

**FY 2011  
COMMUNITY MENTAL HEALTH SERVICES  
BLOCK GRANT IMPLEMENTATION REPORT\***



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

**\*PART D OF THE FY2012-FY2013 COMMUNITY MENTAL  
HEALTH SERVICES BLOCK GRANT APPLICATION AND PLAN**

FACE SHEET

**COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT**

  X   FY 2011

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, 10<sup>th</sup> Floor    
CITY   Chicago   STATE:   Illinois   ZIP:   60601    
TELEPHONE:   312-814-4948   FAX:   312-814-2964  

**II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT**

NAME:   Michelle R.B.Saddler   TITLE:   Secretary    
AGENCY   Illinois Department of Human Services    
ORGANIZATIONAL UNIT:   Office of the Secretary    
STREET ADDRESS:   401 South Clinton Street, 7<sup>th</sup> Floor    
CITY:   Chicago   STATE:   Illinois   ZIP:   60607    
TELEPHONE:   312-793-1533   FAX:   312-463-2060  

**III. STATE FISCAL YEAR**

FROM:   July 1st     20 10   TO:   June 30, 2011    
          Month                          Year                          Month                          Year

**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, 10<sup>th</sup> Floor    
CITY:   Chicago   STATE:   Illinois   ZIP:   60601    
TELEPHONE:   312-814-4948   FAX:   (312) 814-2964    
EMAIL:   MaryE.Smith@illinois.gov

## **FY 2011 MENTAL HEALTH BLOCK GRANT IMPLEMENTATION REPORT 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 variety of collaborative initiatives serve to increase coordination with other state agencies whose services are accessed by individuals receiving mental health services. The FY2011 Implementation Report and the FY2012-FY2013 Mental Health Block Grant Plan reflect these coordination efforts as well as an emphasis on developing and directing care which is consumer and family driven. DMH is actively transforming the mental health service delivery system in Illinois to one that is recovery-oriented. These efforts include increasing consumer and family involvement in planning and implementation activities and expanding the focus on planning and implementation of evidenced-based practices. A wide array of stakeholders representing consumers, family members of individuals with mental illnesses, advocates and public service agencies purchasing or providing treatment to individuals with mental illnesses participate in these efforts. The anticipated outcome is the continued enhancement of activities that support the recovery-orientation of the mental health system and address the needs of consumers and their families.

Serious fiscal challenges are confronting the mental health service system in FY 2012 as in FY 2011. The DMH Fiscal Year 2012 community mental health services budget has again been reduced, however, as in FY 2011, key services including the community residential services line has been preserved. The overall impact of this year's budget 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 FY 2012, the emphasis again will be on maintaining essential services to individuals with serious mental illnesses.

During FY 2012, the priorities of the DMH include: (1) Assurance of an effective array of clinical and support services for persons enrolled in Medicaid and services which are essential for ongoing clinical care and support of individuals with serious mental illnesses who are not enrolled in Medicaid during this period of fiscal constraint. (2) Bi-directional Integration of Primary Health Care and Behavioral Health Care. (3) The provision of services in the least restrictive manner including screening and crisis services for individuals at risk of hospitalization that contribute to reducing the use of hospitalization and identification of individuals who are experiencing psychosis for the first time as a priority population for community-based services.(4) Advancement of the recovery vision including Wellness Recovery Action Planning, expansion of the scope and quality of consumer and family participation, and promotion of the utilization of the Certified Recovery Support Specialist (CRSS) credential. (5) Carrying out the responsibilities stipulated in Implementation Plan of the Williams vs. Quinn Consent Decree with diligence and efficiency. (6) Partnership with state agencies and statewide organizations

in initiatives which respond to ongoing consumer needs such as the criminal justice system, alcoholism and substance abuse services, vocational and employment services, housing opportunity, and services for military personnel. (7) Expansion of System of Care in Illinois. (8) Continuing consultation and partnering with the state Medicaid agency, DHFS, the IDHS Community Health and Prevention Division (CHP) and the Illinois Children's Mental Health Partnership to address the behavioral health needs of women in pregnancy, single mothers with young children, and early childhood interventions. (9) Enhancement of collaborative efforts with state and local partners to address the mental health needs of adults involved with the criminal justice system and youth in the juvenile justice system. (10) Advancements in the use of data to inform and guide decision-making in C&A Services. The FY 2012 Plan has been reorganized to comply with the priorities and format established by the SAMHSA.

### **Mental Health System Performance Indicators**

This FY2011 Report contains Illinois-specific performance indicators, as well as indicators relating to the SAMHSA CMHS National Outcome Measures (NOMS). The system performance indicators are described and referenced in the narrative. 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. The 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.

