**Target:** None as we consider this to be a developmental indicator. There is no basis on which to set target. Note that we indicated that the target is not applicable for FY 09 our FY08 Application.

**Population:** Adults with serious mental illnesses

**Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems  
3: Children's Services

**Indicator:** Percent of adult consumers reporting positively about social supports/social connectedness.

**Measure:** Numerator: Number of adult consumers reporting positively about social connectedness.  
Denominator: Total number of family responses regarding social connectedness.

**Sources of Information:** This information will be collected as a component of the FY 2009 Adult MHSIP Survey.

**Special Issues:** This indicator is developmental and still being refined.

**Significance:** Availability of social support may be related to support for recovery.

**Action Plan:** The DMH will continue to work with CMHS, NRI and the states to refine this indicator. As in previous fiscal years, DMH will select a random stratified sample of individuals receiving treatment in June 2009. This sample will be the basis for the survey which will be disseminated in October 2009 with a goal of all data collected by early November. DMH staff will strive to complete the analysis by the implementation report due date, however data may not be readily available until January 2010.
Name of Performance Indicator: Adult - Improved Level of Functioning (Percentage)

<table>
<thead>
<tr>
<th>(1) Fiscal Year</th>
<th>(2) FY 2007 Actual</th>
<th>(3) FY 2008 Actual</th>
<th>(4) FY 2009 Projected</th>
<th>(5) FY 2010 Target</th>
<th>(6) FY 2011 Target</th>
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<tbody>
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<td>Denominator</td>
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<td>434</td>
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</tbody>
</table>

Table Descriptors:
Goal: Improved functioning for adults with mental illnesses receiving services
Target: Improve consumers perception of functioning by 1% using FY2008 as a basis. FY 2009 data is not yet available.
Population: Adults with mental illnesses receiving treatment
Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
4:Targeted Services to Rural and Homeless Populations
Indicator: Percent of adult consumers reporting positively about functioning.
Measure: Numerator: Number of adult consumers reporting positively about functioning.
Denominator: Total number of adult consumer responses regarding functioning.
Sources of Information: Adult MHSIP Consumer Survey
Special Issues:
Significance: Mental health services should result in improved functioning and reduction in symptoms.
Action Plan: Continue working with the NRI, CMHS and the states to refine/develop this indicator. As in previous fiscal years, DMH will select a random stratified sample of individuals receiving treatment in June 2009. This sample will be the basis for the survey which will be disseminated in October 2009 with a goal of all data collected by early November. DMH staff will strive to complete the analysis by the implementation report due date, however data may not be readily available until January 2010.
Name of Performance Indicator: ACT SERVICE HOURS IN COMMUNITY

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Performance Indicator</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
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<td>214,280</td>
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<td>FY 2009 Projected</td>
<td>67</td>
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<tr>
<td>FY 2011 Target</td>
<td>N/A</td>
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</tr>
</tbody>
</table>

Table Descriptors:
Goal: To assure that a significant portion of the service delivered within the (ACT) programs are provided in the most normalized settings possible in the individual’s community, rather than within the provider’s offices or clinics.

Target: Maintain delivery of services in community locations at the 63% level. (Note: target is based on FY 08 actual data as FY09 data is not currently available.

Population: Adults with serious mental illnesses.

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of service hours for adults being served by the DMH-funded Assertive Community Treatment (ACT) Programs, who receive services outside of the provider’s offices or clinics.

Measure: Numerator: The number of hours of service provided by the DMH-funded (ACT) Programs which occur outside of the provider’s offices or clinics. Denominator: The total number of hours of service provided by the DMH-funded (ACT) Programs.

Sources of Information: DMH ASO Community Reporting System.

Special Issues: ACT services were being revamped in Illinois with an eye toward assuring that services delivered have fidelity to the EBP model.

Significance: The ACT model emphasizes provision of service outside of traditional service settings.

Action Plan: As discussed in the narrative, DMH worked with its ASO to implement a new Community Services Reporting System in FY 2009. DMH community funded providers by contract must submit registration and claims data for all individuals receiving services funded using DMH dollars. Data is submitted daily or weekly to the Community Reporting System maintained by the DMH’s Administrative Services Organization (ASO), the Illinois Mental Health Collaborative for Access and Choice. Once this data is processed, it is then transferred to the DMH Data Warehouse for storage. This information is then used to develop reports. The DMH has created special codes for reporting of ACT. Once all data is received for FY 2009, the indicator will be calculated and the values will be reported in the FY 2009 Implementation Report.
Name of Performance Indicator: CO-OCCURRING DISORDERS -ADULTS

Table Descriptors:

<table>
<thead>
<tr>
<th>(1) Fiscal Year</th>
<th>(2) FY 2007 Actual</th>
<th>(3) FY 2008 Actual</th>
<th>(4) FY 2009 Projected</th>
<th>(5) FY 2010 Target</th>
<th>(6) FY 2011 Target</th>
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<tbody>
<tr>
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</tbody>
</table>

Goal: To improve identification of individuals who have co-occurring mental health and substance abuse disorders.

Target: Identification of percentage of adults with co-occurring disorders at time of intake and reported through the DMH ASO Reporting System. Moderate change expected as this is a point in time measure collected at intake.

Population: Adults with mental illness.

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of adults served with a co-occurring disorders based on diagnostic category.

Measure: Numerator: Number of adults served in the community with a co-occurring mental health and substance abuse diagnosis at intake. Denominator: Total number of adults served in the fiscal year.

Sources of Information: DMH ASO Community Reporting System.

Special Issues: DMH notes that the percentage reported is likely an underestimate.

Significance: DMH ASO Community Reporting System showed that 14% of DMH consumers were identified at intake as having a substance abuse and a mental health diagnosis in FY 2008. This is likely to be under-estimated and demonstrates the importance of ongoing training in identifying and treating persons with dual disorders (MISA).

Action Plan: DMH continues to encourage and support increased training for community mental health professionals in the identification, reporting and treatment of co-occurring disorders. DMH will continue to track number of individuals reported with co-occurring disorders reported at intake. In FY 2009, DMH included an additional variable geared toward determining the extent to which individuals with co-occurring disorders are being screened.
Name of Performance Indicator: ELIGIBLE POPULATION - ADULTS

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</tbody>
</table>

Table Descriptors:

Goal: To assure resources and services are provided to the DMH eligible population

Target: Maintain performance level of 90% (based on FY08 data--FY09 is unavailable) of individuals being served by DMH community-based providers meet the DMH eligibility criteria.

Population: Adults with mental illnesses.

Criterion: 2: Mental Health System Data Epidemiology

Indicator: Percent of adults being served by DMH-funded community-based providers who meet the established criteria for “eligible population” at the time of entry into services.

Measure: Numerator: Number of individuals being served by DMH-funded community-based providers who meet the established criteria for “eligible population” at the time of entry into services. Denominator: Total number of individuals being served by DMH-funded community-based providers.

Sources of Information: DMH ASO Community Reporting Services System.

Special Issues: The DMH Fiscal Year 2010 community mental health services budget has been cut by 8% or approximately 42 million dollars. The impact on programs/services was described in the mental health block grant plan narrative. Because of the draconian nature of these cuts, DMH is not projecting an increase in access to programs.

Significance: State mental health resources and services should be provided to the priority populations of the public mental health system.

Action Plan: The DMH Fiscal Year 2010 community mental health services budget has been cut by 8% or approximately 42 million dollars. The impact on programs/services was described in the mental health block grant plan narrative. Because of the draconian nature of these cuts, DMH is not projecting an increase in access to programs. In FY 2010, DMH will continue to monitor access to services.
Transformation Activities:

Name of Performance Indicator: Employment

<table>
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<tr>
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Numerator: 29,406 28,199 -- -- --
Denominator: 141,807 120,058 -- -- --

Table Descriptors:

Goal: Continue tracking employment status of consumers at case opening
Target: Track number of individuals employed at case opening
Population: Adults with mental illnesses
Criterion: 1: Comprehensive Community-Based Mental Health Service Systems
Indicator: Percentage of adults engaged in full or part time employment that is unsubsidized at case opening
Measure: Numerator: Number of adults reported as employed full or part time in unsubsidized employment at case opening
Denominator: Total number of adults receiving services within the fiscal year.
Sources of Information: DMH-ASO Community Services Reporting System. The data from which this indicator is derived is used to complete URS Tables 4 and 5.

Special Issues:

Significance: Employment is a key issue relating to recovery and resilience. In FY 2008, employment rates were slightly above 20% at point of intake. This descriptive data, collected before services are initiated, is not expected to change. These low levels are consistent with national findings and indicate the importance of further developing employment and supported employment services.

Action Plan: DMH community funded providers by contract must submit registration and claims data for all individuals receiving services funded using DMH dollars. Data is submitted daily or weekly to the Community Reporting System maintained by the DMH’s Administrative Services Organization (ASO), the Illinois Mental Health Collaborative for Access and Choice. Once this data is processed, it is then transferred to the DMH Data Warehouse for storage. This information is then used to develop reports. As discussed in the plan narrative, DMH has established a policy requiring providers to update this information on a bi-annual basis. Once it has been determined that the quality of the data is good, DMH will begin to report change data for this variable. Until then, DMH plans to continue tracking this data while developing specialized employment services.
ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Forensic Outpatient

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<thead>
<tr>
<th>(1)</th>
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<tbody>
<tr>
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**Table Descriptors:**

**Goal:** To track forensic status of adult clients served by the Mental Health system.

**Target:** Track the forensic status of consumers accessing mental health treatment through the Reporting of Community Services (RoCS) data collection system.

**Population:** Adults with mental illnesses.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems

**Indicator:** Percentage of adult clients who were court ordered into treatment due to a finding of Not Guilty by Reason of Insanity (NGRI) or Unfit to Stand Trial (UST) by criminal court at the time of case opening.

**Measure:** Numerator: Number of adults reported as unfit to stand trial, not guilty by reason of insanity or court ordered into treatment at the time of case opening.
Denominator: Total number of adults served in the fiscal year.

**Sources of Information:** DMH ASO Community Reporting System.

**Special Issues:**

**Significance:** Community mental health staff track forensic outpatient status at the time of case opening. Nearly 2% of persons with mental illness are forensic outpatients.

**Action Plan:** DMH plans to continue tracking forensic outpatient information at intake. DMH efforts to link mental health databases with county jails are ongoing and provide another means of identifying persons with current involvement in the criminal justice system, as well as facilitating service provision. (See objectives A1.10 to A1.15, Section III-A).
## Name of Performance Indicator: HISTORY OF INVOLVEMENT WITH THE CRIMINAL JUSTICE SYSTEM

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1) FY 2007 Actual</th>
<th>(2) FY 2008 Actual</th>
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<th>(4) FY 2010 Target</th>
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</table>

### Table Descriptors:

**Goal:** To track forensic status of adult clients served by the Illinois Mental Health system.

**Target:** Track the forensic status of consumers accessing mental health services.

**Population:** Adults with mental illnesses.

**Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems

**Indicator:** Percentage of adult consumers reporting involvement with the Justice System at the time of case opening.

**Measure:**
- **Numerator:** Number of adults reported as involved with the justice system (e.g. probation, parole) at the time of case opening.
- **Denominator:** Total number of adults served in the fiscal year.

**Sources of Information:** DMH ASO Community Reporting System.

**Special Issues:**

**Significance:** Identifying individuals experiencing involvement with the justice system at time of case opening can increase coordination of services between the mental health and justice systems.

**Action Plan:** DMH plans to continue tracking justice system involvement information at intake. DMH efforts to link mental health databases with county jails are ongoing and provide another means of identifying persons with current involvement in the criminal justice system, as well as facilitating service provision and coordination.
Name of Performance Indicator: Living Independently

<table>
<thead>
<tr>
<th>(1) Fiscal Year</th>
<th>(2) FY 2007 Actual</th>
<th>(3) FY 2008 Actual</th>
<th>(4) FY 2009 Projected</th>
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</tbody>
</table>

Table Descriptors:

Goal: To track demographic information on living arrangements of adult clients.

Target: Track number of individuals living independently at case opening. No increase is projected as this data is collected at intake prior to treatment.

Population: Adults with mental illness.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of adults living in private residences*, unsupervised, and considered to be living independently at the time of case opening.

Measure:
- Numerator: Number of adults living in private residence, unsupervised, and considered to be living independently at the time of case opening.
- Denominator: Total number of adults served in the fiscal year.

Sources of Information: DMH ASO Community Reporting System.

Special Issues:

Significance: The proportion of individuals reported as living independently at intake has increased from about 63% to nearly 80% over the past several years. This demonstrates the need for ongoing attention to housing services for individuals with mental illnesses. The increase in consumers who indicate living arrangements of private residence and unsupervised means that targeting of resources to persons with serious mental illness who have the greatest need for housing supports can become more precise.

Action Plan: DMH will continue to assess living arrangements at intake as a means of having baseline data on this indicator regarding the individuals who access DMH funded services.
Name of Performance Indicator: RURAL RESIDENTS SERVED - ADULTS

<table>
<thead>
<tr>
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<td>FY 2010 Target</td>
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<tr>
<td></td>
<td>FY 2011 Target</td>
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<td>N/A</td>
</tr>
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</table>

Table Descriptors:

**Goal:** To assure that individuals with mental illnesses who reside in rural areas are accessing the DMH-funded community-based mental health service system.

**Target:** DMH has set a target of identifying and providing services to 35,000 persons with mental illness in rural areas of the state.

**Population:** Adults with mental illness.

**Criterion:** 4:Targeted Services to Rural and Homeless Populations

**Indicator:** Number of individuals being served by DMH-funded community-based providers who are residents of rural areas at the time of entry into services.

**Measure:** Number of individuals reported by DMH-funded community-based providers who are residents of rural areas at the time of entry into services.

**Sources of Information:** DMH ASO Community Reporting System.

**Special Issues:**

**Significance:** The geography of rural areas adds challenges to the timely and consistent access to services for both service providers and persons with mental illness.

**Action Plan:** DMH aims to expand access to community mental health services for persons residing in rural areas.
ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: TARGET POPULATION - ADULTS

<table>
<thead>
<tr>
<th>(1)</th>
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</table>

Table Descriptors:
Goal: To assure resources and services are provided to the priority population of the publicly funded mental health system.
Target: Increase service level for persons with severe mental illness receiving mental health services in the publicly funded mental health system. Please note that target is based on FY 08 data as FY09 data is not yet available.
Population: Adults with serious mental illnesses.
Criterion: 2: Mental Health System Data Epidemiology
Indicator: Percentage of individuals being served by DMH-funded community-based providers who meet the established criteria for “target population” at the time of entry into services.
Measure: Numerator: Number of adults being served by DMH-funded community-based providers who meet the established criteria for “target population” at the time of entry into services.
Denominator: All adults being served by DMH-funded community-based providers.
Sources of Information: DMH ASO Community Reporting System.
Special Issues: The target group of adults with serious mental illnesses (SMI) is the priority population for the delivery of community mental health services.
Significance: The target group of adults with serious mental illnesses (SMI) is the priority population for the delivery of community mental health services.
Action Plan: DMH will continue to monitor service provision to assure that individuals with severe mental illness receive priority services.
**Transformation Activities:**

**Name of Performance Indicator:** Vocational Placement

<table>
<thead>
<tr>
<th>(1) Fiscal Year</th>
<th>(2) FY 2007 Actual</th>
<th>(3) FY 2008 Actual</th>
<th>(4) FY 2009 Projected</th>
<th>(5) FY 2010 Target</th>
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</table>

**Table Descriptors:**

**Goal:** To track demographic information on vocational placement for adult consumers.

**Target:** Maintain FY 08 target of 2.3% (Please note that FY09 data is not yet available).

**Population:** Adults with mental illnesses.

**Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems

**Indicator:** Percentage of adults who have a vocational placement at the time of case opening.

**Measure:** Numerator: Number of adults reported as having a vocational placement at case opening
Denominator: Total number of adults served in the fiscal year.

**Sources of Information:** Reporting of Community Services (RoCS).

**Special Issues:**

**Significance:** Employment is a key issue relating to recovery and resilience. At intake in FY 2008, vocational placement levels were at less than 3%. This descriptive data collected at intake – before services are initiated – is not expected to change over time. These low levels are consistent with National findings and indicate the importance of further developing employment services.

**Action Plan:** DMH plans to continue tracking this data while developing specialized employment services.
Illinois

Child - Establishment of System of Care

Child - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.
SECTION III-B
CHILD AND ADOLESCENT (C&A) SERVICES PLAN

Criterion 1. Comprehensive Community-based Mental Health System

ESTABLISHMENT OF THE SYSTEM OF CARE

Family Participation

The participation of parents/caregivers and adolescents in planning and evaluating the quality of mental health services is an important aspect of the Illinois public mental health system. DMH has maintained this effort as a priority during FY2009 with activities directed toward increasing family voice and participation in the provision of C&A services statewide and in DMH Regions. DMH continues to:

- Support the establishment of Family Resource Developers within Screening Assessment and Support Services (SASS) programs by contracting for assistance and training for FRD’s through the Illinois Federation of Families, and through the involvement in the monthly FRD meetings of the DMH Family Consumer Specialists. In May and June of 2009 the Family Consumer Specialists held trainings for the FRD’s on Medicaid Billing procedures and sustainability of their positions.

- Hire Family Consumer Specialists (FCS) as C & A staff members of DMH in each region of the state. Four new full time positions were added statewide in FY2008. The fifth FCS staff member was hired for the Southern Region of Illinois in October of 2008. All five of the DMH regions now have a Family Consumer Specialist actively involved.

- Require that Family Resource Developers are members of the Community Support Team when these teams are providing services to youth and their families. Community Support Teams require a consumer participant and in the case of a C & A team this person would be a parent. There is one C & A Community Support Team authorized in the state at this time.

- Increase family participation in Regional Planning Councils, and the IMHPAC. In FY 2008 the leadership of the Child and Adolescent sub-committee of the Illinois Mental Health Planning and Advisory Council was successfully filled by a parent and a community mental health director as co-chairs. The IMHPAC C & A committee continues to be co-chaired by a parent who exhibits strong leadership and advocacy skills. This committee has become increasingly influential within the IMHPAC. Regional family advisory committees are now operating under the leadership of the family consumer specialists in each region.