### **Maintenance of Effort and Children's Mental Health Set-Aside**

A review of the maintenance of effort data for FY2011 reveals that DMH will need to request a waiver based on extraordinary changes in the state's economic conditions which was also the case for FY2010. This request will be submitted to SAMHSA within the next 30 days. DMH has, however, continued to meet the requirements for the Children's Mental Health Set-Aside.

# **FY2011 IMPLEMENTATION REPORT**

## **TABLE OF CONTENTS**

Face Sheet Information	2
Executive Summary	3
Set-Aside For Children Report	6
Maintenance of Effort Report	7
<b>REPORT ON THE FY2011 ADULT PLAN</b>	9
Summary of Progress in Areas Needing Attention in FY2011	9
Significant Events and Changes in FY2011	28
Report on Block Grant Activities and Expenditures	33
Report on FY2011 Adult Performance Indicators	34
<b>REPORT ON THE FY2011 CHILD &amp; ADOLESCENT PLAN</b>	61
Summary of Progress in Areas Needing Attention in FY2011	61
Significant Events and Changes in FY2011	75
Report on Block Grant Activities and Expenditures	78
Report on FY2011 Child/Adolescent Performance Indicators	79
Appendix A: Letter From Planning Council	97
Appendix B: Block Grant Allocations to Agencies-FY2011	99

**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).<sup>1</sup> Each year the State shall expend not less than the calculated amount for FY 1994.

**State Expenditures for Mental Health Services**

Reported by: State FY \_\_\_\_X\_\_\_\_ Federal FY \_\_\_\_\_

Calculated FY 1994	Actual FY 2010	Estimated/Actual FY 2011
\$24,236,971	\$78,159,114	\$69,941,482

**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.

---

<sup>1</sup>. Section 1913(a) of the PHS Act

### **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.<sup>2</sup> 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 principal agency for authorized activities of a non-recurring nature and for a specific purpose.<sup>3</sup> 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.

---

<sup>2</sup>. Section 1915(b)(1) of the PHS Act

<sup>3</sup>. Section 1915(b)(2) of the PHS Act

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

### ***State Expenditures for Mental Health Services***

MOE reported by: State FY   X   Federal FY \_\_\_\_\_

<b>Actual FY2009</b>	<b>Actual FY2010</b>	<b>Estimated/Actual FY2010</b>
<b>\$441,603,453</b>	<b>\$413,282,718</b>	<b>\$333,054,677</b>

#### **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.



**IMPLEMENTATION REPORT**  
**NARRATIVE: SUMMARY OF PROGRESS IN FY2011**  
**REPORT ON THE 2011 ADULT PLAN**

***INTRODUCTION***

*This report provides detailed information regarding the implementation of the Illinois DMH State Block Grant Plan for FY 2011. This first section of the Narrative for Adults summarizes Illinois' progress in addressing areas in need of improvement based upon the outcomes of the stated objectives in the FY 2011 Adult Services Plan. The following narrative description provides a statement of the level of attainment, information on how each objective was attained, and background information to provide context and purpose for each of the objectives. The objectives discussed in this section have been a crucial part of ongoing DMH planning and delivery of mental health service to adult consumers. The next Section provides a description of significant events that have impacted the mental health system in the past year. Information regarding specific allocation of block grant funds is provided in the last section of the Narrative.*

**Consumer Participation**

*Consumer participation objectives 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: Consumer Conferences and WRAP:**

**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 and the use of Wellness Recovery Action Plans (WRAP).**

**Indicators:**

- **Number of Regional consumer conferences held.**
- **Number of participants in the regional WRAP continuing education/refresher trainings conducted in FY2011.**

***This objective has been successfully completed. Five regional consumer conferences were held in FY2011. Two occurred between July 1, 2010 and April 30, 2011 with an aggregate attendance of more than 500 consumers, family members, providers, DMH and other state agency staff. Three regional consumer conferences were held in June 2011: Region***

**3 in Springfield with 330 participants (6/9/11); Region 1 in Chicago with 300 participants (6/22/11); and Region 2 in Rockford with an attendance of 220 on 6/29/11.**

**Refresher/Continuing Education courses are held in each region bi-annually for Certified WRAP Facilitators. Nine regional WRAP refresher trainings were conducted between July 1, 2010 and June 30, 2011. The average number of participants per session was 15.**

DMH Recovery Support Specialists work with stakeholders to design, plan and convene regional recovery conferences. Well-known local and /or national speakers deliver the keynote address which sets the "tone of recovery" for continuing discussions and presentations at the conference.

The Wellness Recovery Action Plan (WRAP) model is well established in Illinois. Through WRAP classes in community agencies and the introduction of the principles of WRAP at consumer forums and conferences, thousands of consumers throughout the state have benefited from receiving orientation and education in the principles and components of this evidence-based practice in recovery-oriented services. Since the inception of the Wellness Recovery Action Plan (WRAP) Initiative in Illinois, more than 300 individuals (including consumers currently receiving services) have received Certificates of Achievement as WRAP Facilitators, through their completion of a 40-hour intensive course.

**Objective A1.2: FY 2011 Consumer Education and Support Teleconferences:**

**In FY2011, 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 FY 2011.**
- **Number of participants in Consumer Education / Support teleconferences.**

***This objective was fully accomplished and is continuing. In FY2011, ten statewide consumer education calls were held between July 1, 2010 and June 30, 2011. There was an average of 480 participants for each consumer education teleconference. The DMH Office of Recovery Support Services reports that, cumulatively, 4,775 individuals called in for education and support in FY2011.***

These calls continue to provide consumers with the tools and information they need to cogently and effectively participate in the development and evaluation of the service system.

The dates and topics of the conference calls were:

- 07/22/10: New Perspectives on Employment
- 08/26/10: New Perspectives on Turning Challenges into Opportunities
- 09/23/10: New Perspectives on Living Independently
- 10/28/10: New Perspectives on Thriving in Times of Change

01/27/11: From Stories to Strategies: Developing Emotional Wellness  
02/24/11: From Stories to Strategies: Developing a Healthy Environment  
03/24/11: From Stories to Strategies: Developing Inner Strength  
04/28/11: From Stories to Strategies: Developing Integrated Healthcare  
05/26/11: From Stories to Strategies: Developing Personal Wellness  
06/23/11: From Stories to Strategies: Developing Crisis and Post Crisis Plans

So far in FY2012, four conference calls have been held covering a variety of topics including financial and occupational wellness, informed advocacy, developing peer supports, and on being creative in the recovery process.

**Objective A1.3: Specialized/Targeted Efforts Related to Recovery:**

**In FY2011, continue to provide recovery-oriented training to all interested stakeholders and support the role of Certified Recovery Support Specialists (CRSS) and their statewide deployment.**

**Indicator:**

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

***This continuing objective was successfully completed in FY2011. The DMH Office of Recovery Support Services reports that 38 recovery oriented training sessions were held in a variety of venues across the State. Stakeholder groups, consumers of mental health services, family members of consumers, mental health and addiction professionals, advocates, college students, occupational therapy professionals, and many others benefitted from these presentations. Topics for these sessions have generally included the foundational principles of mental health recovery, Wellness Recovery Action Planning (WRAP), mentoring, advocacy, crisis planning, recovery support, spirituality, and others.***

**As of November 1, 2011, 145 individuals have achieved their CRSS certification, and all are in good standing with the Illinois Certification Board (ICB).**

During FY2011, a total of 150 individuals received competency training for the CRSS credential and preparation for application and examination with the Illinois Certification Board (ICB). 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 FY2012, the DMH Office of Recovery Services is planning to host webinars for providers to help increase agencies' understanding of the role, value, function, and advantages of hiring CRSS professionals with the aim of increasing the number of agencies hiring CRSS professionals in FY2013.

***NAMI Illinois***

Additional support for consumer and family participation is available through NAMI-

Illinois. We are pleased to report that NAMI-Illinois is a very active education and information resource for consumers and families in the State. In FY2011 (July 1, 2010 through June 30, 2011) NAMI-Illinois reports processing 2,332 requests for information on a wide range of consumer – related subjects, sending out 45 periodic electronic updates (“e-news”) to 1,749 individuals on it listserv, and distributing 7,867 brochures, pamphlets, and bookmarks which provided information on mental illnesses, NAMI Illinois information, educational programs, Illinois specific information on diagnosis and treatment, and hospital care. In FY2011, NAMI Affiliates started 35 Family to Family classes across the State, including two specifically for veterans and their families; three Peer to Peer classes, and 14 NAMI Affiliates held ongoing NAMI Connection Recovery Support Groups.\* The NAMI In Our Own Voice (IOOV) is an education program which trains individuals with mental illness to speak to community audiences about their experiences and has proven to be an effective tool in diminishing stigma that often surrounds mental illness.