- Increase parent- to-parent support in the Mental Health Juvenile Justice Initiative.

- Assist and partner with the parent-led support group that is concerned with the enhancement of the quality of services in the Individual Care Grant (ICG) program through the provision of technical assistance. The ICG parent group continues to be a robust voice in the development of child services in Illinois.
DMH staff continue to play a supportive role and provide logistical support to the ICG parent group. This includes family notifications, supporting costs for meeting space, and technical assistance and education.

**Family Resource Developers**

DMH requires Family Resource Developers (FRDs) to be hired in SASS agencies. Increasing value has been placed on the expertise FRDs bring to the SASS teams. Of the 43 agencies providing SASS services, only three of the agencies have never hired a FRD. There is generally a modest level of turnover in the FRD staff, and at the point that the FY 2008 FRD survey was conducted, of 43 reporting agencies, 84% had FRDs employed. The 84% statistic has remained consistent over the past two fiscal years and likely represents a reasonable turnover rate of approximately 16%.

Monthly meetings are held for the FRDs in order to provide education, resource development and support for the positions. FRDs from the federally funded System of Care demonstration grant also attend these meetings. While the survey results could not specify the number of FRD positions that were FY 2008 new hires, it was noted that their support role has expanded as some agencies are using FRDs to assist with Individual Care Grant application processes and service planning. Other agencies have hired more than one FRD into their agency as they continue to recognize the value of the position.

**Objective C1.1.** Continue to work with parents and parent-led organizations to facilitate parent-to-parent support through the use of Family Resource Developers and continue work with parents and parent-led organizations to encourage substantive feedback on enhancing the quality of services at all levels of care.

**Indicators:**

- **Number of FRDs hired by SASS programs to facilitate parent-to-parent support.**
- **Percentage of FRD positions filled in FY 2010.**
- **Number of FRD’s hired in C & A programs other than SASS.**
- **By the end of FY2010, maintain the five Family Consumer Specialists, one in each DMH region, to provide family voice to the DMH system and to increase the extent to which the DMH service system is family driven.**

**Family Advisory Councils**

The Teen Advisory Council was suspended in Summer 2008 due to a significant change in members’ education status and summer jobs. The liaisons to the group considered the value of having youth who represent a limited geographic area compared to larger representation of the state as a whole. A strategic decision was made to change the Teen Advisory structure after discussions with other states on the models they use to ensure youth and family participation. Instead of the one Teen Advisory Council the state currently operates five (5) ‘Family Advisory Councils’, one in each DMH region. These Family Councils include both parents and youth and are convened by the DMH Family Consumer Specialist in each region. The Councils are also part of the effort to move the system towards Family Driven Care.

**The Family Driven Care Initiative**
In 2009 Illinois was one of six states that received a SAMHSA award which paid expenses to participate in a policy academy focused on Family Driven Care. This project has supported collaboration with other child serving systems and supporters (DCFS, ISBE, CHP, DJJ, DASA, IFF, ICMHP) to address the extent to which the system is Family Driven. The one-year project involves work towards goals of a qualitative and quantitative survey of families and providers, development of a multi-agency Family Driven Care Commission, and the beginning development of a state recognized certification for parent providers.

**Objective C1.2.:** In FY2010 advance Family Driven Care in Illinois by: establishing a Family Driven Care Commission; completing a needs assessment by quantitative survey and through utilizing the family advisory councils in each region to conduct focus groups for qualitative input; and, developing the competency requirements and curriculum for the certification of parent providers.

**Indicators:**

- A Family Driven Care commission is established and operational by the end of FY2010.
- Number of focus groups convened in FY2010 to complete a qualitative needs assessment.
- A quantitative survey is conducted to determine baseline implementation of family driven care.
- A proposal of a protocol for certification and an established curriculum by the end of the fiscal year.
- Completion of a final report on the accomplishments of the grant-funded initiative.

**Teen WRAP**

The WRAP curriculum was modified to address the needs of youth. There are three agencies piloting WRAP in Chicago, one in LaSalle, the forensic adolescent inpatient unit in Springfield, and a sixth agency in southeastern Illinois will be trained this year. Representatives of the pilot sites for Teen WRAP meet monthly via teleconference to review the status of this new and innovative project throughout the past year. Agencies as a whole have had very good success in running Teen WRAP groups and have provided them in various locations and with various age groups. The Teen WRAP committee continues to operate and a ‘refresher’ training is being planned to bring these agencies together again in the Summer or Fall of 2009. Discussions will begin to consider how to bring this curriculum to a larger scale. This new adaptive program has been well received with satisfactory results and appears to have a promising future.

**Evidence-Informed and Evidence-Based Practices**

DMH has an evidence based practice subcommittee that is co-chaired by DMH staff and a leader of the Community Behavioral Healthcare Association, the trade organization of
the mental health centers. This committee is comprised of a diverse membership; including parents, university professors, child advocacy organizations, community mental health agencies and DMH staff. Recognizing the extreme diversity of the population in Illinois and the narrow definition of specific EBP models, the EBP committee advised the DMH C&A Statewide Office to actively promote Evidence Informed Practice (EIP). Evidence Informed Practice is defined as “a collaborative effort by children, families and practitioners to identify and implement practices that are appropriate to the needs of the child and family, reflective of available research, and measured to ensure the selected practices lead to improved meaningful outcomes”. The three Evidence-Based Practices which are National Outcome Measures (NOMs) are not being implemented in Illinois. These are:

- Number of Persons with SED Receiving Therapeutic Foster Care
- Number of Persons with SED Receiving Multi-Systemic Therapy
- Number of Persons with SED Receiving Family Functional Therapy

A five-pronged strategy, adopted in FY2006, for moving Illinois forward in its use of Evidence-informed practice for children and adolescents is being pursued:

1. Educate C & A agency leadership on an Evidence Based Practice Paradigm.
2. Train providers in specific evidence-based treatments.
3. Develop partnerships between universities that train the C & A workforce and the community provider, agencies. Develop the ability of training institutions to teach evidence-based practice during the early training of practitioners.
4. Review the extent to which Illinois Division of Mental Health policy supports or impedes evidence based practices.
5. Provide education to consumers on evidence-based practice.

During FY 2009 a significant amount of progress has been achieved toward these strategies:

**Training For Providers:**

- A third cohort has been enrolled in November of 2008 for this training series. There are presently 27 agency groups who have participated in this series. Importantly, in the Spring of 2009 the evaluation of this project indicated that youth who were treated by clinicians who participated in these trainings improved at statistically superior rates versus those treated by comparison clinicians. The training model has been adapted, and outcomes for each cohort will continue to be evaluated to rate the impact of the model with youth outcomes.
- In FY2008, seven training sessions were offered statewide on the topics of evidence based engagement strategies, and use of outcome instruments. Web based training was held utilizing a train – the – trainer model to orient staff to the web based system. In FY2009 Dr Benjamin Ogles provided training on the OHIO Scales and in using measurement in clinical care. Dr Phillip Kendall provided a four part training series on using cognitive behavioral therapy with youth suffering from anxiety disorders.
• In FY2009 Illinois started a Learning Collaborative pilot with 12 community mental health agencies. The learning collaborative group meets monthly for 6 months. The topic being focused on is evidence based engagement strategies. Mary McKay PhD is the expert technical consultant. The initial response has been extremely positive from the participants and data from the evaluation should be forthcoming in Fall 2009.

• DMH is requiring C &A providers to participate in a web-based outcome analysis system effective on 7/1/09. This system allows families, providers, supervisors, agency directors and the state mental health authority to access data which can be used to inform decisions regarding effectiveness of service, training needs of the system, and a description of the system as a whole. Clinicians use the OHIO Scale and families and youth complete the Columbia Impairment Scale on a quarterly basis. Training efforts have been underway to orient the child serving agencies to effectively utilize these instruments and technologies. (See Objective C2.1 in the Quantitative Targets section)

• Northern Illinois University is in the process of developing a virtual classroom that can be used by all the community mental health providers serving children, and another that will support information for families. The content of these sites is being developed and added. Roll out of the system will occur in FY2010.

Partnerships with Universities
In FY2008, three Masters level training programs across the state began to graduate students with certifications in evidence based child and adolescent services. These three programs have continued and are graduating their second cohort. Two of the programs are thriving but one has had difficulty in recruiting students. Additional technical assistance was provided to this program in Summer 2009. An effort is underway to add a fourth program in the southern part of the state during FY2010. This initiative will increase the ability of the workforce to provide evidence-based intervention to youth in Illinois in the long term.

Education to Consumers
Family Consumer Specialists host monthly statewide ‘Parent Empowerment Calls’ to provide parents with information that will allow them to more effectively drive and evaluate their children’s care and the system at large. Consumer conferences for parents on evidence-based practices are scheduled, and education campaigns for families on the use of outcome measures are being developed. Recently (June 2009) Dr. Mary McKay presented on evidence-based practices at a parent conference in Springfield. The EBP committee has designed a brochure for parents that will soon be distributed to agencies on Evidence Informed Practice in order to help families know what to ask for and expect regarding care for their children.

The following objective will be a priority for FY 2010:

Objective C1.3. Continue to advance the implementation of evidence-informed practices in the child and adolescent service system:
• In FY2010, introduce video based training methodologies in an effort to
further disseminate the current training resources to the more rural areas of the state.

- Broaden the impact of the EBP certification program by contracting with a fourth training University in the southern area of the state.
- Continue to offer training opportunities on evidence-based engagement strategies
- Continue consumer education through statewide ‘Parent Empowerment Calls’ to provide parents with information that allows them to both effectively drive and evaluate their children’s care and the system at large

**Indicators:**

- Number of training events provided in FY2010 which advance evidence-informed practices.
- A virtual classroom system is operational by the end of the fiscal year.
- A contract and curriculum is established with a fourth university to provide certification at the graduate level.
- Number of statewide parent empowerment calls completed and the number of parents participating in the calls.

**Individual Care Grants for Children with Mental Illness**

The DMH Individual Care Grant (ICG) Program provides funds for residential treatment or intensive community treatment for children and adolescents with serious emotional disturbances who meet the criteria of severe mental illness and impaired reality testing. The Illinois Mental Health Collaborative for Access and Choice provides support for administrative procedures. The ICG program is family driven, meaning that families make the decision regarding whether they wish to utilize their grant for residential or community based services. These decisions are generally made with consultation from the mental health providers working with the family. Services provided include intensive, home-based support, treatment, and therapeutic stabilization services that allow the child to remain at home. The ICG program is unique in the sense that parents do not have to relinquish custody of their children to obtain these services. An ICG Advisory Council was established in FY2001 and continues to provide input to planning and service delivery.

Community-based ICG services are coordinated through agencies funded to provide SASS services. Agency staff work with families to identify appropriate support services. As of April 1, 2009 the Collaborative began administering the community-based ICG program. ICG/SASS providers now require approval for service plans when thresholds of $1570 for child support and $3000 for behavior intervention services are reached. The SASS agency serves as a fiscal agent by purchasing the services specified in the approved...
plan and monitoring their effectiveness in meeting the youth’s clinical needs. ICG services are available across the state.*

For some youth, the Community Based ICG program serves as an excellent "step down" transition from residential care, for others, the community-based services are effective in preventing the need for institutional placement. Community-based ICG services are also an effective transitional support for the movement from child and adolescent services to adult services. Considerable efforts have gone into providing up to twelve months of post ICG funding to facilitate transitional integration into the community and into the adult service system. The program offers a number of supports, including child support services, case coordination services, behavior management services, and therapeutic stabilization services. Collaborations have been developed between special recreation associations and community SASS programs to assist youth in developing supportive relationships and new behavior patterns in the community.

As of April 30, 2009 the ICG program received 808 requests for applications in FY2009, up slightly from the same period last year when the program had received 780. Of 151 applications returned to the ICG program for eligibility determination, the ICG program has so far awarded 56 grants this fiscal year. In FY2008, 203 youth were served in community-based care out of the 496 youth in the program which represents 41% of the total population, and is consistent with the percent served in community based care in FY2007.

As of July 2008 the ICG program began the implementation of the Ohio Scales and the Columbia Impairment Scale as outcome measures for ICG recipients. Residential and community-based providers now report this data on a quarterly basis. This information is available for provider review and analysis of treatment progress of ICG youth. FY2009 is the baseline year for these measures. Analysis of the data will occur early in FY2010.

The ICG program continues to strive for continuity of services. FY 2010 will see continuing transition to the Illinois Medicaid Rule (Rule 132) requiring a focus on

* Four categories of services are available to ICG recipients under the community-based model. These include:

1. **Therapeutic Stabilization** is an essential part of in-home services, providing a timely one-to-one relationship between the child and a contractual agent of the SASS agency for the purpose of facilitating age-appropriate, normalizing activities of the child. This intervention allows for up to 21 hours per week of service per child. The number of hours approved must be justified by the level of the child’s functional impairment.

2. **Behavior Management Intervention** is a time-limited child and family training/therapy intervention focused toward amelioration or management of specific behaviors that jeopardize the child’s functioning in the home/family setting. This intervention typically teaches/models techniques and skills that can be used by the parent/guardian and other family members. This intervention is typically used to purchase expertise to support a child that requires expertise above and beyond that generally available in the local community mental health agency, an example would be the services of a dietician or fitness trainer to address the needs of a child who has gained a great deal of weight while taking psychotropic medications, or de-escalation training for parents.

3. **Child Support Services** are time-limited funding to cover costs that would otherwise be prohibitive to the parents for the child to participate in community activities when those activities are related to objectives in the child’s current individual services plan. These services often include therapeutic recreation, music, art, after-school programs, or therapeutic summer camps.

4. **Young Adult Support Services** are time-limited funding for young adults to cover costs of services and supports, to aid the young adult in his or her transition to community living. These services may include a young adult taking a class in a community college to teach money management or cooking skills.
treatment practices and claiming practices. The effectiveness of these practices will be studied through post payment review. The ICG program is developing a Child and Family Team (CFT) model in FY2010 as a means of improving communication between providers and families, improving the transitional process and continuity of services for youth transitioning from residential to community services, and reducing length of stay in residential facilities. Training in the model is planned and would include parents/caregivers, community based ICG/SASS workers, residential providers, the children themselves, and any others who could participate as team members.

**Objective C1.4.** In FY2010, continue to strengthen community service options in the DMH ICG program through increasing the number of youth served, implementation of outcome measures, and the introduction of a Child Family Team (CFT) approach.

**Indicators:**
- Number of children served through ICG community service options in FY 2010.
- Completion of a report on the results of the first year of outcome measurement using the Ohio Scales and the Columbia Impairment Scale.
- Number of training sessions provided on the CFT model
- Number of functional Child and Family Teams by the end of FY2010.

**Public Awareness Campaign**
The Report of the President's New Freedom Commission on Mental Health noted that the "stigma that surrounds mental illnesses is one of three major obstacles preventing Americans with mental illnesses from getting the excellent care that they deserve". One way in which to address this issue is to implement strategies geared toward reducing the stigma families and children experience when afflicted with serious emotional disturbances and mental disorders. *The DMH “Say It Out Loud” Campaign is directed to adults, children and families. For a description of the campaign, see Adult-New Developments and Issues and the Adult Plan-Establishment of System of Care.*

**Objective C1.5:** In FY2010, continue the public awareness campaign to reduce negative portrayals associated with mental illnesses. Complete an initial evaluation of the effects of the Campaign.

**Indicators:**
- Materials developed for dissemination that address resource and access issues.
- Completion of a report on the evaluation of the campaign with documented outcomes and lessons learned.
- A report of the key achievements of the campaign and the significant public venues utilized to bring the message to all the citizens of Illinois.

**Assessing Parent/Caregivers Perception of Care**
The DMH uses the National Outcome Measures (NOMS) along with additional system indicators to track mental health system service delivery and outcomes to aid in service
planning. The Division has adopted the MHSIP: Youth Services Survey for Families to collect feedback from caregivers of children ages 0 – 12 who are receiving community mental health services funded by the DMH. The survey has been successfully completed annually since FY2007. The measures reported through the survey are: Client Perception of Care, Increased Social Supports/Social Connectedness, and Improved Level of Functioning.

The Youth Services Survey for Families is part of the Mental Health Statistics Improvement Program (MHSIP) Quality Report performance measures. The annual surveys address two goals of the Division: data-based decision-making in a continuous quality improvement environment and to enhance and expand the involvement of families and caregivers in the review, planning, evaluation and delivery of mental health services. Variables included in the analysis are: residence in Chicago, severity of emotional disturbance, race/ethnicity, and length of time in treatment. The information compiled in this report can be used for management, planning, quality improvement and feedback to providers, consumers and family members regarding state and federally funded services. The survey will be conducted again in FY2010.

Objective C1.6 (NOM): The percentage of parents/caregivers reporting positive outcomes in perception of care, increased social supports/social connectedness and level of functioning as measured through the Youth Services Survey for Families will increase in FY2010. Please note that an increase in return to/stay in school and a decrease in criminal justice involvement is not projected due to the developmental nature of these indicators. These indicators are however listed below.

Indicators:
Percentage of parents/caregivers reporting positively about outcomes with reference to the following national outcome measures:
- Client Perception of Care (Outcomes Domain)
- Return To/Stay in School
- Decreased Criminal Justice Involvement
- Increased Social Supports/Social Connectedness
- Improved Level of Functioning

Other C&A Performance Indicators
Performance indicators are described in the Child-Goals, Targets and Action Plans section.

The web based outcomes analysis system noted above (Objective 1.3) will allow families, providers, supervisors, agency directors and the state mental health authority to access data which can be used to inform decisions regarding effectiveness of service, training needs of the system, and a description of the system as a whole. The aggregate data provided (See Objective C2.1 in the Quantitative Targets section) from this system also offers opportunity for additional performance measurements.
Illinois

Child - Available Services

Child - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

- Health, mental health, and rehabilitation services;
- Employment services;
- Housing services;
- Educational services;
- Substance abuse services;
- Medical and dental services;
- Support services;
- Services provided by local school systems under the Individuals with Disabilities Education Act;
- Case management services;
- Services for persons with co-occurring (substance abuse/mental health) disorders; and
- Other activities leading to reduction of hospitalization.
AVAILABLE SERVICES

Available Services and Resources in the Comprehensive System of Care

Health, Mental Health and Rehabilitation.