### **Forensic Services**

*Forensic Services oversees and coordinates all forensic mental health services for the Division of Mental Health (DMH). This responsibility includes coordinating the inpatient and outpatient placement and treatment 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).*

#### **Objective A1.4: Jail Data Link Project**

**In FY2011, maintain linkage services for individuals with serious mental illness released from Illinois jails.**

#### **Indicators:**

- **Percentage of eligible individuals linked to services.**
- **Percentage of Linkages still in treatment at 30 days.**
- **Percentage of Linkages still in treatment at 60 days.**

*This objective was accomplished for a limited number of individuals with serious mental illness eligible for linkage when released from Illinois jails.*

**In FY2011, 1,079 detainees (18% of those eligible), were linked to services within thirty days of release from jail. 572 of the linked detainees (53%) remained in**

---

\* Family to Family is a free 12-week education course for family members and friends of individuals with mental illness taught by NAMI family members and covers information about illnesses of the brain and their treatment; coping skills; and advocacy. Peer-to-Peer is a free nine-week course on recovery for any person with serious mental illness who is interested in establishing and maintaining wellness taught by teams of three trained “mentors”, or peer-teachers, who are themselves experienced at living well with mental illness. NAMI Connection is a weekly recovery support group for people living with mental illness in which people learn from each others’ experiences, share coping strategies, and offer each other encouragement, support, and understanding. NAMI Connection groups offer a casual and relaxed approach to sharing the challenges and successes of coping with mental illness. Each group meets weekly for 90 minutes, is offered free of charge and follows a flexible, but consistent structure.

**treatment after thirty days. In FY2011, collection of 60 day retention data was initiated and it was learned that of the 572 individuals engaged at the 30 day level, only 81 or 14% remained engaged at 60 days.**

The **Jail Data Link Project** blends technological advancements and clinical systems integration by providing 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. The Project has gradually expanded from its pilot in Cook County to ten counties in Illinois.

Cook County Jail linkage continues to need dedicated case managers to facilitate and follow up linkage arrangements. Will, Peoria, Jefferson, St Clair, Winnebago and Rock Island Counties are continuing to link individuals into community services. An additional obstacle is that many of the consumers identified by Jail Data Link have either lost their Medicaid funding while detained in jail or entered jail without funding. Non-Medicaid funding is needed to assist community agencies with providing services that can initiate and sustain these individuals' recovery process and reduce jail recidivism as well as inpatient hospital admissions.

#### ***Continuity of Care-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.*

**ObjectiveA1.5. Community Monitoring of Persons Adjudicated as NGRI :**  
**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.**

*This objective was accomplished. The tracking system has been maintained.*

**A total of 92 (61 Males, 31 Females) individuals adjudicated as NGRI were maintained in the community on Conditional Release (CR) status in FY2011. Thirteen persons (10 males, 3 females) were adjudicated as NGRI and released and**

maintained in the community during the year. During this fiscal year, 26 individuals were removed from the tracking system for various reasons such as discharge by the Court after reaching their maximum commitment date or early discharge from conditional release. A total of 5 individuals (4 males, 1 female) were subject to revocation of conditional release by the Courts and return to inpatient status. As of the end of the fiscal year there were 76 “active files” being maintained in the tracking system. Agency compliance with court reporting and service delivery requirements for this population has been 95%.

**Objective A1.6: 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

*This objective was accomplished. This tracking system, established in FY2010, was satisfactorily maintained in FY2011.*

During FY 2011, a total of 64 individuals (43 males, 21 females) were ordered by the Courts into Outpatient NGRI treatment. Of these, a total of 21 (15 males, 6 females) were removed from the tracking database due to a change in their legal status. Agency compliance with court reporting and service delivery requirements for this population has been at 96%.

### ***Fitness Restoration***

*DHS provides fitness restoration services on both 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.*

**Objective A1.7: Outpatient Fitness Restoration Service Monitoring and Expansion.**

**Maintain a tracking system for persons receiving outpatient fitness restoration services.**

**Indicators:**

- Number of adult persons receiving outpatient fitness restoration services in FY 2011.
- Number of juveniles receiving outpatient fitness restoration services in FY2011.
- 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 FY2011.

*This objective was accomplished.*

The tracking system documented a total of 84 individuals (55 Adults and 29 Juveniles) who received Outpatient Fitness Restoration Services in FY2011. There were 54 new cases referred for Outpatient Fitness Restoration Services during FY2011. The compliance rate for Community Service Provider Agency timeliness of reporting was 93% and rate of service provision was 100%.

#### *Continuity of Care -UST*

*Forensic services tracks individuals discharged from DMH hospitals after inpatient fitness restoration services. In FY2011 Forensic Services continued 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 A1.8: Monitoring of Persons with UST Status Returning to the Community:**

**Provide continuity of care for individuals found unfit to stand trial (UST) that have been 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 patients reported in correctional custody.