Health

“There is no Health without Mental Health” has been the slogan of the Division of Mental Health for the past seven years. The DMH continues to emphasize the importance of assisting families of children and adolescents with serious emotional disturbances in accessing Medicaid and state insurance benefits.

Illinois Health Care Programs:

The State of Illinois has a key initiative to ensure access to health care for children and adolescents- All Kids which is administered by the Illinois Department of Health Care and Family Services (DHFS). Funded by the Legislature in FY2006, All Kids is the Governor’s state program that offers comprehensive, affordable health insurance for children in Illinois. All Kids was the first program in the nation to make sure that every uninsured child, regardless of income or medical condition has access to health care. All Kids began July 1, 2006 when the previous insurance program, KidCare, was folded into All Kids. Children who had not been eligible under the Kid Care program became eligible for benefits under the All Kids expansion. The program provides access to healthcare services for all children 18 years or younger who live in Illinois. Every uninsured child may be eligible regardless of income, current health condition or citizenship. Children must have no insurance coverage for a 12 month period to qualify for All Kids except a newborn child, a parent who lost a job which provided insurance benefits, and a child on COBRA insurance. Children with insurance coverage may also qualify if their families meet certain preset income limits. All Kids provides access to the following services: doctor visits, hospital visits, dental care, vision care including eyeglasses, prescription drugs, check-ups, immunization shots, and it covers special medical services such as medical equipment, speech therapy and physical therapy and mental health services. The amount a family pays is based on their income: Some families will have no monthly costs. Families who have more income will pay reasonable monthly premiums and co-payments. There are never any co-payments for regular check-ups or immunizations.

In addition to the All Kids program, Family Care extends healthcare coverage to parents living with their children 18 years old or younger. Family Care also covers relatives who are caring for their children in place of their parents. Like All Kids, Family Care covers doctor visits, dental care, specialty medical services, hospital care and emergency services. Parents can get Family Care if they live in Illinois and meet income limits which go up as the family size goes up. For example, a family of four can make up to $36,000 per year and may be eligible for Family Care. Parents must be US citizens or meet immigration requirements. Applications for coverage by these programs are easy to obtain through a toll-free telephone number (1-866-ALL-KIDS) or on-line at www.allkidscovered.com.
Through All Kids, Illinois has created a continuum of health benefits coverage for low-income children in the state. The plans are funded by state revenue, as well as federal funds under Title XIX, Medicaid, and Title XXI, the State Children’s Health Insurance Program. All Kids Assist covers children from birth through age 18 whose family income is at or below 133 percent of poverty. All Kids Moms and Babies covers pregnant women and their babies with family income at or below 200 percent of poverty. Individuals enrolled in these plans have no cost sharing requirements. All Kids Share covers uninsured children with family income above 133 percent and at or below 150 percent of poverty. Families pay a small co-payment for some services. All Kids Premium covers uninsured children with family income above 150 percent and at or below 185 percent of poverty. The families of these children pay modest monthly premiums in addition to co-payments for some services. Children who have health insurance whose family income is above 133 percent and at or below 185 percent of poverty are eligible for All Kids Rebate. Under this program, the state reimburses families for all or part of the cost of purchasing private or employer-sponsored health insurance for their children. All Kids Assist and All Kids Moms and Babies cover a full range of Medicaid services including dental care. All Kids Share and All Kids Premium cover the same services with the exception of abortions and home and community-based waiver services. All four plans cover a broad range of benefits for special needs populations. The same provider networks (including physicians, pharmacies, and community mental health and substance abuse providers) are used for all four plans.

Mental Health Services

The array of core mental health services purchased on behalf of Illinois citizens with mental illnesses are based on the tenets of the Community Support Program (CSP) and Child and Adolescent Support Services (CASSP) models. The following is a brief synopsis of core services provided to children and adolescents.

Acute Care. Acute Care Program services provide a rapid response to children and youth in a mental health crisis, to members of the support system, and the community on a 24-hour a day basis. These services are intensive, short-term, and are oriented toward stabilization of an individual’s condition and management of disruptive and life threatening symptoms. Services include crisis-emergency services (e.g. mobile, walk-in and telephone response, crisis residential services and hospital-based services.

Mental Health Treatment These services, which are intended to reduce psychiatric symptoms and promote adaptive functioning, are based on an evaluation of an individual’s mental health service needs and an individual treatment plan (ITP) that is monitored, reviewed, and modified as needed on an ongoing basis. In addition to the core services offered in outpatient settings (e.g., Assessment, Treatment Planning and Monitoring; Counseling and Therapy Services; Psychiatric Services: Medication-related Services), youth with serious emotional disturbances and their families may receive specialized core services including Screening, Assessment and Support Services (SASS); Child and Adolescent Wraparound Services; and services through the Individual Care Grant Program for Children with Mental Illness (ICG/MI).
Screening, Assessment and Support Services (SASS) programs were first established in 1989. The primary objectives of SASS are to develop community-based screening and assessment capability, intensive home-based services, and crisis intervention services. The philosophy of service is short-term intervention which is child-centered, family-focused and community-based. Parents are involved in service provision and evaluation. Since FY2005, the DMH has participated in a significant effort to deliver SASS services collaboratively with the Department of Children & Family Services (DCFS) and the Department of Healthcare & Family Services (DHFS).

Wraparound Services. The Wraparound Approach is essential to the provision of case management services. DMH has defined the way these services are to be provided to families, offering both traditional and non-traditional supports by using the local network of community providers and associations. In this approach, there is a definable planning process involving the child and family, which results in an individualized plan for that child and family that focuses on strengths and needs across multiple settings.

Individual Care Grant For Children with Mental Illness. The DMH Individual Care Grant (ICG) Program provides funds for residential treatment or intensive community treatment for children and adolescents with serious emotional disturbances who meet the criteria of severe mental illness and impaired reality testing. If the funding is awarded for a community grant, parents and providers work together to provide highly individualized services in the community. These individualized services include intensive home-based support, treatment and respite care which allow the child to remain at home. A parent, along with the community mental health center may also decide that residential treatment is the appropriate option. Families are encouraged to place their children close to home to optimize parental involvement in treatment.

Rehabilitation

As noted in the adult service section rehabilitative support services are funded by DMH. For children, the service focus is on Case Management which consists of supportive services including Case Management, Client Transitional Subsidies, and Transition to Adult Services.

Employment Services

Employment is considered one of the key services required for youth transitioning to adulthood. The DHS Division of Rehabilitation Services (DHS/DRS) helps high school students with disabilities plan for their future and assists these students in finding employment with services provided through the Transition Program and the Secondary Transition Experience Program (STEP). DHS/DRS have a strong commitment to serving school age youth with disabilities. The counselors work closely with transition specialists housed in high schools, staff in individual schools and school districts, and community partners to help students achieve their employment, post-secondary education and independent living goals. Whether in school or out, a young person with any limiting disability may be eligible for assistance. DMH and the DHS Division of Rehabilitation Services (DRS) have collaborated closely in a joint effort -“The Brand New Day Initiative” - to increase access to vocational rehabilitation services including supportive and subsidized employment and to improve the coordination of psychiatric and vocational services. Locally, services for youth and adults are obtained through joint
planning and service efforts by community mental health centers (CMHCs) and local offices of DRS.

Other DRS Transition Initiatives that serve students with disabilities and benefit youth with SED include:

- **STEP Program** ~ The Secondary Transition Experience Program (STEP) is a work training/placement program to prepare youth for transition to employment during and after high school. The purpose of STEP is to offer students with disabilities, as part of their Individual Education Plan (IEP) and Transition Plan, the opportunity to participate in career exploration, independent living experiences and community work experiences in preparation for a life after high school, and particularly employment. DRS has 150 STEP contracts which serve approximately 600 high schools.

- DRS maintains Cooperative Agreements with Illinois State Board of Education and local school districts. DRS Transition Specialists participate in ongoing education/vocational rehabilitation planning and in the development of the vocational/transition portion of the IEP. The cost of these specialized counselors is shared between the local school district and DHS/DRS. Services for students who have not achieved their vocational objectives by the time they leave school are continued through the local DRS office. Each DHS/DRS office assigns Vocational Rehabilitation counselors to schools to assist students’ transition from school to work.

- **NEXT STEPS**, a training and resource system, uses volunteer teams to provide training to parents and caregivers in planning and advocacy for positive transition outcomes for children and youth with disabilities. The NEXT Steps service network of 22 teams statewide is sponsored by DRS. Teamwork and workshops focus on four critical goals of Transition: Employment and Education, Independent Living, Social and Interpersonal relationships, and Self-Advocacy. Continuous outreach to un-served or underserved populations is practiced.

- **Transition Planning Committees**: DRS coordinates and sustains local Transition Planning Committees (TPCs) which identify existing resources and unmet needs, facilitate an on-going exchange of information, and develop local customer training programs.

**Housing Services**

Housing services are generally not provided to children and adolescents, but they do benefit from housing services and programs if they are in a homeless family that requires shelter or if they are living with an adult consumer who is being set up with permanent supportive housing. Child-serving agencies are cognizant of the critical needs of families and may refer or link them to appropriate housing services when the need is apparent. Residential Treatment services are provided through the ICG/MI program to children and adolescents who are unable to function in their home and community environments due to the seriousness of their level of emotional disorder. Children in the child welfare system may be placed in foster care and receive SASS services or they may be placed in group home or residential treatment programs by DCFS.
Education Services

Special Education In Illinois
The Illinois State Board of Education (ISBE) reports that 15% of Illinois students of school age (ages 6-21) received special education services in the 2005-2006 school year (the last published Annual State Report on Special Education Performance). Ten percent (10%) of those receiving special education services were classified as Emotionally Disturbed (ED) (28,789 students), the special education category that most closely approximates the federal definition of Serious Emotional Disturbance. Another 8,143 students were classified under Autism.

For pre-school children ages 3-5 years, the number receiving special education services increased annually from 31,389 in 2002-2003 to 35,708 in 2005-2006 growing by +6.44% in 2004, +4.66% in 2005, and +2.12% in 2006. More infants and toddlers with disabilities are being identified and served at a younger age. These children transition to early childhood special education services when they reach the age of 3. Collaboration with Head Start, pre-kindergarten, and child care programs has resulted in identification of more pre-school aged children who may need special education services and has provided more placement options for children with IEPs. There was a gradual increase in the number identified with Autism going from 2.9% in 2003 to 3.67% in 2006, (1,312 of the 35,708 children in that age group who received special education services in 2006), reflecting greater accuracy in the early childhood diagnosis of this disorder. ISBE identified 236 children in this age group as being in the ED category bringing the total number of children ages 3-21 classified with an emotional disability in 2006 to 29,025. This total number has decreased in the past two school years to 26,625 students in the 2007-2008 school year.

Transitional Education
A new law establishes uniformity in the School Code making students statewide eligible to receive special education services up until the day of their 22nd birthday. It helps assure that students with disabilities are able to continue to receive the educational services they need to become productive adults. For young adults in the Individual Care Grant (ICG) Program, educational and vocational services must be an integral part of the transition plan as they move to adulthood. Since the ICG youth are identified as having serious emotional disturbances, early vocational training is highlighted and some begin this as part of their residential treatment. The Adult Network and ICG Transition Coordinator also work with the Division of Rehabilitation Services (DRS) and with the Illinois State Board of Education (ISBE) to develop, coordinate and finalize transition plans for these young adults.

School Systems: Service provision under the Individuals with Disabilities Education Act (IDEA)
When DMH partnered with ISBE and DCFS to implement the wraparound approach to the delivery of children's services, it was clear that children served under the Individuals with Disabilities in Education Act (IDEA) were most often those who required
community based mental health care. The Wraparound approach strengthened the collaboration needed to serve these youth and made the shared agenda of community mental health providers and schools of greater importance. The DMH has pursued a model of service provision that meets the needs of local schools while also addressing the needs of children served through the Individuals with Disabilities in Education Act (IDEA). The model is organized around the needs of the families, schools and communities. This approach includes universal, selected and targeted strategies while addressing cultural factors, stigma, outreach and other barriers to engagement. As a result students experience school wide behavioral interventions, which promote learning and provide positive approaches to the task of learning as well as integrated mental health services.

Substance Abuse Services for Youth
Services for youth with substance use problems are provided through the IDHS Division of Alcoholism and Substance Abuse (DASA), which administers funding to a network of community-based substance abuse treatment programs. DASA programs provide a full continuum of treatment including outpatient and residential programs for persons addicted to alcohol and other drugs.

Services For Youth with Co-Occurring (Substance Abuse/Mental Health)Disorders
The DMH C & A Directors, in collaboration with the DASA, continues to explore the need for staff training and current program capacity issues to address the clinical needs of this population in the Chicago area.

Medical and Dental Services
Both of these essential healthcare services are available to children and youth with SED regardless of income and are accessed through case management or referral. Mental Health providers actively assist families to obtain health insurance coverage for their children under the All Kids program and to be assisted with medical bills through Medicaid. SASS agencies in particular, require families to apply for Medicaid benefits as part of their admission process. In some areas subsidized clinics are available to provide these services at minimal cost and access can be facilitated by the mental health provider.

Support Services

IDHS
A variety of services are available to youth with serious emotional disturbances through IDHS. Liaisons have been developed between local community mental health centers and local IDHS offices for the purpose of facilitating family entitlements and identifying those IDHS families who are in need of assistance in accessing mental health services for their children.

Family Assistance Program
The IDHS administers the Family Assistance Program which is legislatively mandated in Illinois. The Family Assistance Program provides a monthly stipend to enrolled families
who have a child with a serious emotional disturbance (SED) or developmental disability (DD), which they can use for treatment and/or specialized care services at their own discretion. Parent enrollees must have an annual income of no more than $50,000. The program currently serves 30 families of SED children.

**MHJJ- Juvenile Justice System.**

Experts in mental health and juvenile justice estimate that the rate of mental disorder among youth in the juvenile justice system is substantially higher than among the general population of youth. It has been estimated that 14% of youth in juvenile detention have a major depressive disorder and may also have a co-occurring substance abuse disorder. These youth have disorders that can be effectively treated with psychopharmacological and behavioral interventions, which are usually more successful when they are coordinated with other major service systems impacting the child and family. DMH has funded the Mental Health Juvenile Justice Initiative since FY2000 to address this need. This successful initiative is now statewide and provides services to juveniles detained in all the detention centers in Illinois.

**Post-Traumatic Services**

For the past three years the Illinois Department of Children & Family Services (DCFS) has funded a training initiative for child welfare staff and service providers to examine and respond to the trauma children and families have experienced as a result of physical abuse, neglect, sexual abuse and domestic violence and its effect on their behavior, performance and adjustment, especially in foster care and other supportive environments. The DMH statewide Child and Adolescent Services office has consultatively participated in the development of the initiative. In FY2008, funding was provided through the Illinois Children’s Mental Health Partnership to expand this education and training initiative to mental health providers. DMH C&A staff work closely with DCFS to adapt the components of the DCFS approach to a broader population and develop an effective training model to support mental health trauma work with children. The Train-the-Trainer phase has been completed and certified trainers began delivering training to DCFS and DMH funded provider staff in FY2009.

**Case Management for Children and Adolescents**

Youth with serious emotional disturbances and their families, by the nature of their difficulties, cannot be served in isolation. Case Management, a required service for youth with serious emotional disturbances who receive substantial services through the public mental health system, is defined as the coordination of services between the mental health provider and other agencies in order to provide the child and family with immediate and comprehensive care. It is considered a critical component in the effort to assure continuity of care, to sustain youth with serious emotional disturbance in his/her community, enhance his/her quality of life, and thereby reduce the use of state hospitals. Community mental health agencies serving children have been required to participate in local networks of child-serving agencies, which facilitate supportive services to families. In an outpatient setting, case management is an outreach-oriented set of service activities at variable levels of intensity, determined by client need, with the intention of maintaining the client’s linkage to necessary mental health services and social supports.
within the least restrictive clinically appropriate setting. Intensive case management is provided to especially high risk groupings of children who have multiple, severe needs requiring extensive in-home supports and involvement among various child-serving systems.

The Screening Assessment Support Services (SASS) initiative was designed to support an integrated network of individualized services that would meet the specific needs of youth and their families. SASS programs offer case management services to facilitate access to the health, welfare, educational, medical, dental, and vocational services required by these youth and their families. In crisis situations or in cases following hospitalization, A SASS case manager assumes primary responsibility for identifying and accessing needed services for the child and family through mobilizing the family’s natural helping network and utilizing community resources. All SASS providers are required to sign Continuity of Care Agreements with state hospitals and state-funded hospital programs for youth and are monitored for compliance by CCSRs through performance measurements.

**Youth Transitions:**
The DMH recognizes the importance of developmental passage for young adults with serious emotional disturbance and strongly encourages active clinical support to youth who are in need of continuing into adult services. These youth are typically without the education and vocational skills that could facilitate their employment and may also lack the family support that many young adults now enjoy until their mid-twenties. Those who have lived in institutional settings for a long time do not have the community living skills or the community connections that aid in the transition to adult life. Without support, these youth are at risk for joblessness, homelessness, incarceration and welfare dependence. Adult Networks and community-based providers work with the young adult to assure needed services and supports are in place.

Grants of $100,000 each have been awarded to two agencies in each region to conduct pilot projects in transitioning youth. The projects addressed two transitional groups: (1) Youth who have received services in the Child & Adolescent System who are 16 and older and need to prepared to enter adulthood and be served by the Adult system. (2) Youth with serious emotional disturbances transitioning from correctional services back into their home communities are targeted for services regardless of their age. To facilitate the transition process for those re-entering from correctional services, two full time statewide C&A staff members were assigned the task of acting as liaisons with the eight state correctional centers which house youth. The focus of these pilots was on infrastructure building and basic services. These programs are providing information on the service models that work best.