*This objective was accomplished. During FY2011, 304 individuals (245 males, 58 females) were discharged from Inpatient UST status as “fit for trial” and referred to community agencies. Of these, agencies reported 127 individuals as following through with appointments within thirty days, while 37 were reported as remanded into correctional custody.*

#### ***Length of Stay Data***

*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 to collect data with which to monitor length of stay. The performance measurements to address the objectives below were developed with input from staff from all hospital forensic programs and central office quality management staff.*

**Objective A1.9: Monitoring Length of Stay:**

**Reduce the length of stay in DMH hospital forensic programs 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.**

*The activities of this objective were accomplished and are continuing in FY2012. However, a significant reduction in average length of stay in DMH hospital forensic programs has not yet been realized.*

**Forensic performance measures were completed and data collection was initiated in FY2010 and continued in FY2011.**

**Data for the above indicators was collected quarterly on forensic program length of stay at four hospitals. The average days for each quarter were averaged for the year and yielded the following information:**

- **The average length of time between DHS receipt of court orders to the actual placement of patients in forensic inpatient programs ranged from 52 days to 89 days. The overall average was 68 days.**
- **The average length of time from inpatient admission to recommendation for a court hearing based on resolution of fitness issues ranged from 41 to 121 days. The overall average was 87 days (one day more than FY10).**
- **The time between recommendation for a court hearing and discharge from the inpatient program ranged from 20 days to 31 days. The overall average was 27 days (4 days more than FY10).**

Increases in all performance times in state-operated forensic programs were noted between the FY2010 initial baseline data and FY 2011. Most notable was the increase in admission wait time to DMH hospitals (68 days in FY2011 compared to 42 Days in FY2010). Extended waiting time in jail after a court order delays access to necessary hospital treatment and increases potential DHS exposure to a finding of contempt of court. Much of the delay can be attributed to inadequate bed capacity, increased referral volume, increased numbers of misdemeanor referrals, and reductions in bed capacity created by long-term NGRI patients. DMH continues to address this issue.

DMH Forensic Services is using this data as a management information tool to work with forensic hospitals on improving and making the forensic process more efficient towards reducing length of stay. This data also reflects the need for greater forensic capacity to



decrease admission delays. The rate of referrals from courts appears to always out pace discharges from forensic hospital units.

### ***The MHSIP: Adult Consumer Survey***

The Division has adapted the MHSIP: Adult Consumer Survey to collect feedback from adult recipients of community mental health services funded by the DMH. Information is collected on 7 domains including access to services and outcomes; with additional questions on the impact of services on criminal justice involvement. The Adult Consumer Survey is part of the Mental Health Statistics Improvement Program (MHSIP) Quality Report performance measures. 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 National Outcome Measures (NOMS) listed in the objective below are currently collected through the MHSIP Consumer Survey.

### **Objective A1.10 (NOM): Assessing Consumer Perception of Care:**

**The percentage of consumers reporting positive outcomes through the Adult Consumer Survey will increase in FY2011.**

#### **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**

*This objective is currently being accomplished. During October 2011, the FY2011 Consumer Survey was mailed to a random sample of 2,600 consumers who received services in June 2011. An analysis of the responses is being completed in November 2011 and a fully descriptive report is anticipated by February 2012. Data for FY2011 on the above indicators is reported in the section for FY2011 Adult Performance Indicators.*

**The FY2010 Consumer Survey was completed during FY2011 and serves as the baseline from which to track consumer satisfaction with services and the newly developed national outcome measures for social connectedness and improved functioning. In the FY2010 survey results, the percentage of adult consumers reporting positive outcomes improved 7 percentage points from FY2008, from 60% to 67%, and well surpasses the FY2011 target of 61.4%; 74% showed decreased criminal justice involvement; Increased Social Supports/Social Connectedness significantly increased from 63% in FY2008 to nearly 73% in FY2010; and Improved Level of Functioning increased slightly from 62% to 66% (the FY2011 target was 66%).**

**Data for the above indicators in FY2011 approximates the FY2010 results. The percentage of adult consumers reporting positive outcomes remains at 67%; 72% showed decreased criminal justice involvement; Increased Social Supports/Social**

**Connectedness is stable at 72% in FY2011; and Improved Level of Functioning decreased very slightly to 65.2%.**

*The FY2010 Adult Consumer Survey*

In 2010, DMH surveyed 2600 adult consumers who received services at DMH funded community mental health centers. Participants were chosen at random and the survey was sent to their home address. The consumers were asked to rate on a scale of 1 to 5 whether they agreed or disagreed with 26 statements. All surveys were confidential. The 26 questions comprising the survey were combined to create the results for the domains listed below.