Child Welfare wards who reach the age of 18-21 and are in need of specialized services due to serious emotional disturbances are the subjects of collaborative work between DMH and the Department of Children & Family Services (DCFS). DCFS has funded two Transitional Living Programs (TLPs) for wards with serious emotional disturbance and DMH has funded the required mental health services. Although capacity is available for 50 residents, the programs are serving 25 residents at any given time as a means of
providing more intensive programming. The Thresholds program in Chicago has fifteen residents and the SIRSS program in Carbondale serves ten. An oversight committee composed of staff and providers from both departments meets monthly to review and develop a common agenda and work out problematic situations. DCFS funded providers and mental health providers have been successful in resolving conflicts stemming from programmatic attitudes and policies.

**Activities Leading to a Reduction in Child and Adolescent Hospitalization**

A variety of strategies have resulted in a significant reduction in admissions to state hospitals from 1,272 children and adolescents in FY1989 to 58 in FY2009. Currently, there are only two state operated inpatient programs for children and adolescents. One is a small 9-bed inpatient program at Choate Mental Health Center near the southern tip of Illinois. It serves 6-9 children with serious disturbances at any given time due to the absence of other inpatient resources in that area. McFarland MHC located at Springfield, has a 25 bed forensic unit for adolescent boys that generally serves only 15 boys at a time given the requirement for more intensive team intervention with this higher risk cohort. (Forensic services are also provided for DMH by contract with Streamwood Hospital.)

The Screening, Assessment, and Support Services (SASS) program has had a major impact on hospital admissions. SASS was initiated by the DMH in 1989 with a primary responsibility of screening adolescents prior to their admission to state hospitals. As DMH began to fund community hospitalization, SASS expanded its screening efforts for these services providers as well. The SASS program was expanded to a tri-agency funded program (DMH, DCFS and DHFS) in FY 2005. Wraparound funding, as described above, is also utilized in efforts to keep children twelve years of age and under out of state hospitals in several areas of Illinois. This initiative utilizes SASS and other specialized community-based services to maintain the child in the community.

**Decreased Rate of Readmissions**

DMH will continue to monitor the number of youth readmitted to state hospitals within 30 days of discharge and the number of youth readmitted to state hospitals within 180 days of discharge with a FY2010 goal of maintaining or decreasing the level of re-hospitalization through the use of community based services that provide alternatives to hospitalization. See the Child-Goals, Targets, and Action Plans section for data and information about these indicators which are a National Outcome Measure (NOM)

**Objective C1.7(NOM):** Continue efforts to decrease 30 day and 180 day readmission rates to DMH state hospitals.

**Indicators:**
- Percentage of youth readmitted to state hospitals within 30 days of being discharged
- Percentage of youth readmitted to state hospitals with 180 days of being discharged.
Illinois

Child - Estimate of Prevalence

Child - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children
ESTIMATE OF PREVALENCE

Prevalence Estimate

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 2008 census information to 111,086 or 7% of the population of children and adolescents aged 9 to 17 based on a 13.4% (FY2007) poverty rate.
Illinois

Child - Quantitative Targets

Child - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1
Criterion 2: Mental Health System Data Epidemiology

Child QUANTITATIVE TARGETS

Definitions of DMH Population Eligible to Receive Services

Descriptive eligibility criteria for core services provided in the Illinois public mental health system have been developed and specified using certain broad clinical-diagnostic categories as well as more specific indicators of need. Two groups of consumers are the focus for service provision: a larger “eligible” group and a smaller “target” group. Persons who fall in the eligible group meet minimum criteria of mental illness or emotional disorder as well as significant impairment in life functioning and may be served in the Illinois mental health system. Persons who are considered part of the “target” population meet much stricter criteria, have a more debilitating level of impairment due to mental illness and must be served. The CMHS prevalence estimation methodology seems to overlap the target and eligible population definitions that are currently used by the DMH. While there is a substantive gap between the total prevalence and the annual numbers served, we know that a certain percentage of these individuals may not need or request service in a particular year and an unknown proportion of those who do need service may be served in the private sector. Estimating the size of the un-served portion of the total estimated prevalence is contingent upon the availability of utilization data for psychiatric services provided in the private sector. That data is not currently available.

Definitions of DMH Eligible and Target Populations

The Eligible Population (Adults and Children/Adolescents):

- Must have a mental illness, defined as “a mental or emotional disorder verified by diagnosis contained in the DSM-IV or ICD9-CM which substantially impairs the person’s cognitive, emotional and/or behavioral functioning, excluding the following unless they co-occur with a diagnosed mental illness: V-codes, organic disorders, psychoactive substance induced organic mental disorders, mental retardation, pervasive developmental disorders associated with mental retardation, and psychoactive substance use disorders.
- Must have significant impairment in an important area of life functioning as a result of the mental disorder identified above and as indicated on the Global Level of Functioning (GAF) for adults and Children’s Global Assessment Scale (CGAS) for children.
- All ages

Definition of Child and Adolescent Target Population:

- Must be 0 years of age through 17 years of age.
- Must have a serious emotional disturbance as defined by the diagnostic, functional, and utilization criteria.
Children and Adolescents Receiving Services in FY2009

DMH Target Population

In FY2007, the percentage of children and adolescents meeting the DMH target population criteria was 33.4%. However, in FY2008 it substantially increased reaching 40.1%. Data for FY2009 will be provided in the Implementation Report. Since FY2005, the data for this indicator has likely been an underestimate due to the fact that the DMH still has no access to SASS data.

DMH Eligible Population

The number of youth with Serious Emotional Disturbance (eligible population) reported served in FY2008 was 35,648 approximately 88.4% of the total served- a very slight increase from the percentage served in FY2007 (87.7%). FY2009 data will be provided in the Implementation Report. Since FY2005 the data for this indicator is likely an underestimate due to the fact that the DMH still has no access to SASS data.

DMH tracks access through three key performance indicators. These are:

Increased Access to Services (NOM)

Indicator:
- Number of persons served.

Increased Access to Services by the DMH Target Population

Indicator:
- Percentage of the DMH Child/Adolescent target population receiving services.

Increased Access to Services by the DMH Eligible Population

Indicator:
- Percentage of the DMH Child/Adolescent eligible population receiving services

Progress In Performance Measurement for Children and Adolescents with SED

See the Adult Plan- Quantitative Targets for a discussion of progress in performance measurement and Illinois experience of collaboration with federal initiatives. This background is applicable to children’s services as well as adults.

Child and Adolescent Outcomes Analysis: In FY2007, the DMH contracted with a web-based research company to develop a Web-based Clinical Outcomes Analysis system. The system was completed and training of users had begun by the end of FY2008. The system consists of four measures: (1) The OHIO Scale-Worker version; (2) The Columbia Impairment Scale for Parents; (3) The Columbia Impairment Scale for Youth; and (4) Goal Attainment Scaling methodology (optional). The instruments are used at case opening, quarterly thereafter, and at closing. Users of the web-based system will be able to generate immediate feedback reports at each level of service. Clinicians will be able to generate reports and graphic profiles on their individual clients across specified time periods that are shared with the client and family. Access to this data is a valuable
benefit to the client and family as a means of being able to see, use, and share an objective assessment of progress and accomplishments as well as identification of issues to work on. A term coined to describe this aspect is “refrigerator art”- something posted in a common place for all the family to see. Agency site coordinators of the system will be able to generate agency wide service reports. DMH will be able to compile system-wide data from all the participating agencies.

The web-base Outcomes Analysis System began operating in July of 2008. Implementation has gone well overall. Training was done again in Fall 2008 on the Ohio Scales, and a monthly Technical Assistance call and Net meeting is held for users of the system. At present there are 142 agencies participating with 1,934 users in the system. As of June 1st 19,796 youth had received assessments and 29,724 Ohio Scales had been completed. Comparatively, the statewide Initial Problem Ohio Score was 23.35 and the 90 day Problem Ohio Score decreased to 10.01. The statewide Initial Functioning Ohio Score was 46.34 and the 90-day Functioning score increased to 49.44. These results indicate improvement in the youth who have so far been assessed. As the data comes in it is clear that the youth in the system in Illinois are overall making progress in their care.

In FY2010 the Outcomes system is being expanded to include the Devereux Early Childhood Assessment Scales (DECA), an instrument to be used with children age 0 – 5. The DECA assessments for infants, toddlers and clinicians will be added to the web system and trainings will be held for providers on both use of the instruments and mental health work with young children.

**Objective C2.1: By the end of FY2010, provide training on the integration of the Web-based system into treatment planning and agency decision-making. Introduce the Devereux Early Childhood Assessment Scales(DECA) and provide training for all providers serving young children ages 0-5.**

**Indicators:**

- The number of agencies utilizing the web-based outcomes analysis system with technical assistance.
- The number of training sessions devoted to integration of the web-based clinical outcomes system into clinical practice.
- The number of early childhood providers reporting DECA assessments.
- The number of DECA assessments reported by the end of FY2010.
Illinois

Child - System of Integrated Services

Child - Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:

- Social services;
- Educational services, including services provided under the Individuals with Disabilities Education Act;
- Juvenile justice services;
- Substance abuse services; and

Health and mental health services.
Criterion 3: Children’s Services

SYSTEM OF INTEGRATED SERVICES

The grant under section 1911 for the fiscal year involved will not be expended to provide any service of such system other than comprehensive community mental health services: The Block Grant funds of this grant will be expended to provide only comprehensive community mental health services. Other funding sources have been and will be available to fund the interagency collaborative efforts described below.

Responsible Agency for the Coordination of all Children’s Services:
Children’s Services in Illinois are provided by several agencies under the direction of the Office of the Governor. The most prominent are: the IDHS, the Department of Children and Family Services (DCFS), the newly established Department of Juvenile Justice (IDJJ); and the Department of Healthcare and Family Services (DHFS). The Illinois State Board of Education (ISBE) oversees and provides guidance for educational services including health and social services funded by and provided in local school systems.

Responsible Agency For the Coordination of State Children’s Health Insurance Program (SCHIP): The Department of Health and Family Services (DHFS) is responsible for coordinating this effort which is known as All Kids (See Criterion I).

Responsible Agency For Mental Health Services For Children:
The coordination and development of a community-based system of public mental health services for children and families is the responsibility of the DMH.

Description of Interagency Collaboration Initiatives

Background. Beginning with the award of the Child and Adolescent Support Services Program (CASSP) grant in 1985, the IDHS has actively pursued interagency collaboration with other departments invested in providing services to children and families. The Joint Services Children Initiative funded by the DCFS and the DMH from 1986 to 1988 designed and delivered services to adolescents at risk of restrictive care either through involvement in child welfare or mental health. Subsequently, the Directors of the DMH and the DCFS finalized congruent geographic boundaries that facilitate access to service (1992). In 1994, the DMH, in collaboration with the Illinois State Board of Education, DCFS, and DASA, assisted in the development of Child and Adolescents Local Area Networks (C&A-LANs) and in the provision of Wraparound training throughout Illinois to increase coordination of care for youth with emotional or behavioral challenges. The Wraparound approach strengthened the collaboration needed to serve these youth and made the shared agenda of community mental health providers and schools of greater importance. The DMH has also pursued a model of service provision that meets the needs of local schools while also addressing the needs of children served through the Individuals with Disabilities in Education Act (IDEA).

Inter-Agency Collaboration – Child Serving Systems

DMH staff continues to work in collaboration with other State departments, IDHS Divisions and private service providers to improve services to children and adolescents.
with severe emotional disturbance and other human service needs. These collaborations include the following:

**DMH and DCFS.** The focus of this collaboration is transition services for youth moving from child welfare services to adult mental health services.

**DMH and the Children’s Mental Health Partnership** – DMH and the Children's Mental Health Partnership are collaborating on early intervention pilot projects, and on transition Services for youth with SED.

**DMH and DASA** – The focus of this collaboration is on infrastructure building to provide services for Children and Adolescents with co-occurring mental health and substance abuse problems.

**DMH and ISBE**- A Federal Department of Education Grant was awarded to increase the integration of school mental health services and community mental health centers.

Many local collaborations exist such as the collaboration of the McHenry County 708 Board and the University of Illinois - Rockford on a SAMHSA System of Care grant.

**Social Services**

The DMH collaborates with other IDHS Divisions such as Human Capital Division and Community Health and Prevention as well as free-standing state agencies such as DCFS and DHFS to access many of the social services that are needed by children and adolescents and their families.

**Wraparound Services**

The Wraparound service approach continues to be essential to the provision of case management services for children. These services, which are provided to families, offer traditional and non-traditional supports by using the local network of community providers and associations. In this approach, there is a definable planning process involving the child and family which results in an individualized plan that focuses on strengths and needs across multiple settings. The DMH provides funds to SASS programs throughout the state to support wraparound services.

**Teen R.E.A.C.H**

This program was developed by the DHS Division of Community Health and Prevention (DCHP) and began in 1998 with approximately $8.5 million in funding from TANF available through the IDHS as a result of the success of the welfare-to-work program and the national movement to self-sufficiency. By the end of FY2008, this program had grown to an expenditure of $17 million encompassing 87 community-based agencies which served 27,543 youth between the ages of 6 and 17. The mission of Teen REACH (Responsibility, Education, Achievement, Caring and Hope) is to expand the range of choices and opportunities to enable, empower, and encourage youth from 6 through 17 years of age to achieve positive growth and development, improve their expectations for future success, and avoid and/or reduce harmful, risk-taking behaviors through educational and prevention services delivered during out of school hours. Teen REACH targets low-income youth, with an emphasis on youth from families receiving public
assistance, and youth at risk of dropping out of school or juvenile delinquency. Minority youth represent approximately 84 percent of the participants. This program is the result of collaborative prevention planning which included the DMH and is based upon the realization that structured activities after the school day can mean the difference between success for a young person or the emotional sequel of a life scarred by drugs, gangs, pregnancy, and dropping out of school. Regular participation in Teen REACH appears to reduce violent behaviors while providing regular opportunities to reinforce self-esteem and self worth, as documented by the agencies. This innovative community based after-school program is considered one of the necessary supports to families in achieving self-sufficiency.

Illinois was awarded a grant under the U.S. Department of Education’s Gaining Early Awareness and Readiness for Undergraduate Programs (GEAR UP) initiative. Teen REACH is collaborating with the Illinois’ GEAR UP program, which further strengthens Teen REACH as a resource for preparation towards higher education and transition to young adulthood.

Educational Services, Including Services Provided Under the Individuals with Disabilities Education Act (IDEA)

The Surgeon General’s Report on Mental Health states that schools are a major setting for the potential recognition of mental disorders in children and adolescents. Many community mental health agencies, recognizing the critical role a school plays in a child’s life, have developed strong working relationships with schools. Ideally, services should be initiated before there is a mental health problem that interferes with academic success. However, capacity across the array of mental health services, including child psychiatric expertise, is not sufficient to identify, assess and treat children before there is a crisis in that child’s life. The DMH developed the Positive Behavioral Interventions and Supports (PBIS) model for mental health services in schools to address children’s mental health needs that are beyond the school’s expertise. The model is organized around the needs of the families, schools and communities and includes universal, selected and targeted strategies while addressing cultural factors, stigma, outreach and other barriers to engagement. As a result students experience school wide behavioral interventions that promote learning and provide positive approaches to the task of learning as well as integrated mental health services. The DMH has continued with an expert group to initiate the model that utilizes school consultation teams, offers psychiatric expertise, and expands community mental health capacity to respond to the needs of students and their families.

The McHenry County System of Care: A System of Care grant was awarded to McHenry County and funded in 2006. System of Care grants are funded by the United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration/Center for Mental Health Services. DMH has partnered with the McHenry County Mental Health Board to implement system of care transformation, on a local level. The mission of this project “is to meet the social and/or emotional needs of families, children, and youth by providing leadership to develop and sustain a community
of care that provides continuous support and easy access at every level of care. The grant will improve access to services for four underserved populations: preschoolers with serious social/emotional problems, youth with serious emotional disturbances and co-occurring substance abuse problems, young adults 18-21 years old with mental illnesses, and Latino children.

McHenry County Family CARE (Child & Adolescent Recovery Experience) emphasizes the use of the System of Care values and principles to empower youth and families as well as to implement system-wide collaboration. The use of Child and Family Teams engages traditional and non-traditional supports in care planning while family members are taught how to manage their care, resources and desired outcomes. Parents of SED youth, are employed throughout the community as Family Resource Developers and Child and Family Team Facilitators, providing peer support and resources to family members in need and assisting them in navigating mental health and education systems across the county. A variety of committees including an active Family Council and Youth Council have been formed and are meeting with the aim of involving stakeholders in designing effective mental health services which build on the strengths of consumers and address cultural and linguistic needs. A Governance Council includes professionals, family members and youth to ensure that the project is family driven, youth guided, culturally competent, and able to shape policies and strategies to improve mental health care and develop a comprehensive system of care for McHenry County.

The goals of the McHenry County Child and Adolescent Recovery Experience (Family CARE) have been to:

- Enhance the capacity, accessibility, availability, and quality of services and supports for youth with complex behavioral and emotional needs with a special emphasis on the following populations: early childhood (0-7), transition age youth (17-22), youth with a co-occurring mental health and substance use disorder, and Latino Youth.
- Develop a network of culturally and linguistically sensitive services and supports for youth with complex behavioral and emotional needs.
- Develop additional peer-to-peer support options available to youth with complex behavioral and emotional needs, and their parents, across the community.
- Fully implement national and local evaluations and track the system of care in order to evaluate system processes and track the improved functioning of youth with complex behavioral and emotional needs within the four populations of focus, and their families, within the community.

As Family CARE moves forward, significant effort is placed on promoting Evidence Informed Practices which includes enhancing school/mental health partnerships, developing a trauma-informed system of care, collaborative cross-system training and professional development, the development of a local family organization, and cultural competency organizational planning and implementation. School coordinators, who may also be parents of SED youth, are partnered within several local school districts to help facilitate program access and keep school personnel linked with vital community resources. The team obtained a suicide-prevention grant from another source to provide
suicide-prevention training for system of care families, youth, and partners. Recent process evaluation has highlighted the need for the initiative to further expand the continuum of care, continue strengthening the Governance Council, engage more community partners in system of care development, adhere to a logic model/logic model/strategic plan and significantly increase the focus on evaluation and continuous quality improvement.

Social Emotional Learning in Illinois Schools
The DMH has continued its on-going collaborative efforts with the Children's Mental Health Partnership in FY2008. The Illinois Children’s Mental Health Partnership (ICMHP) was established in FY 2003 and charged with developing a comprehensive, multi-year Children’s Mental Health Plan. The plan that was developed included requirements for the Illinois State Board of Education (ISBE) to incorporate social and emotional development standards as part of the Illinois Learning Standards. The ISBE and ICMHP partnered with the Collaborative for Academic, Social and Emotional Learning (CASEL) and a team of twenty five educators to develop 10 standards aligned with the following three goals: (1) students should develop self-awareness and self-management skills, (2) students should develop social awareness and interpersonal skills and (3) students should demonstrate decision making skills and responsible behavior. One hundred developmentally appropriate benchmarks and 600 performance descriptors are now posted on the ISBE web site. This partnership effort was supported by small grants to school districts to offset the costs of enhancing mental health services in schools and implementing a Statewide Professional Development Plan to support leadership teams for schools as they draft SEL implementation plans.

Juvenile Justice Services
Youth in the juvenile justice system have disorders that can be effectively treated with psychopharmacological and behavioral interventions. These interventions are usually more successful when they are coordinated with other major service systems impacting the child and family. Research has demonstrated that the majority of juveniles in detention centers meet the criteria for a psychiatric diagnosis and one in six has a serious mental illness. Many of those also have a co-morbid substance abuse disorder (Teplin, et al. 2005). The juvenile justice system frequently either fails to identify these youth or fails to provide the necessary mental health treatment. The Mental Health Juvenile Justice (MHJJ) program was conceived and implemented to address this critical need. MHJJ provides an alternative to incarceration for juvenile detainees with serious mental illnesses, by arranging for the necessary mental health services to address individual clinical needs.

Mental Health and Juvenile Justice
Mental Health Juvenile Justice Program (MHJJ) is designed to divert youth, with serious mental illnesses, from the juvenile justice system and into community-based care. The Division of Mental Health initially funded MHJJ as a pilot project in 2000 in just seven
counties and was subsequently expanded to each of the 17 Illinois counties with a detention center and one county without a detention center. The program was initially conceived as an alternative to secure detention, though eligibility criteria have been expanded to intercept youth at the earliest stages of justice involvement. In FY2008 two additional community agencies in Cook County offered MHJJ services with the goal increasing outreach and linkage to the Latino community. The MHJJ program now covers 34 Illinois counties, involves 21 community agencies and has approximately 60 staff.

The MHJJ program aims to strengthen the linkages among the courts, probation, detention, schools, mental health, and other community-based services. In addition, MHJJ recognizes family engagement at all levels is vital to achieving best outcomes. Consistent with this priority, a number of MHJJ agencies have been able to offer parent – to-parent support through their Family Resource Developers. Youth are referred to the MHJJ program from a variety of sources (judges, attorneys, probation officers, etc). Specially trained MHJJ liaisons then screen the youth for the presence of a serious mental illness such as a major affective disorder or psychosis. Once found eligible, a functional assessment is conducted. This assessment not only identifies areas of functional impairment, but also areas of strength that can be leveraged in the development of an individualized action plan. Based on the action plan, MHJJ liaisons link youth with appropriate community-based services and continue monitor the progress of each youth for a period of six months. Access to a flexible spending is available to supplement the youth’s treatment ancillary services or family stabilization for which no other source of funding is available.

The data for the FY 2008 indicators and the data through May for FY 2009 are detailed below:

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<tr>
<th></th>
<th>FY2008</th>
<th>FY2009 (May 2009)</th>
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<tr>
<td>Enrolled</td>
<td>592</td>
<td>565</td>
</tr>
</tbody>
</table>

FY2008: FY ’08 = 82.04% linked to services, FY ’08 = 26.9% re-arrest rate
FY2009: FY ’09 = 82.54 % linked to services, FY ’09 = 31.3% re-arrest rate

In FY2009, minority enrollment continued to increase. This trend is consistent with FY2008 findings. It is also reflective of the MHJJ program’s targeted outreach to, and education of, referral sources regarding minority youth with serious mental illnesses. Both the percentage of minority youth referred (51.7%) and the percentage of minority youth enrolled (54.9%) increased this fiscal year. This will continue to be a priority.
objective for the program particularly in light of the overrepresentation of minority youth in the juvenile justice system.

In FY2010, the overall mission of MHJJ will remain unchanged and liaisons will increase their efforts to intercept youth at the earliest stages of their justice involvement. Since the number of service sessions is associated with positive outcomes maintaining and increasing the number of service sessions offered will continue to be a priority. MHJJ will continuously increase the clinical services most strongly associated with positive outcomes. In FY2008, these services were identified as individual treatment (therapy and substance abuse) and case management. In addition, increasing the rate of program completion will also be a key objective. The annual evaluation and outcome analysis consistently demonstrates that completion of the MHJJ program is associated with overall clinical improvement, decreased functional impairment, and reduced rates of recidivism for youth.

The following additional initiatives will be undertaken by the program in FY2010:

1. Increase parent-to-parent support in the Mental Health Juvenile Justice Program. Ongoing MHJJ evaluation findings indicate that parent engagement is associated with the most positive outcomes. As a result, a focus of program enhancement in FY2010 will be family engagement and working with agencies to increase the number of parent liaisons available.

2. Collection of accurate information regarding race and ethnicity during the referral process will facilitate a more detailed analysis of any differences that exist with respect to referrals, enrollment, service linkages and outcomes. Adopting the national standard for recording this type of data would improve its accuracy and analysis.

**Objective C3.1. In FY2010, increase the number of youth receiving services through the Mental Health Juvenile Justice Initiative (MHJJ)**

**Indicators:**
- Number of youth served by the program statewide.
- Number linked to services, and
- Number of youth re-arrested

**Substance Abuse Services for Dually Diagnosed (MISA) Youth**

DMH C & A staff in collaboration with the DHS Division of Alcoholism and Substance Abuse (DASA) are continuing to explore staff training needs and to assess program capacity requirements for addressing the clinical needs of this population.

As part of assessment at intake, mental health staff track the proportion of children and adolescents who are dually diagnosed with mental health problems and substance abuse (see Performance Indicator). As reported above, relatively few children are identified (a little over 1%).

**Health and Mental Health Services**
**Access to Health Care:**
Collaboration with the Department of Healthcare and Family Services supports access to healthcare programs which ensure access to health care for children and adolescents: ALLKIDS, an expansion of the previous KidCare program, was implemented in July 2006. See above-Criterion I.

**Community Health and Prevention**
Collaboration between the DMH and the Division of Community Health and Prevention (DCHP) is addressing two arenas: (1) Mental health services to families that have experienced domestic violence; (2) Identification of children’s mental health needs in child care settings. The DMH participates in the quarterly meetings of the DCHP Healthy Child Care Illinois initiative and contributes to the development of the initiative’s annual meetings in which nurse consultants from around the state came together to discuss the mental health needs of children in child care settings. Additionally, the DMH is collaborating with DCHP and the members of the Postpartum Depression Task Force to address the needs of women who experience depression during pregnancy and postpartum.

**Community and Residential Services Authority**
Since 1986, the DMH has been an actively participating member of the Community and Residential Services Authority (CRSA), which was created in 1985 by the Illinois General Assembly. The membership of the Authority includes child-serving state agencies, education, public and private sector gubernatorial appointees and members of the General Assembly. CRSA combines interagency deliberations to resolve multiple agency disputes and to plan for a more responsive, efficient and coordinated system to address the needs of children and their families. Many of the children who experience behavior disorders or severe emotional disturbances have multiple and diverse service needs which do not clearly fit the service eligibility criteria or funding streams of state and local public agencies. CRSA successfully negotiated the participation of eight state human service agencies in a pooled fund which is used to carry out an inter-agency service plan when children and families are unable to fully qualify for services from a state agency.

**Illinois Children’s Mental Health Partnership (ICMHP)**
The Children's Mental Health (CMH) Act of 2003 created the Illinois Children's Mental Health Partnership (ICMHP). The Partnership is charged with developing a Children's Mental Health Plan containing short-term and long-term recommendations for providing comprehensive, coordinated mental health prevention, early intervention and treatment services for children from birth to 18. The ICMHP is comprised of members of child-serving agencies and other mental health system stakeholders including parents of children with emotional and serious emotional disturbances. DMH Child and Adolescent Service System staff are active members of the ICMHP and are active partners in promoting its vision.

The ICMHP has been successful in garnering state funds for children’s mental health needs. The DMH Child and Adolescent Office works closely with the ICMHP in planning how the funds are to be used and implementing those plans. In FY2008,
ICMHP obtained a $6.5 million budget which included funding for the expansion of key projects in services to transitioning youth, early childhood consultation, early intervention and the introduction of early childhood treatment programs.

**Mental Health Transitional Services**

DMH, in collaboration with ICMHP, has offered Requests for Service Plans (RSP), to solicit proposals to develop and provide mental health services that address the unique and special needs of older adolescents (16-17 years old) with SED who are transitioning from C&A services to adult services and for any youth with mental health needs and/or social/emotional impairment who is transitioning from correctional services to the community. In FY2007 and FY2008, DMH awarded a total of ten (10) pilot sites for $1,000,000 in statewide funding. In addition to providing an array of mental health services all projects were expected to build community infrastructure that will facilitate and support expansion of transition services for youth and the effectiveness of services, as well as development of a system of care for transitioning youth. During FY2008, the ten (10) grant programs registered and served 245 youth 16-18 year old youth with SED and 38 youth of various ages who returned to the community from the Illinois Department of Juvenile Justice. In the first half of FY2009 203 youths with SED and 92 from the juvenile justice population have been served. Some reported challenges have been: engaging families or other supports in the treatment process, maintaining youth in treatment, and obtaining financial resources to assist youth with daily expenses like transportation and housing. Some reported successes have been: establishment of working relationship with local providers of adult mental health services, implementation of groups designed to assist youth develop adult life skills, and engaged youth demonstrate significant improvement in functioning. These pilot programs provide vital information as to the service models and intervention strategies that work best for the target population groups addressed.

In FY2010, due to fiscal constraint and the lack of continuation funds, the five pilot programs originally funded for a three-year period in FY2007 have been discontinued. The five programs funded in FY2008 will continue, one in each DMH region. The ICMHP and DMH are evaluating the data and information gained from the pilots so far with the aim of developing plans for statewide services to transitional youth for possible implementation in FY2011. The following objective continues to be relevant:

**Objective C3.2:** During FY 2010, continue to monitor and evaluate each transitional service site with special emphasis on: determination of appropriate utilization rates and service outcomes; identification of effective intervention strategies; and identification of regional similarities or differences relevant to service need and delivery.

**Indicators:**

- Total number of transitioning youth served at each site.
- Total amount of services reported and Medicaid billed to DMH’s electronic data reporting system.
• Provider documentation of outcomes, lessons learned, gaps and challenges in the service system, networking, and successful or promising service delivery strategies and/or innovations.
• Number of meetings held with all the providers to share experiences and solutions to problematic issues.

Early Intervention
The Mental Health Early Intervention Initiative is a granting opportunity to agencies with the aim of identifying children and adolescents at risk, especially those at risk of mental health or social/emotional impairment, and to intervene early. Case finding needs to go on in venues outside the normal service paths for children with serious disturbances. In FY2007 and FY2008, $1,000,000 was awarded to ten agencies. Two agencies in every region are now in a position to coordinate early intervention services. Flexibility has been emphasized as each agency developed its own plan and approach to early intervention based on the unique geographic, cultural, and interagency service environments in each region. A major goal of this initiative is to identify and engage children and adolescents with mental illness or social/emotional problems who are untreated, and those at risk of serious emotional disturbance or social/emotional problems. In FY2008, these programs served 608 youth and their families and provided outreach, linkage, and other brief contact services to 1,372 children who were not registered as clients, for a total of 6,050 direct service hours. At mid-fiscal year in FY2009, 409 registered consumers and 534 unregistered consumers had received services for a total of 4,175 direct service hours and $64,428 was billed to Medicaid. In quarterly reports providers have indicated the following successful engagement strategies: For the 0-5 age group- providing services at daycares and pre-schools yields the best engagement outcomes. For older children providing services within the school setting is most successful. However parent participation is lacking. Addressing the parent-child relationship is most the successful strategy for addressing behavior issues of young children. The overall objectives of this initiative are to implement a statewide system of early intervention services and to develop a network of providers.

In FY2010, due to fiscal constraint and the lack of continuation funds, the five pilot programs originally funded for a three-year period in FY2007 have been discontinued. The five programs funded in FY2008 will continue, one in each DMH region. The ICMHP and DMH are evaluating the data and information gained from the pilots so far with the aim of developing a plan for statewide early intervention services with implementation possible in FY2011. The following objective continues to be relevant:

Objective C3.3: In FY 2010, continue to monitor and evaluate each early intervention site with special emphasis on: determination of appropriate utilization rates and service outcomes; identification of effective intervention strategies; identification of regional similarities or differences relevant to service need and delivery; identification of opportunities for additional expansion of the initiative to more providers and communities; and introduction of a uniform web-based mental health assessment or screening tool for young children age 0-5.
Indicators:
- Total number of children and families served by the end of the fiscal year.
- Total amount of services reported and Medicaid billed to DMH’s electronic data reporting system.
- Provider written reports that document outcomes, lessons learned, gaps and challenges in the service system, and networking outcomes.
- Provider documentation of successful or promising service delivery strategies, innovations and/or service models.
- A statewide report documenting outcomes, lessons being learned, gaps and challenges in the service structure, and successful innovations in early intervention services to children and families is drafted, reviewed, approved, and disseminated.
- The number of web-based assessments/screenings completed by Mental Health Early Intervention programs during the fiscal year.

Early Childhood Mental Health

The Early Childhood Mental Health Program was established during FY2008. DMH Child and Adolescent Services and the Illinois Children’s Mental Health Partnership (ICMHP) have identified early childhood mental health as a priority in Illinois and collaborated in the release of a Request for Service Plan (RSP) that invited applications to provide an array of developmentally appropriate mental health services to children ages 0-5 who are experiencing mental health and/or social/emotional development problems. Five (5) child-serving mental health providers, one in each of the five regions, were funded to: a) provide mental health assessment and treatment services to children age 0 – 5 years with psychological or social/emotional development needs; b) provide parent support services to families of eligible children; c) provide services that are child focused and family driven; and d) develop connections to referral systems/networks for early childhood. By mid-FY 2009, 135 registered consumers and 26 unregistered consumers had received services. Providers delivered 2,382 hours of direct service. The five most reported services delivered in the order of prevalence were: therapy or counseling with families, community support to an individual, case management/collaboration, mental health assessment, and therapy or counseling to an individual. This initiative is continuing in FY2010.

Objective C3.4: During FY 2010, through monitoring and program evaluation determine whether each Early Childhood Mental Health program is continuing to achieve the service and system development requirements of their grant. Introduce a uniform web-based assessment/screening tool such as the Devereux Early Childhood Assessment (DECA); and collaborate with providers to identify strategies to address needs and gaps in each service region, and to develop recommendations for the enhancement of Early Childhood Services.

Indicators:
- The number of children ages 0-5 served in FY2010.
• A description of services provided to children and their families/caretakers and the number of service hours provided for each service in FY2010.

• Number of meetings convened with participating providers to share information on best practices, program outcomes, unmet needs, and strategies to address service gaps and needs.

• The number of web-based assessments/screenings completed by Early Childhood programs during the fiscal year.

In support of this program, an Early Childhood Consultation program was expanded statewide in FY2008. This program began as a joint venture of the Illinois Children’s Mental Health Partnership and Michael Reese Hospital’s Early Childhood program. The consultation and treatment program was very successful in Chicago but Michael Reese’s funds were limited to Chicago. The Illinois Children’s Mental Health Partnership obtained sufficient funds to extend the program to seven agencies in the state in FY2007 and to cover 10 to 12 agencies in FY2008. Consultants are paid to travel to the selected agencies and provide case consultation, education in early childhood issues, and training to selected agency staff for a period 12-18 months. Agencies successfully completing the training and consultation program then receive funds to expand their services and provide support to other agencies in their area that are developing this specialization. The project is directly administered by ICMHP.

During FY2009, DMH C&A staff worked with the Illinois Children’s Mental Health Partnership in a collaborative relationship to identify the parameters relevant to early childhood consultation. DMH C&A Services will continue to prioritize the further expansion of services to this age group and evaluation of the process.
Illinois

Child - Geographic Area Definition

Child - Establishes defined geographic area for the provision of the services of such system.
CRITERION 3: CHILD SERVICES

GEOGRAPHIC AREA DEFINITION

Establishment of a defined geographic area for the provision of the services of such system: At the State Level, defined geographic areas (Comprehensive Community Service Regions (CCSRs)) have been established for the provision of services. At the local level, each funded provider has a defined geographic catchment area within the region and provides services to clients residing in that particular area.
Illinois

Child - Outreach to Homeless

Child - Describe State's outreach to and services for individuals who are homeless
CRITERION 4: Targeted Services To Homeless And Rural Populations.

OUTREACH TO HOMELESS

The Homeless Population in Illinois

The IDHS Emergency Food and Shelter (EF&S) program issues an annual report that reviews trends in services provided to homeless persons in Illinois. See the Adult-Outreach to Homeless Section. The Annual Emergency Food & Shelter Report noted that in FY2008, 6,280 households with children accounted for 12,559 participants under the age of 18 (27.6% of the total served) of which 51.4% (6,458) ranged from newborn infants through five years of age (14.22% of the total number of individuals served). Combined with the 18 - 21 age group (2,914) 34% of the homeless persons served by the EF&S program were under the age of 22. Income as a precipitator of homelessness was reported by 27.4% of the households of females with children and by 38% of homeless couples with children. Eviction was the most common reason given by these households as the primary cause of their homelessness. Of the 6,946 homeless households that cited reasons for homelessness related to family and neighborhood (overcrowded conditions, domestic violence, gang violence, and disputes with neighbors and landlords), over one third (2,360) were single females with children.