Of the 2600 surveys were sent out to consumer's homes, 582 were returned, yielding an adjusted response rate of 25%. The majority of respondents (60%) were between the ages of 45 and 64; 27% were age 25-44; 5.5% were over age 65, and nearly 5% were 18 through 24 years of age. In reference to Race/Ethnicity, 68% were White, 18% Black, 8% Hispanic, and 14% in the "Other" and Multi-race categories. The results show that consumers responded very positively to questions related to satisfaction with services and quality of care and most agreed that services improved their day-to-day lives.

The results are listed in descending order showing the greatest number of positive responses in the general satisfaction domain, the least in the functioning domain. This is consistent across the scores in three previous years and is an area of concern.

Reporting Positively about General Satisfaction	86%
Reporting Positively about Participation in Treatment Planning	86%
Reporting Positively about Access	85%
Reporting Positively about Quality and Appropriateness	83%
Reporting Positively about Social Connectedness	74%
Reporting Positively about Outcomes	67%
Reporting Positively about Functioning	66%

A comparison of survey results from FY2008 through FY2010 shows significant increases in two domains: participation in treatment planning, from 73% to 86% and social connectedness from 63% to 74%. These two areas have been the focus for improvement efforts by DMH. Other observations were:

- Overall Satisfaction with Care was the domain with the highest percentage of positive responses with 86% in 2010; Functioning and Outcome domains showed the lowest percent of positive responses: 66% and 67%.
- Respondents reported greater positive outcomes in 2010 (67%) than reported in 2008 (60%)
- 83% of respondents responded positively to statements regarding quality and appropriateness of care.

- While responses to the Participation in Treatment Planning domain have remained stable nationally, it has steadily risen in Illinois from 2008 (73% to 86%).

***Evidence Based Supported Employment (EBSE)***

*Supported Employment Services in Illinois are based on 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 partnered in a joint effort 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.*

**Objective A1.11- EBSE: Continue to maintain the implementation of Evidence Based Supportive Employment.**

**Indicators:**

- **Number of consumers receiving supported employment in FY2011. (National Outcome Measure)**
- **Number of consumers in supported employment who are employed in competitive jobs in FY2011.**
- **Number of sites at fidelity level at the end of FY2011**
- **Number of consumers who transition out of IPS in FY2011 due to successful employment**

*This objective was extraordinarily accomplished in view of the significant challenges in implementing this evidence-based practice this past fiscal year.*

**In FY2011, 1993 consumers (unduplicated count) received supported employment (IPS/EBSE) services from programs known to be at fidelity. There were 23 sites at fidelity level by the end of the fiscal year. A total of 244 people were transitioned off the IPS caseload because they were successfully employed and no longer required specialized employment supports. The number of IPS consumers who were employed in competitive jobs peaked in the fourth quarter of FY2011 at 361.**

Efforts to expand and improve implementation during the past two years have included:

- Consumer participation in all fidelity reviews and in crafting recommendations. Additionally, two consumer “think tanks” (focus groups across the State, consumer leaders from state agencies and active IPS sites) began looking into how recovery supports and the CRSS can be used to improve employment outcomes for IPS programs.
- Ongoing Technical Assistance -1695 hours of technical assistance were provided to the IPS sites to increase fidelity to the IPS Supported Employment Model in FY2010. In FY2011, approximately 2300 hours of technical assistance were provided to 150 staff and support personnel in IPS sites across the State. The IPS technical assistance team completed training in a new method of teaching job development to IPS sites that targets improvement of outcomes.

- Support from NAMI IL included a plenary session at the NAMI IL Conference in October 2009 that focused on the role of employment in recovery and a full day track on IPS and Work Incentives Planning and Assistance at their state conference in October 2010. NAMI IL piloted a unit of the Family-to-Family Course on the role of work in recovery and IPS in Illinois which has been established in the curriculum and built into their training for new Family-to-Family facilitators.
- IPS sites and capacity have been expanded with the infusion of ARRA and Title XX funds. Fidelity IPS services are now provided at 23 locations/sites and IPS services are being developed at an additional 12 locations. DRS has distributed ARRA funds to ten adult sites and eight sites specializing in transitioning youth and young adults.

Outcomes have been positive and encouraging. In Calendar Year 2009 IPS outcomes increased by 4% even though the state's unemployment rate increased by 3.6% during that same period. In other words, IPS is producing better outcomes than the general public with obtaining employment. The rehabilitation rate of persons receiving IPS is 0.57 as compared to a rehabilitation rate of 0.52 for total persons served (all disability groups) at those same local vocational rehabilitation offices.