Mental health planning and services to homeless youth is complicated by the inherent invisibility of this population as well as the priority of meeting their basic needs when they are reachable. Likewise, homeless families are not exempt from the problems presented by their children with severe emotional disturbance but these are often overshadowed by the urgency of meeting the family's survival needs. Over the years, workgroups have been convened which consisted of homeless youth service/shelter providers and DMH-funded mental health providers to identify barriers to effective services for this client group. The IDHS maintains services to homeless youth who are 20 years of age or younger and cannot return home and/or lack the housing and skills necessary to live independently. The Homeless youth program is administered by community-based agencies and is available in 34 Illinois counties and the Chicago Metropolitan Area. The IDHS-funded programs provide these important services for homeless youth:

- **Emergency/Interim Housing:** Either through placement in a shelter, group home or by purchasing lodging, youth are given a safe, clean, dry place to sleep.

- **Transitional Living:** Focus on skills necessary to support oneself, including education, employment services, and subsidized housing.

- **Outreach:** Programs seek to find homeless youth and assess their needs. Program staff may attempt to reunite them with family or refer them to transitional services.

In FY2008, 21 Homeless Youth providers served approximately 690 youth, ages 14-20 in their emergency shelters and transition living programs. An additional 55 youth were reportedly served in the Homeless Youth Outreach programs across the state. The
program was funded at $4.9 million in FY2008. Each youth is assessed for needs and strengths and a case plan is developed for service provision that includes case management, provision of food and shelter, life skills training, employment assistance, advocacy, education assistance, and parenting skills. Mental health services are accessed when needed.

Homeless youth/shelter providers have worked successfully with mental health service providers in several areas of Illinois. SASS agencies in Rockford and East St. Louis continue to work closely with shelters, usually providing an initial mental health assessment, crisis intervention service, and mental health case management.

Services In the Metropolitan Chicago Area:
Beacon Therapeutic Center's Shelter Outreach Services (S.O.S.) program utilizes a wraparound service delivery model which focuses on trauma informed, strengths based intervention with children and parents in the shelter setting and provides targeted case management and mental health services to women and children in 22 shelters on the south, north, and west sides of Chicago. Services focus on the identification of untreated mental illness, developmental delays, substance abuse, needs assessment, advocacy, coordination services and follow-up supportive services. Mental health services are intensive and include crisis services, assessment, referral and linkage. All services are community based and linkages are made with programs designed to intervene with young children. The intervention team consists of qualified mental health professionals and case managers. Ancillary staff includes a child psychiatrist, psychologists, health educator, child development specialists, and other mental health.

This program is exemplary in that it has actively focused available resources to meet the needs of the homeless children it serves. The United Way has provided funding to establish a “medical home” model of service for the children aged 3 to 5 and their families in the program. This has resulted in outreach to homeless families with young children requiring medical care and referral and linkage with health providers who follow up on the health needs of the child. The program participates in a group of nine providers statewide who are receiving early childhood consultation services (See Objective C3.5 in Section 3) which has allowed for some sharing of interventions and approaches unique to homeless children with mental health providers. Beacon Therapeutic School’s Shelter Outreach Service reports that it served 1900 (rounded figure) homeless children and 850 homeless families residing in Chicago shelters during FY2008. The program found and secured appropriate permanent housing for 268 families through its case management services.

Tracking Mental Health Services to Homeless Youth
A System Performance Indicator was created in FY1999 to track the number of homeless youth entering community-based services in the public mental health service system. In FY2008 293 youth were reported as homeless at point of entry to community-based services. This performance indicator is now a national outcome measure and is titled: Increased Stability in Housing-Percent of Child/Adolescent Clients who are Homeless or Living in Shelters This measure permits an initial evaluation of the system’s ability to provide access to mental health services for runaway youth and children in families who are homeless and who have serious emotional disturbances.
Illinois

Child - Rural Area Services

Child - Describes how community-based services will be provided to individuals in rural areas
RURAL AREA SERVICES

The term "rural" in Illinois is used to refer to residents in 76 non-Metropolitan Statistical Area (MSA) counties and residents not in municipalities of 25,000 or larger. (Rural Revitalization: The Comprehensive State Policy For the Future, Governor's Rural Affairs Council, April, 1990 pp. 2-4) Based on Illinois' definition of rural areas, 76 non-metropolitan counties are being targeted for assessment of the mental health needs of residents, evaluation of current services and programs, and the identification and eventual resolution of problems in service delivery unique to rural environments. The DMH is a member of the Governor’s Rural Affairs Council and provides the mental health perspective on rural issues. The Council provides an opportunity to network with a variety of state government agencies and community institutions, which can support mental health services for youth in rural areas.

Available Services In Rural Areas

The establishment of SASS programs in rural areas has addressed the need for family-based crisis intervention and intensive mental health services to rural families and has been of inestimable value to families of youth with serious emotional disturbances. Since FY1997, when SASS services were made available in all 76 rural counties through the addition of 23 new programs in Southern Illinois, the problem solving encountered by SASS programs and the local area networks in these areas in delivering services has provided valuable information for strategic service planning of services in rural settings.

Accompanying the SASS expansion in the rural areas of Illinois, the CCSRs serving these areas have undertaken the planning and coordination of services for families with children and youth having serious emotional disturbances. Agencies that were pocketed in isolation now network with other child-serving agencies. There has also been increasing emphasis on the unique and central function of schools as networking partners in the process of improving access and availability of services to rural families.

Mental Health Services to Youth Residing in Rural Areas

DMH continues to focus on increasing access to child psychiatry for children/adolescents residing in rural areas. We continue to track the number of rural youth served (see System Performance Indicator titled: Rural Residents Served: C&A which provides the number of children being served by DMH-funded community-based providers who are residents of rural areas at the time of entry into services. (Goals, Targets, Action Plans section)

The C&A population of the 76 Illinois counties designated as rural was 471,894 according to 2000 census figures, yielding a mental health prevalence estimate of 33,032 (at 7%). In FY 1999, 9,294 individuals under 18 years old who live in the above 76 rural counties received DMH funded services. There appears to be a recent trend toward increased access of services by this population as 10,247 youth received services in FY2005, 11,014 in FY2006, 11,590 in FY2007, and 12,430 in FY2008.

Child Psychiatry Consultation Program

DMH Central and Southern regional staff have worked closely with community providers to enhance child expertise and to reconfigure SASS (Screening, Assessment and Support Services) to meet the needs of children and adolescents residing in rural areas. The
reconfiguration of services has focused on the provision of services by providers closely tied to these communities, and the use of a consultative model to ensure that a Child Psychiatrist is available to the community psychiatrist when no child psychiatric services are available. Two strategies have been undertaken to address the shortage of child psychiatrists: (1) Both Regions have applied for designation as professional shortage areas for child psychiatry and (2) The statewide DMH Deputy Director for child and adolescent services, who is a Child Psychiatrist, has been working with the American Academy of Child Psychiatry to recruit board eligible child psychiatrists to provide services in these regions.

Providing consultative services to local program staff has provided an innovative vehicle for supporting the delivery of services in the state’s foremost rural regions while efforts to recruit psychiatric staff are underway. The Child and Adolescent Training Institute at the University of Illinois in Chicago implemented a program of child psychiatry consultation through the use of video-conferencing. This program, which began in March of 2002, matched three child and adolescent psychiatrists from urban areas to three rural community mental health centers that have very limited access to child and adolescent psychiatrists. Over the course of several years, child psychiatrists at the University of Illinois have performed many psychiatric consultations. This program has been highly valued by participating community mental health centers.

In FY2008, DMH budgeted approximately $300,000 for a pilot project which allows six agencies to each purchase $50,000 of qualified psychiatric consultation time to be provided through a Tele-Psychiatry approach ranging from informal case discussions to formal case reviews, and a telemedicine approach in which the child is present for assessment. The Tele-psychiatry initiative was established in Regions 4 and 5. Six agencies are now involved in the two regions. The project was awarded in February 2008 to Aunt Martha's Youth Services as the vendor. Services include assessment, treatment and ongoing monitoring of youth. The equipment was purchased and the t1 lines were installed. Actual services began in July 2008 and a total of 161 individuals have been served since the beginning of the fiscal year.

**Objective C4.1:** Continue to implement telepsychiatry services in six rural sites in Illinois. Establish baseline for service utilization and assess the need for further enhancement and expansion in FY2010.

**Indicator:**
- Number of youth served FY2010
- Number of psychiatry hours provided in FY2010.
Child - Resources for Providers

Child - Describes financial resources, staffing and training for mental health services providers necessary for the plan;
RESOURCES FOR PROVIDERS
The DMH continues to work towards an integrated system of care that includes both state hospitals and community-based providers, including those responsible for emergency health services regarding mental health. There are 124 child-serving agencies in Illinois. In this section, initiatives to enhance financial resources and human resources for children and adolescents including significant achievements are described. There is also a brief analysis of the systems strengths, needs and priorities.

Enhancing Financial Resources
See the ADULT- RESOURCES FOR PROVIDERS Section for a discussion of this topic and a discussion of Federal Financial Participation (FFP) which are applicable to both adults and children.

Increasing Financial Resources For The Child And Adolescent Population
The DMH and its partners have been successful in increasing financial resources to provide/purchase services for children and adolescents and their families through several sources. The system of care grant awarded by SAMHSA CMHS to McHenry County in FY 2005 was also funded at $9 million dollars per year over a six year period. The McHenry SOC will continue through FY2011. In FY2008, $6.5 million dollars has been allocated for mental health services for children and adolescents through a partnership with the Illinois Children’s Mental Health Partnership.

Enhancing Human Resources
Human resource development is critical in terms of supporting community-based services for adults with serious mental illness and children with serious emotional disturbance and their families.

Activities Related to Human Resource Development
The DMH has contracted with the University of Illinois at Chicago Department of Psychiatry to oversee the implementation of a Statewide Child and Adolescent Training Initiative. Three training modules have been presented at seven locations in the State with over 2000 attendees. Two significant outcomes have resulted: (1) telepsychiatry consultation has been introduced in some of the states rural areas (See Criterion 4) and (2) work with community mental-health trade organizations and the University of Illinois at Chicago on the development of a curriculum geared towards the needs of persons with Bachelors and Masters degrees was completed. The curriculum was promoted and marketed to both the academic and provider communities. The DMH Statewide C&A staff continue to collaborate with the University of Illinois on these efforts as well as others.

Another initiative to help enhance the competencies of C&A service providers is the provision of education and training in Evidenced Informed Practices and consultation to child and adolescent providers. These efforts are expected to continue and NET-Learning will be initiated in FY2010. (See Child- Establishment of a System of Care-Objective C1.3 for detailed information) A training initiative for mental health providers on working with children who have experienced trauma is currently being developed in collaboration with the Department of Children and Family Services. Training on WRAP for providers who work with teens is ongoing. There are three agencies piloting WRAP
in Chicago, one in LaSalle, the forensic adolescent inpatient unit in Springfield, and a sixth agency in southeastern Illinois will be trained this year.

The DHS Division of Mental Health continues to work towards an integrated system of care that includes both state hospitals and community-based providers, including those that are responsible for emergency health services regarding mental health.
Illinois

Child - Emergency Service Provider Training

Child - Provides for training of providers of emergency health services regarding mental health;
EMERGENCY SERVICE PROVIDER TRAINING

Mental Health and Law Enforcement Training

The DMH regularly collaborates with law enforcement agencies and emergency services at general hospitals to facilitate appropriate and effective psychiatric intervention to persons in crisis. This training is applicable to both adults and children and a description can be found in Adult-Emergency Service Provider Training section.

Disaster Response: Emergency Health Services

As reported in the Adult Section of this application, the Governor has designated the DMH as the lead State agency for disaster resource coordination, training and recovery functions related to mental health. Working in the collaborative context of the overall Statewide Disaster Plan, DMH is coordinating Illinois’ disaster preparedness for state operated and state funded psychiatric service entities. Disaster response for families and mental health services for children and youth are the responsibility of DMH in collaboration with other child-serving state agencies.
Illinois

Child - Grant Expenditure Manner

Child - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved
GRANT EXPENDITURE MANNER

Allocation Of Block Grant Dollars In FY2009

Allocations of Block Grant dollars to specific agencies for service provision are displayed in Table 10 which is appended. The Illinois plan for the expenditure of the FY2010 Community Mental Health Services Block Grant is directed at providing services in community settings for adults with serious mental illness and children and adolescents with serious emotional disturbances. The Illinois block grant fund amount for FY2010, based on projections from FY2009 is $16,023,807. Please note however that the grant awards to community providers represent the best known information available as per their issuance in July of 2009. The state budget as appropriated and approved reflects the FY 2009 level of award continuing to be provided. Administrative expenses, which are capped at 5%, amount to $801,190. In FY2009, block grant dollars were allocated (for adults and children combined) as follows:

- Community Consumer Support - $3,373,678
- Psychiatrist Services In Mental Health Centers (Psychiatric Leadership)- $11,566,916.00
- Special Projects - $180,000.00

A table detailing allocation of dollars to agencies providing services to adults and children has been included in the appendix.

Approximately 23% of block grant funds are allocated to C&A Services For FY2010, block grant funds will be directed toward the following community-based services for youths with serious emotional disturbances: psychiatric services and crisis services. The child and adolescent funding allocation of mental health block grant dollars is consistent with the State Mental Health Plan for Children and Adolescents.

PERFORMANCE INDICATORS GOALS, TARGETS, AND ACTION PLANS

SEE SECTION ON PERFORMANCE INDICATORS (SEPARATE DRAFT)
**Name of Performance Indicator:** Increased Access to Services (Number)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1) FY 2007 Actual</th>
<th>(2) FY 2008 Actual</th>
<th>(3) FY 2009 Projected</th>
<th>(4) FY 2010 Target</th>
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**Goal:** Increase access to services

**Target:** Maintain access to services for children/adolescents with mental illnesses at the FY 2008 level.
(Note: FY2009 data not available; targets are based on FY 2008 data.)

**Population:** Children and adolescents with emotional and serious emotional disturbances

**Criterion:**
1. Mental Health System Data Epidemiology
2. Children’s Services

**Indicator:** Number of child/adolescents receiving services from DMH-funded community-based providers.

**Measure:** Number of child/adolescents receiving services from DMH-funded community-based providers.

**Sources of Information:**
DMH ASO Community Reporting System. This indicator is generated from URS Table 2A and 2B.

**Special Issues:**
The DMH Fiscal Year 2010 community mental health services budget has been cut by 8% or approximately 42 million dollars. The impact on programs/services was described in the mental health block grant plan narrative. Because of the draconian nature of these cuts, DMH is not projecting an increase in access to programs.

**Significance:** Services should be accessible to children and adolescents with mental health needs.

**Action Plan:**
DMH community funded providers by contract must submit registration and claims data for all individuals receiving services funded using DMH dollars. Data is submitted daily or weekly to the Community Reporting System maintained by the DMH’s Administrative Services Organization (ASO), the Illinois Mental Health Collaborative for Access and Choice. Once this data is processed, it is then transferred to the DMH Data Warehouse for storage. This information is then used to develop reports. FY 2009 data will be reported in the FY 2009 Implementation Report.
Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

<table>
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<td>80</td>
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</tbody>
</table>

Table Descriptors:
Goal: To decrease readmissions of individuals to state hospitals within 30 days by providing treatment that results in sufficient clinical stabilization such that subsequent treatment is provided in the least restrictive setting.

Target: Maintain or decrease 30 day readmission rates of children and adolescents to DMH state hospitals

Population: Children and adolescents with serious emotional disturbances.

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems 3: Children's Services

Indicator: Decreased rate of civil readmissions to state psychiatric hospitals within 30 days.

Measure: Numerator: Number of civil readmissions to any state hospital within 30 days Denominator: Total number of civil discharges in the year

Sources of Information: DMH Inpatient Clinical Information System (ICIS).

Special Issues: The Illinois DMH contracts the majority of inpatient services for children and adolescents to community hospitals, therefore the number of admissions and readmissions reported are very small. Data for private hospitals is not collected for the Inpatient Clinical Information System.

Significance: Individuals with mental illnesses should receive services in the least restrictive settings possible. However, there are times when access to inpatient services is required. Treatment provided in these settings however should not result in an individual's return to the inpatient setting within a short period of time.

Action Plan: DMH will continue to monitor the number of Children and adolescents readmitted to state hospitals within 30 days of discharge with a FY 2010 goal of maintaining or decreasing the level of re-hospitalization by maintaining services in the community that provide alternatives to re-hospitalization. As noted above, this information is entered into the DMH ICIS.
**Name of Performance Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

<table>
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<tr>
<td>Denominator</td>
<td>94</td>
<td>80</td>
<td>--</td>
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</tr>
</tbody>
</table>

**Goal:** To encourage assurance of sufficient clinical stabilization of individual from the state hospital though planning and preparation of post-hospital community-based mental health services prior to being discharged.

**Target:** Maintain or decrease level of readmission rate to state hospitals within 180 days (Note: targets are based on FY 2008 indicator value as FY 2009 data is not yet available.)

**Population:** Children and adolescents with serious emotional disturbances.

**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

**Indicator:** Decreased rate of civil readmissions to state psychiatric hospitals within 180 days.

**Measure:**
Numerator: Number of civil readmissions to any state hospital within 180 days
Denominator: Total number of civil discharges in the year

**Sources of Information:** Inpatient Clinical Information System.

**Special Issues:**
The Illinois DMH contracts the majority of inpatient services for children and adolescents to community hospitals, therefore the number of admissions and readmissions reported are very small. Data for private hospitals is not collected for the Inpatient Clinical Information System.