However, EBSE is facing several challenging issues:

- The loss of DMH capacity grants for IPS and the vocational services that cannot be provided under the Illinois Medicaid Rule (132) has been a setback. Consumers enrolled in Medicaid continue to receive Community Support and other funded employment –related services. However, most IPS programs stopped serving persons who were not eligible for Medicaid due to insufficient resources to provide and integrate the mental health treatment portion of the IPS model.
- A major portion of the funding for IPS is contingent on producing good employment outcomes. IPS is paid via a braided funding model in which the DRS portion of the model is outcome driven i.e., providers are paid milestone payments when a person has been successfully working in a job that fits their preferences for 15 days, 45 days, and 90 days.
- Frequent turnover of employment specialists (line staff), coupled with training effort and time needed to learn to implement the EBP, poses challenges to sustainability.
- In FY2011, some programs used ARRA funds to support IPS positions. Some of these agencies plan to eliminate at least a portion of these positions in FY2012 after ARRA funds expire. Because primary program revenues (without ARRA) are outcome-based, several agencies are considering downsizing programs out of concern for initial financial outlay requirements without revenue guarantees.

## FY2011 IPS Activity Report

	7/1 –9/30, 2010	10/1 –12/31, 2010	01/1–3/31, 2011	4/1-6/30, 2011
<b>Number of locations at fidelity</b>	<b>21</b>	<b>21</b>	<b>22</b>	<b>23</b>
<b>Number of consumers receiving supported employment</b>	<b>1,010</b>	<b>993<sup>1</sup></b>	<b>1066<sup>3</sup></b>	<b>1174</b>
<b>Number employed in competitive jobs</b>	<b>335</b>	<b>329</b>	<b>323<sup>4</sup></b>	<b>361</b>
<b>Number of working people transitioned off the IPS Caseload successfully employed</b>	<b>55</b>	<b>71<sup>2</sup></b>	<b>53</b>	<b>59</b>

**Notes:**

<sup>1</sup> The decrease in persons served appears related to two factors: (a) discharges of those who do not have Medicaid and (b) staff changes.

- 6 agencies decreased the number of FTE employment specialists providing IPS services.
- 7 agencies increased the number of FTE employment specialists providing IPS services. Caseloads are typically smaller while new staff are being trained.

<sup>2</sup>The greater number of people transitioned off the IPS caseload appears to represent persons without Medicaid being transitioned without supports soon after they achieved DRS status 26 (successful outcome). The EBP calls for supports to be provided beyond this, typically for about 1 year, but these longer term supports are no longer funded by DMH for persons without Medicaid.

<sup>3</sup>With the infusion of ARRA funds through DRS, several IPS sites were able to hire additional staff. In addition, another site at one of the agencies reached fidelity.

<sup>4</sup>When new staff start, outcomes typically decrease because it generally takes 6 to 8 months for a new employment specialist to start to get job placements.

### **Permanent Supportive Housing**

**Objective A1.12: By the end of FY 2011, through the provision of rental subsidies, implement a statewide permanent supportive housing initiative which targets an additional 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 FY 2011. (National Outcome Measure)**
- **Number of DMH-funded providers participating in the program.**
- **Amount of money expended for the program in FY 2011.**

*Although the stated target was not fully achieved, this objective has been substantively accomplished in FY2011 and is continuing in FY2012.*

**As of November 2011, 356 additional consumers were approved for Bridge subsidies during the fiscal year and 163 consumers were successfully placed in supported**

**housing through the PSH initiative. Due to budgetary limitations, an open round was delayed for most of FY2011 which resulted in a reduction of the placement activity seen in previous fiscal years.**

The Permanent Supportive Housing Initiative (PSH) continued to make noteworthy progress during FY2011 with PSH opportunities secured by consumers on a statewide basis. As of 11-21-11 the DMH Permanent Supportive Housing Bridge Subsidy Initiative had approved 1,231 DMH bridge subsidies, and of those approved – 727 consumers have utilized their subsidy and moved into a unit. Since the end of FY2010 when 875 consumers had been approved for Bridge subsidies and 564 had actually secured housing through PSH, 356 additional consumers have been approved and 163 have secured housing. DMH has utilized approximately \$8.5 million of dedicated funding to this Permanent Supportive Housing expansion. Additionally, DMH partnered with the Department of Healthcare and Family Services (DHFS) which provided \$1 million for PSH subsidies and services to meet the needs of 200 consumers served through the Money Follows the Person Federal Demonstration (MFP). DMH partners with seven (7) service provider entities to carry out Subsidy Administration duties covering the entire state. The DMH Permanent Supportive Housing (PSH) Bridge Subsidy Initiative is open and available to all DMH service providers currently under IDHS/DMH contract when an open round is conducted. Due to budgetary limitations, an open round was delayed for most of FY2011 which resulted in a reduction of the placement activity seen in previous fiscal years. By the conclusion of FY2011 about 90 agencies (about 50%) had applied for access to this Initiative on behalf of the consumers they represented.