**Significance:**
Individuals with mental illnesses should receive services in the least restrictive settings possible. However, there are times when access to inpatient services is required. Treatment provided in these settings however should not result in an individuals return to the inpatient setting within a short period of time.

**Action Plan:**
DMH will continue to monitor the number of Children and adolescents readmitted to state hospitals within 180 days of discharge with a FY 2010 goal of maintaining or decreasing the level of re-hospitalization by maintaining services in the community that provide alternatives to re-hospitalization. As noted above, this information is entered into the DMH ICIS.
CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑ Indicator Data Not Applicable

Name of Performance Indicator: Evidence Based - Number of Practices (Number)

<table>
<thead>
<tr>
<th>(1) Fiscal Year</th>
<th>(2) FY 2007 Actual</th>
<th>(3) FY 2008 Actual</th>
<th>(4) FY 2009 Projected</th>
<th>(5) FY 2010 Target</th>
<th>(6) FY 2011 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Indicator</td>
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<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Numerator</td>
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</tr>
<tr>
<td>Denominator</td>
<td>N/A</td>
<td>N/A</td>
<td>--</td>
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<td>--</td>
</tr>
</tbody>
</table>

Table Descriptors:

Goal: DMH currently has no plans to implement and track the EBPs that are part of the National Outcome Measures - Not Applicable

Target: DMH is not currently implementing the EBPs that are part of the National Outcome Measures

Population: Children with serious emotional disturbances

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: Number of Child/Adolescent EBPs implemented

Measure: Number of Child/Adolescent EBPs implemented

Sources of Information: Not Applicable

Special Issues: The DMH is focusing on an Evidenced Informed Practice approach that is described in the narrative. As such, the EBPs identified as NOMS are not being implemented in Illinois.

Significance: DMH is not currently implementing the EBPs that are part of the National Outcome Measures

Action Plan: DMH is not currently implementing the EBPs that are part of the National Outcome Measures
Transformation Activities: □ Indicator Data Not Applicable.

Name of Performance Indicator: Evidence Based - Children with SED Receiving Therapeutic Foster Care (Percentage)

<table>
<thead>
<tr>
<th></th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Year</td>
<td>FY 2007 Actual</td>
<td>FY 2008 Actual</td>
<td>FY 2009 Projected</td>
<td>FY 2010 Target</td>
<td>FY 2011 Target</td>
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</tr>
<tr>
<td>Performance Indicator</td>
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</tr>
<tr>
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<td>N/A</td>
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</tr>
</tbody>
</table>

Table Descriptors:

Goal: Not Applicable. Illinois is not implementing this EBP.
Target: The DMH is not currently planning to implement therapeutic foster care.
Population: Children and adolescents with serious emotional disturbances.
Criterion: 1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services
Indicator: Number of children and adolescents receiving therapeutic foster care
Measure: Number of children and adolescents receiving therapeutic foster care
Sources of Information:

Special Issues: Foster care is provided through the state welfare agency. The DMH does not anticipate that it will implement this EBP.

Significance:

Action Plan: The DMH has no current plans to implement therapeutic foster care as this service would be administered by the state child welfare agency.
**Transformation Activities:** [ ] Indicator Data Not Applicable

**Name of Performance Indicator:** Evidence Based - Children with SED Receiving Multi-Systemic Therapy (Percentage)

<table>
<thead>
<tr>
<th></th>
<th>(1) Fiscal Year FY 2007 Actual</th>
<th>(2) FY 2008 Actual</th>
<th>(3) FY 2009 Projected</th>
<th>(4) FY 2010 Target</th>
<th>(5) FY 2011 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Indicator</td>
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<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Numerator</td>
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</tr>
<tr>
<td>Denominator</td>
<td>N/A</td>
<td>N/A</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

**Table Descriptors:**

**Goal:** NOT APPLICABLE. DMH has no plans to implement multi-systemic family therapy in Illinois.

**Target:** None. The DMH is not currently providing this EBP.

**Population:** Children and adolescents requiring multi-systemic therapy.

**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

**Indicator:** Number of children/adolescents receiving multi-systemic therapy

**Measure:** Number of children/adolescents receiving multi-systemic therapy

**Sources of Information:**

**Special Issues:** The DMH is not currently implementing multi-systemic therapy. Rather it is focusing on evidence-informed practices.

**Significance:**

**Action Plan:** While multi-systemic therapy is practiced by a few child serving agencies, the DMH is not currently implementing multi-systemic therapy with children. DMH is focusing on evidence-informed practices.
CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: □ Indicator Data Not Applicable.

Name of Performance Indicator: Evidence Based - Children with SED Receiving Family Functional Therapy (Percentage)

<table>
<thead>
<tr>
<th>(1) Fiscal Year</th>
<th>(2) FY 2007 Actual</th>
<th>(3) FY 2008 Actual</th>
<th>(4) FY 2009 Projected</th>
<th>(5) FY 2010 Target</th>
<th>(6) FY 2011 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Indicator</td>
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<td>N/A</td>
<td>N/A</td>
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</tr>
<tr>
<td>Numerator</td>
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<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Denominator</td>
<td>N/A</td>
<td>N/A</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

Table Descriptors:

Goal: NOT APPLICABLE. DMH has no plans to implement this EBP.

Target: None. the DMH is not currently implementing this EBP.

Population: Children and adolescents with serious emotional disturbances.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services

Indicator: Number of children/adolescents receiving family functional therapy

Measure: Number of children/adolescents receiving family functional therapy

Sources of Information:

Special Issues: DMH is focusing on evidence informed practices and has no specific plans to implement family functional therapy at this time.

Significance:

Action Plan: The DMH has no plans at this time to implement family functional therapy as it is focusing its effort on evidence-informed practices.
**Name of Performance Indicator:** Client Perception of Care (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(2) FY 2007 Actual</th>
<th>(3) FY 2008 Actual</th>
<th>(4) FY 2009 Projected</th>
<th>(5) FY 2010 Target</th>
<th>(6) FY 2011 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Indicator</td>
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<tr>
<td>Numerator</td>
<td>277</td>
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<tr>
<td>Denominator</td>
<td>501</td>
<td>426</td>
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</tr>
</tbody>
</table>

**Table Descriptors:**

**Goal:** To assess the percentage of caregivers of children served by the DMH-funded community-based mental health service system that report positively about outcomes for children and adolescents receiving services.

**Target:** Increase by 3% the percentage of caregivers reporting positive outcomes for their children/adolescents receiving DMH funded mental health services. (Please note that targets are based on FY 08 actual data as FY09 data is not available.

**Population:** Parents/caregivers of children/adolescents receiving DMH funded mental health services.

**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems
3: Children’s Services

**Indicator:** Percent of Families Reporting Positively About Outcomes

**Measure:**
Numerator: Number of caregivers reporting positively about outcomes of treatment
Denominator: Total number of family responses regarding perceptions of outcomes

**Sources of Information:** This data is derived from the Youth Services Survey and is reported on URS Table 11.

**Special Issues:** DMH currently only surveys caregivers of youth 11 and younger due to concerns of maintaining confidentiality of youth 12 to 17.

**Significance:** Individuals receiving treatment should have positive outcomes for treatment.

**Action Plan:** As in previous fiscal years, DMH will select a random stratified sample of individuals receiving treatment in June 2009. This sample will be the basis for the survey which will be disseminated in October 2009 with a goal of all data collected by early November. DMH staff will strive to complete the analysis by the implementation report due date, however data may not be readily available until January 2010.
CHILD - GOALS TARGETS AND ACTION PLANS

**Name of Performance Indicator:** Child - Return to/Stay in School (Percentage)

<table>
<thead>
<tr>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
<th>(6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Year</td>
<td>FY 2007 Actual</td>
<td>FY 2008 Actual</td>
<td>FY 2009 Projected</td>
<td>FY 2010 Target</td>
<td>FY 2011 Target</td>
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<td>Performance Indicator</td>
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<td>Numerator</td>
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</tr>
<tr>
<td>Denominator</td>
<td>75</td>
<td>179</td>
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</tr>
</tbody>
</table>

**Transformation Activities:**

**Table Descriptors:**

**Goal:** Monitor school attendance of children/adolescents with serious emotional disturbances receiving mental health treatment

**Target:** No target specified due to low response rate and developmental nature of the indicator. Please note that no target was projected for FY 09 as well.

**Population:** Children and adolescents with emotional and serious emotional disturbances.

**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

**Indicator:** Percent of parents reporting improvement in child's school attendance.

**Measure:**
Numerator: Number of parents reporting improvement in child's school attendance. (Both new and continuing clients).
Denominator: Total responses (excluding not available) new and continuing clients combined

**Sources of Information:**
Annual Youth Services Survey

**Special Issues:**
Currently the data is derived from questions included on the Annual Youth Services Survey conducted by DMH. DMH is not projecting targets due to the response rate for this variable as well as the developmental nature of the indicator.
DMH currently only surveys caregivers of youth 11 and younger due to concerns of maintaining confidentiality of youth 12 to 17.

**Significance:** Children/adolescents with ED/SED should benefit from receiving mental health services

**Action Plan:**
As in previous fiscal years, DMH will select a random stratified sample of individuals receiving treatment in June 2009. This sample will be the basis for the survey which will be disseminated in October 2009 with a goal of all data collected by early November. DMH staff will strive to complete the analysis by the implementation report due date, however data may not be readily available until January 2010.
Name of Performance Indicator: Child - Decreased Criminal Justice Involvement (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>FY 2007 Actual</th>
<th>FY 2008 Actual</th>
<th>FY 2009 Projected</th>
<th>FY 2010 Target</th>
<th>FY 2011 Target</th>
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</thead>
<tbody>
<tr>
<td>Performance Indicator</td>
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<td>Denominator</td>
<td>3</td>
<td>110</td>
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</tr>
</tbody>
</table>

Table Descriptors:
Goal: Monitor Juvenile Justice Involvement for children/adolescent who have forensic issues and who are receiving mental health treatment

Target: Data for this indicator was collected in 2008, however due to the developmental nature of the measure and the low response rate we have elected not to set a target for 2010. Please note that no target was projected for FY09.

Population: Children/adolescents with serious emotional disturbances who are involved with the justice system and who are receiving mental health services

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

Indicator: Percent of children/youth consumers arrested in Year 1 who were not rearrested in Year 2.

Measure: Numerator: Number of children/youth consumers arrested in T1 who were not rearrested in T2 (new and continuing clients) Denominator: Number of children/youth consumers arrested in T1 (new and continuing clients combined).

Sources of Information: Youth Services Survey for Families (Caregivers)

Special Issues: This indicator is still developmental; as such DMH is not projecting targets.

DMH currently only surveys caregivers of youth 11 and younger due to concerns of maintaining confidentiality of youth 12 to 17.

Significance: The provision of mental health services should have an impact on the outcomes for children/adolescents involved in the justice system.

Action Plan: As in previous fiscal years, DMH will select a random stratified sample of individuals receiving treatment in June 2009. This sample will be the basis for the survey which will be disseminated in October 2009 with a goal of all data collected by early November. DMH staff will strive to complete the analysis by the implementation report due date, however data may not be readily available until January 2010.
Name of Performance Indicator: Child - Increased Stability in Housing (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Performance Indicator</th>
<th>(1) FY 2007 Actual</th>
<th>(2) FY 2008 Actual</th>
<th>(3) FY 2009 Projected</th>
<th>(4) FY 2010 Target</th>
<th>(5) FY 2011 Target</th>
<th>(6)</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>.83</td>
<td>.77</td>
<td>.83</td>
<td>.77</td>
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<tr>
<td>Numerator</td>
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<td>293</td>
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<tr>
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<td>35,684</td>
<td>37,859</td>
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</tr>
</tbody>
</table>

Table Descriptors:

Goal: Increase stability in housing by reducing number of children who are homeless/living in shelters. Indicator specifies increase however, it is currently only a snapshot of consumer's status at admission; thus we would not project an increase.

Target: Track percentage of children who are homeless or living in shelters. This data is collected at one point in time at intake prior to treatment. Note that FY 2010 are based on FY 08 actual as FY 09 data is not available.

Population: Children/adolescents with emotional or serious emotional disturbances who are homeless or living in shelters

Criterion:

1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

Indicator: Percent of Child/Adolescent clients who are homeless or living in shelters.

Measure: Numerator: Number of child/adolescent clients who are homeless or living in shelters.

Denominator: All child adolescent clients with living situation excluding persons with Living Situation Not Available.

Sources of Information:
DMH ASO Community Reporting System.

Special Issues: The data currently reported is point in time and only reflects youth status at intake/admission. Currently there is not a mechanism to track change over time, thus at this point DMH can only report status at intake.

Significance: Children/adolescents with emotional and serious emotional disturbances should have a stable living environment.

Action Plan: DMH community funded providers by contract must submit registration and claims data for all individuals receiving services funded using DMH dollars. Data is submitted daily or weekly to the Community Reporting System maintained by the DMH’s Administrative Services Organization (ASO), the Illinois Mental Health Collaborative for Access and Choice. Once this data is processed, it is then transferred to the DMH Data Warehouse for storage. This information is then used to develop reports. During the past year, DMH established a policy requiring providers to update this information on a bi-annual basis. Once it has been determined that the quality of the data is good, DMH will begin to report change data for this variable.
**Transformation Activities:**

**Name of Performance Indicator:** Child - Increased Social Supports/Social Connectedness (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>FY 2007 Actual</th>
<th>FY 2008 Actual</th>
<th>FY 2009 Projected</th>
<th>FY 2010 Target</th>
<th>FY 2011 Target</th>
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<td>Denominator</td>
<td>501</td>
<td>417</td>
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</tr>
</tbody>
</table>

**Table Descriptors:**

**Goal:** Monitor caregivers perception that their child's social connectedness has improved as a result of participating in treatment.

**Target:** Developmental Measure - No target established

**Population:** Children/adolescents with serious emotional disturbances

**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

**Indicator:** Percent of families reporting positively about social connectedness.

**Measure:**
Numerator: Number of families of child/adolescent consumers reporting positively about social connectedness.
Denominator: Total number of family responses regarding social connectedness.

**Sources of Information:** Youth Services Survey for Families (Caregivers)

**Special Issues:**
Currently the data is derived from questions included on the Annual Youth Services Survey conducted by DMH. DMH is not projecting targets due to the response rate for this variable as well as the developmental nature of the indicator.
DMH currently only surveys caregivers of youth 11 and younger due to concerns of maintaining confidentiality of youth 12 to 17.

**Significance:** Treatment should result in positive outcomes for children.

**Action Plan:** As in previous fiscal years, DMH will select a random stratified sample of individuals receiving treatment in June 2009. This sample will be the basis for the survey which will be disseminated in October 2009 with a goal of all data collected by early November. DMH staff will strive to complete the analysis by the implementation report due date, however data may not be readily available until January 2010.
**Name of Performance Indicator:** Child - Improved Level of Functioning (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Performance Indicator</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
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<td>FY 2008 Actual</td>
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<td>FY 2009 Projected</td>
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<td>FY 2010 Target</td>
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<td>--</td>
</tr>
<tr>
<td>FY 2011 Target</td>
<td>N/A</td>
<td>--</td>
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</tr>
</tbody>
</table>

**Table Descriptors:**

**Goal:**
Increase caregivers' perception of functioning of children as a result of treatment.

**Target:**
No target established for FY09 as there was no basis for establishing. FY10: Maintain or increase caregivers' perception of functioning of children receiving treatment.

**Population:**
Children and adolescents with emotional/serious emotional disturbances.

**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems
2: Children's Services
3: Targeted Services to Rural and Homeless Populations

**Indicator:**
Percent of families reporting positively about functioning.

**Measure:**
Numerator: Number of families of child/adolescent consumers reporting positively about functioning.
Denominator: Total number of family responses regarding functioning.

**Sources of Information:**
Annual Youth Services Survey for Families (Caregivers)

**Special Issues:**
Currently the data is derived from questions included on the Annual Youth Services Survey conducted by DMH. DMH is not projecting targets due to the response rate for this variable as well as the developmental nature of the indicator. DMH currently only surveys caregivers of youth 11 and younger due to concerns of maintaining confidentiality of youth 12 to 17.

**Significance:**
Treatment should result in positive outcomes for children.

**Action Plan:**
As in previous fiscal years, DMH will select a random stratified sample of individuals receiving treatment in June 2009. This sample will be the basis for the survey which will be disseminated in October 2009 with a goal of all data collected by early November. DMH staff will strive to complete the analysis by the implementation report due date, however data may not be readily available until January 2010.
**Name of Performance Indicator:** CORRECTIONS HISTORY - C&A

<table>
<thead>
<tr>
<th>(1)</th>
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<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
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<tbody>
<tr>
<td>Fiscal Year</td>
<td>FY 2007 Actual</td>
<td>FY 2008 Actual</td>
<td>FY 2009 Projected</td>
<td>FY 2010 Target</td>
<td>FY 2011 Target</td>
</tr>
<tr>
<td>Performance Indicator</td>
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<td>1</td>
<td>N/A</td>
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<tr>
<td>Numerator</td>
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<td>456</td>
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</tr>
<tr>
<td>Denominator</td>
<td>37,773</td>
<td>40,313</td>
<td>--</td>
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</tr>
</tbody>
</table>

**Table Descriptors:**

**Goal:**
To track forensic status of children and adolescents served by the Illinois Mental Health system.

**Target:**
Forensic population expected to remain relatively constant at approximately 1%.

**Population:**
Children and Adolescents with serious emotional disturbances.

**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems

**Indicator:**
Percentage of children and adolescent clients reporting involvement with the Department of Corrections/Juvenile Justice at the time of case opening.

**Measure:**
Numerator: Number of children and adolescents reported as Department of Corrections clients (e.g. probation, parole) at the time of case opening.
Denominator: Total number of children and adolescents served in the fiscal year.

**Sources of Information:**
DMH ASO Community Reporting System

**Special Issues:**

**Significance:**
Tracking this information helps to insure coordination of services between the mental health system and juvenile corrections.

**Action Plan:**
Community mental health staff track the number of children and adolescents who are forensic outpatients (0.8%), as well as those who are on probation or parole (a little over 1%) at the time of case opening. This data is collected as part of clinical assessments. DMH will continue to track these percentages in FY 2010.
Name of Performance Indicator: Co-Occurring Disorders C&A

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Performance Indicator</th>
<th>FY 2007 Actual</th>
<th>FY 2008 Actual</th>
<th>FY 2009 Projected</th>
<th>FY 2010 Target</th>
<th>FY 2011 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>1.05</td>
<td>1.10</td>
<td>1</td>
<td>1</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Denominator</td>
<td>395</td>
<td>456</td>
<td>--</td>
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<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

Table Descriptors:

Goal: To increase community-based mental health service for persons who have co-occurring disorders of mental illnesses and substance use.

Target: The target for this indicator is expected to remain at approximately 1%.

Population: Children and adolescents with serious emotional disturbances and co-occurring substance use disorders.

Criterion: 3: Children's Services

Indicator: Percentage of Child and Adolescents (C&A) served with a mental illness and substance use diagnosis.

Measure: Numerator: Number of clients served in the community with a substance abuse diagnosis.

Denominator: Total number of all child and adolescents receiving services.

Sources of Information:

Special Issues: There is underreporting for this population because many mental health professionals prioritize mental health issues as principle treatment concern in reporting to the state mental health authority.

Significance: Many individuals with serious mental illnesses and emotional disturbances have co-occurring substance abuse disorders.

Action Plan: DMH will continue to track this information in FY 2010 with a goal of increasing the capacity for identification of dually diagnosed youth.
Name of Performance Indicator: ELIGIBLE POPULATION - C&A

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1) FY 2007 Actual</th>
<th>(2) FY 2008 Actual</th>
<th>(3) FY 2009 Projected</th>
<th>(4) FY 2010 Target</th>
<th>(5) FY 2011 Target</th>
</tr>
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<tbody>
<tr>
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<td>88.40</td>
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</tr>
<tr>
<td>Denominator</td>
<td>37,773</td>
<td>40,313</td>
<td>--</td>
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<td>--</td>
</tr>
</tbody>
</table>

Table Descriptors:

Goal: To assure resources and services are provided to children and adolescents in the priority population of the public mental health system.

Target: Maintain percentage of children and adolescents receiving mental health services who meet eligibility requirements. Please note the target is based on FY08 actual as FY 09 data is not yet available.

Population: Children and adolescents with serious emotional disturbances

Criterion: 2: Mental Health System Data Epidemiology

Indicator: Percent of children and adolescents being served by DMH-funded community-based providers who meet the established criteria for “eligible population” at the time of entry into services.

Measure:
- Numerator: Number of children and adolescents being served by DMH-funded community-based providers who meet the established criteria for “eligible population” at the time of entry into services.
- Denominator: All children and adolescents being served by DMH-funded community-based providers.

Sources of Information: DMH ASO Community Reporting Services System

Special Issues:

Significance: This indicator is part of the monitoring process to insure that mental health services are accessible and accessed by those who need them most.

Action Plan: The DMH Fiscal Year 2010 community mental health services budget has been cut by 8% or approximately 42 million dollars. The impact on programs/services was described in the mental health block grant plan narrative. Because of the draconian nature of these cuts, DMH is not projecting an increase in access to programs. In FY 2010, DMH will continue to monitor access to services.
Name of Performance Indicator: FORENSIC OUTPATIENT-C&A

<table>
<thead>
<tr>
<th></th>
<th>(1) FY 2007 Actual</th>
<th>(2) FY 2008 Actual</th>
<th>(3) FY 2009 Projected</th>
<th>(4) FY 2010 Target</th>
<th>(5) FY 2011 Target</th>
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<td>Fiscal Year</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Performance Indicator</td>
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<td>1.20</td>
<td>.80</td>
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<tr>
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<td>483</td>
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<td>Denominator</td>
<td>37,773</td>
<td>40,313</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

Table Descriptors:

Goal: To track forensic status of children and adolescents served by the Illinois mental health system.

Target: Maintain the percent of children and adolescents with involvement in the juvenile justice system.

Population: Children and adolescents with serious emotional disturbances.

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of children and adolescent clients who had been court ordered into treatment due to not guilty by reason of insanity, found unfit to stand trial, or by criminal court at the time of case opening.

Measure: Numerator: Number of children and adolescent clients reported as unfit to stand a trial, not guilty by reason of insanity, criminal, or directed for court ordered treatment at the time of case opening. Denominator: Total number of children and adolescents served in the fiscal year.

Sources of Information:
DMH ASO Community Reporting Services System

Special Issues:

Significance: The service needs of this small but high risk group require that assessment and adequate services are provided and tracked.

Action Plan: DMH will continue to track these percentages in FY 2010.
Name of Performance Indicator: LIVING ARRANGEMENTS-C&A

<table>
<thead>
<tr>
<th></th>
<th>(1)</th>
<th>(2)</th>
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<th>(5)</th>
<th>(6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance Indicator</td>
<td>93.82</td>
<td>89</td>
<td>93</td>
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<td>Numerator</td>
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</tr>
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<td>40,313</td>
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<tr>
<td>Goal:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>To track demographic information on living arrangements for child and adolescent clients.</td>
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<tr>
<td>Target:</td>
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</tr>
<tr>
<td>Maintain percentage of children and adolescents with mental emotional disturbances who live in private residences. The target is based on FY 2008 actual data as FY 2009 data is not yet available.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Population:</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Children and adolescents with mental illness.</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Criterion:</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1:Comprehensive Community-Based Mental Health Service Systems</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Indicator:</td>
<td></td>
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</tr>
<tr>
<td>Percentage of children and adolescent clients living with parents or other relatives in private residences at the time of case opening.</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Measure:</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Numerator: Number of children and adolescents reported as living with parents or other relatives in private residence at the time of case opening.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Denominator: Total number of children and adolescents served in the fiscal year with known living arrangements.</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Sources of Information:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DMH ASO Community Reporting Services System</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Special Issues:</td>
<td></td>
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</tr>
<tr>
<td>Community mental health staff track living arrangements at intake for children and adolescents to assess service needs. At the time of case opening in FY 2008, the vast majority of children and adolescents lived with parents or other relatives in a private residence (89%). Nevertheless, services are needed to help those children who do not reside with their families.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Significance:</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Action Plan:</td>
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<td></td>
</tr>
<tr>
<td>DMH will continue track these percentages in FY 2010.</td>
<td></td>
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Name of Performance Indicator: RURAL RESIDENTS SERVED - C&A

<table>
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<th>Numerator</th>
<th>Denominator</th>
<th>(1)</th>
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<th>(3)</th>
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<td>FY 2007 Actual</td>
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<td>N/A</td>
<td>N/A</td>
<td>12,430</td>
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<td>FY 2009 Projected</td>
<td>12,000</td>
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</tr>
<tr>
<td>FY 2010 Target</td>
<td>12,000</td>
<td>--</td>
<td>--</td>
<td>N/A</td>
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</tr>
<tr>
<td>FY 2011 Target</td>
<td>N/A</td>
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</tr>
</tbody>
</table>

Table Descriptors:
Goal: To assure that children with emotional disturbances who reside in rural areas are accessing the DMH-funded community-based mental health service system.

Target: Maintain the number of children/adolescents residing in rural areas using telepsychiatry and other strategies.

Population: Children and adolescents with emotional disturbances who live in rural areas of the state.

Criterion: 4: Targeted Services to Rural and Homeless Populations

Indicator: Number of children being served by DMH-funded community-based providers who are residents of rural areas at the time of entry into services.

Measure: Number of children being served by DMH-funded community-based providers who are residents of rural areas at the time of entry into services.

Sources of Information: DMH ASO Community Services Reporting System

Special Issues:
Significance: The geography of rural areas adds challenges to the timely and consistent access to services for both service providers and persons with mental illness.

Action Plan: The DMH Fiscal Year 2010 community mental health services budget has been cut by 8% or approximately 42 million dollars. The impact on programs/services was described in the mental health block grant plan narrative. Because of the draconian nature of these cuts, DMH is not projecting an increase in access to programs. In FY 2010, DMH will continue to monitor access to services.
**Name of Performance Indicator:** SASS SERVICE HOURS IN COMMUNITY

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1) FY 2007 Actual</th>
<th>(2) FY 2008 Actual</th>
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<th>(4) FY 2010 Target</th>
<th>(5) FY 2011 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Indicator</td>
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<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Numerator</td>
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<tr>
<td>Denominator</td>
<td>N/A</td>
<td>N/A</td>
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</tr>
</tbody>
</table>

**Table Descriptors:**

**Goal:** To assure that a significant portion of services delivered within the SASS programs are provided in the most normalized settings possible in the individual’s community, rather than within the provider’s offices or clinics.

**Target:** A target is not set because the data source does not capture complete information at this point in time.

**Population:** Children and adolescents with serious emotional disturbances.

**Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems

**Indicator:** Percentage of children identified as members of the DMH “target” population being served by the DMH-funded community-based service system who receive SASS services.

**Measure:** Numerator: Number of hours of service provided by the DMH-funded SASS Programs which occur outside of the provider’s offices or clinics. Denominator: Total number of hours of service provided by the DMH-funded SASS Programs.

**Sources of Information:** DMH ASO Community Services Reporting System

**Special Issues:** This data is no longer reported directly to the DMH. Data was not available for FY 2005-FY 2009. DMH will retain this indicator as a placeholder because of its importance. We hope to reacquire the information in FY 2010.

**Significance:** SASS programs aim to provide services in the most normalized settings possible in the individual’s community, rather than within the provider’s offices or clinics.

**Action Plan:** DMH is still working to retrieve this information and is retaining this indicator as a placeholder pending re-requirement of this data as it is important to monitor delivery of these critical services.
Name of Performance Indicator: TARGET POPULATION - C & A

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
<th>(6)</th>
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</thead>
<tbody>
<tr>
<td>Performance Indicator</td>
<td>FY 2007 Actual</td>
<td>FY 2008 Actual</td>
<td>FY 2009 Projected</td>
<td>FY 2010 Target</td>
<td>FY 2011 Target</td>
<td></td>
</tr>
<tr>
<td>Numerator</td>
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<td>40</td>
<td>--</td>
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<tr>
<td>Denominator</td>
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<td>16,166</td>
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Table Descriptors:

Goal: To assure that resources and services are provided to children and adolescents in the priority population of the public mental health system.

Target: To maintain the percentage of child and adolescent mental health clients who have serious emotional disturbances receiving services.

Population: Children and adolescents with serious emotional disturbances.

Criterion: 2: Mental Health System Data Epidemiology

Indicator: Percentage of individuals being served by DMH-funded community-based providers who meet the established criteria for “target population” at the time of entry into services.

Measure:
- Numerator: Number of children and adolescents being served by DMH-funded community-based providers that meet the established criteria for “target population” at the time of entry into services.
- Denominator: All children and adolescents being served by DMH-funded community-based providers.

Sources of Information: DMH ASO Community Services Reporting System.

Special Issues:

Significance: Children and adolescents with severe emotional disturbances (SED) are the priority target for mental health services.

Action Plan: DMH aims to increase the proportion of children and adolescents served who meet the DMH criteria for the target population however, the DMH Fiscal Year 2010 community mental health services budget has been cut by 8% or approximately 42 million dollars. The impact on programs/services was described in the mental health block grant plan narrative. Because of the draconian nature of these cuts, DMH is not projecting an increase in access to programs. In FY 2010, DMH will continue to monitor access to services.
Ms. Barbara Orlando
Grants Management Office
Division of Grants Management, OPS, SAMHSA
1 Choke Cherry Road
Rockville, MD 20857

Dear Ms. Orlando:

As Co-Chairs to the Illinois Mental Health Planning and Advisory Council, John W. Shустitzky and I, Linda Denson would like to convey our support of the Department of Human Services, Division of Mental Health’s Community Mental Health Services 2010 Block Grant application. This application has been painstakingly reviewed by ourselves and the Planning Committee.

During the course of the last several years, faced with ever diminishing resources, funding and human potential, the Illinois Department of Human Services, Division of Mental Health has strived to maintain critical community services. As part of that challenge the Division of Mental Health has placed a priority for the inclusion, training and development of the IMHPAC, guided by its Planning Committee to understand the comparative data analysis and evaluation process. As Co-chairs we enthusiastically embrace this level of Council preparedness.

We will continue to meet our challenges by holding IMHPAC meetings bi-monthly (6 times per year). Standing Committees meet during interim months resulting in a process that allows an active role in Block Grant discussion, planning and submission. The Council is comprised of 53 members: adult & adolescent consumers of mental health services, family members (including parents of children who experience SED), mental health service providers, community leaders and representatives of several state agencies.

Illinois looks forward to active participation in the Federal Block Grant System,

Sincerely

Linda Denson
Illinois Mental Health Planning and Advisory Council
President and Chief Executive Officer
CEO, Sankofa Organization of Illinois, Inc.
P.O.Bux 607294
Chicago, IL 60660-7294

John W. Shустitzky, Ph.D., Co-Chair
Illinois Mental Health Planning and Advisory Council
President and Chief Executive Officer
Pillars
333 North La Grange Road, Suite One
LaGrange Park, IL 60526
August 12, 2009

Linda Denson, Co-Chair
Illinois Mental Health Planning and Advisory Council
Sankofa Organization of Illinois
P.O. Box 607294
Richton, Illinois 60010

John W. Shustitzky, Ph.D., Co-Chair
Illinois Mental Health Planning and Advisory Council
President and Chief Executive Officer
Pillars
333 North La Grange Road, Suite One
La Grange Park, IL 60526

Dear Ms. Denson and Dr. Shustitzky:

As Co-Chairs of the Illinois Mental Health Planning and Advisory Council (IMHPAC)
Planning Committee, we are writing this letter to support the Illinois 2010 Division of Mental
Health Block Grant Application. This new application reports on many of the past achievements
while, at the same time, reflects on the many challenges that exist for consumers and providers in
the State Mental Health System. As such, this letter is to review with you some tasks undertaken
by IMHPAC and our future goals.

IMHPAC established five predominant goals during the FY 2008 Retreat:
  1. Accelerate Consumer Involvement
  2. Improve Council Function
  3. Establish IMHPAC as a Mental Health Authority
  4. Increase outreach and access to services for individuals (limited English proficiency,
     rural, multiple diagnoses /dual diagnoses, aging, etc.)
  5. Evaluation and data collection

IMHPAC has been successful in increasing consumer participation in various Council activities.
For example, over the last several years, there has been greater involvement in the review and
editing of drafts of the Block Grant Application. The Council continues to be conscientious
about maintaining consumer representation and participation through on-going recruitment of
primary and secondary consumers, regular orientation of new members, and efforts to ensure that
all members of the Council understand the terms and meanings of acronyms and language
particular to the Illinois state mental health system.

A step towards improving Council functions has been the development of a Council webpage
that provides public access to minutes and notices of meetings. Additionally, as a way to better
understand and evaluate the State service-delivery reports, the Planning Committee held a
Performance Data and Outcomes Measures Workshop on May 14, 2009. This workshop was attended by approximately twenty Council Members.

As the Council strives to improve itself, it continues to be overwhelmingly apparent that IMHPAC needs to have a full time, independent staff liaison to facilitate day to day operations and logistics for IMHPAC functions. The Planning Committee finds this position of critical importance to the future success of IMHPAC activities. At a recent meeting the Council voted to re-affirm its 2008 request that administrative dollars, as allocated by CMHS/SAMSHA through the block grant, should be used to support this position; or such other funds as the Division of Mental Health should find available.

With regards to improving “Outreach /Access” services for individuals, we are well aware that the recent IL budgetary crisis has likely resulted in fewer individuals being served. For this reason, we must continue to be vigilant that all available resources, including the Block Grant dollars, get used in the most effective and efficient manner.

With Illinois’ recent contracting with an Administrative Service Organization, more timely and comparative data is becoming available for analysis and evaluation of needs, services and spending so that the state plan can become more targeted to the greatest areas of need. Our goal is to build on this year's activities by recommitting to a data-driven planning process for funding future initiatives.

This level of evaluation will enable the Planning Committee, in conjunction with the Planning Council, to begin reviewing use of block grant dollars at a deeper level. Simultaneously the Committee will seek to redirect block grant dollars for programs that can be sustained by other funding streams. We strive to ensure that Block Grant dollars are used strategically to purchase the most needed services that will enhance services throughout the state of Illinois. Psychiatric Leadership Services are among those in question.

Despite the challenges before us, we look forward to a continued Federal Block Grant System which supports vital programs that otherwise would not exist in our State. As we move past this difficult economic period in our Nation, we remain hopeful of a brighter future and healthier individuals. We believe this is concretely expressed in the Illinois 2010 Division of Mental Health Block Grant Application.

Sincerely,

Cathy St. Clair  Daniel B. Martinez, M.D.
Co-Chair      Co-Chair
Illinois

Appendix A (Optional)

OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.
## FY10 Block Grant awards by Vendor and Approp

### Adult Services

<table>
<thead>
<tr>
<th>Vendor Name</th>
<th>FY10</th>
<th>Unit Plan Code</th>
<th>Award Amount</th>
</tr>
</thead>
<tbody>
<tr>
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<td>40CL001011</td>
<td>22876440A</td>
<td>$1,726.00</td>
</tr>
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<td>ADVOCATE NORTHSIDE</td>
<td>10CL001608</td>
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<td>$318,338.00</td>
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<tr>
<td>ALEXIAN CENTER FOR MENTAL HLTH</td>
<td>40CL001017</td>
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<td>$214,843.00</td>
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<tr>
<td>ASIAN HMN SVCS OF CHICAGO INC</td>
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<td>$56,244.00</td>
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<td>ASSOCIATION FOR INDIVIDUAL DEV</td>
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<td>ASSOCIATION HOUSE OF CHICAGO</td>
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<td>$35,234.00</td>
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<tr>
<td>BEN GORDON CENTER</td>
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<tr>
<td>BOBBY E WRIGHT CCMHC</td>
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<td>CHESTNUT HEALTH SYSTEMS INC</td>
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Approp 22876440B $3,827,815.00

Total both approps $15,120,594.00