DMH 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). Lease documents are in the name of the consumer, so tenant landlord relationships are maintained. The DMH Bridge Subsidy Initiative provides tenant-based rental assistance opportunities to eligible consumers who are capable of living in their own housing units within the community. DMH is 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. 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.

## Individuals Approved and Eligible for PSH Housing By Priority Population Group

<b>All Approved Applications by DMH Priority Population Grouping (As of November 21, 2011)</b>	
<b>Priority Population</b>	<b>Total</b>
Aging out DCFS ward	34
Aging out ICG recipient	5
At risk of placement in long term care	45
Extended long term patient at state hospital	14
Experiencing homelessness	316
Resident of DMH funded residential	390
Resident of long term care	427
<b>Grand Total</b>	<b>1,231</b>

**Objective A1.13 – ACT: Continue provision of Assertive Community Treatment that meets national fidelity model requirements.**

**Indicators:**

- **Number of persons with SMI receiving Assertive Community Treatment in FY 2011 (National Outcome Measure)**
- **Number of ACT teams meeting National fidelity standards by the end of FY 2011.**

***This objective was met. In FY2011, 678 individuals received services from ACT Treatment Teams that meet national fidelity standards. At the end of FY2011, there are eight ACT Teams in Illinois that meet these standards.***

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. FY 2011 saw a further decline in the number of ACT teams, as two additional teams were not able to meet fidelity to the ACT model. There are now eight ACT teams in Illinois. Each was reviewed for fidelity in FY2010, using a tool based on the Dartmouth tool, with the only modifications being where the state Medicaid rule is more stringent than the Dartmouth standard.

During FY2012, Illinois expects to see expansion of ACT as it prepares for the movement of individuals from IMDs into the community as part of the Williams Consent Decree. To provide the necessary capacity to address the needs of an anticipated 500 Williams class members in FY2012 and FY2013, it is expected that some existing teams in Illinois will expand, while other existing teams may actually be divided into two teams, each of which is then expanded and some new teams may be created. Technical assistance will be provided to these developing and expanding teams.

**Objective A1.14 (NOM) - Decreased Rate of Civil Readmissions:**

**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.**

*This objective continues to be addressed.*

**DMH continues to monitor the number of adults readmitted to state hospitals within 30 days of discharge and the number of adults readmitted to state hospitals within 180 days of discharge with the goal of maintaining or decreasing the level of re-hospitalization through the use of community based services that provide alternatives to hospitalization. However, it is to be expected that individuals with serious mental illnesses, may, at times of crisis and relapse, require access to inpatient services for evaluation and stabilization in a safe, structured, and supportive environment. See the Report on FY2011 Adult Performance Indicators section for comparative data and information about these indicators that are a National Outcome Measure (NOM)**

**Objective A1.15 (NOM) -Other Evidence-Based Practices:**

**Continue efforts to increase the implementation of Family Psycho-education 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 Psycho-education.**
- **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.**

*This objective continues to be addressed but implementation has been limited, largely due to serious fiscal constraints.*

**Family Psycho-education implementation efforts have continued in DMH Region I. DMH administrative staff continue to discuss implementation of Illness Management and Recovery (IMR) and Medication Management within the state. However, active planning has not occurred due to the lack fiscal resources. Integrated Treatment of Co-occurring Disorders has primarily focused on developing provider interest and capacity to meet the service challenges posed by this model.**

The activities of the Family Psycho-education (FP) implementation grouping Region 1 have resulted in the formation of a number of family psycho-education programs. Currently, three agencies in the region are continuing to implement varying models of family psycho-education. Several other agencies have developed programs in conjunction with these implementation teams. All of them report 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.

A three-year Training and Evaluation grant funded by SAMHSA/CMHS provided agencies with tailored technical assistance and consultation geared toward strengthening each agency's ability to move toward providing IDDT. The IDDT project emphasized statewide education and leadership to promote IDDT and demonstrated that consultation and technical assistance are the key means of strengthening the ability of agencies to move toward providing Integrated Dual Diagnosis Treatment services. DMH and DASA are working toward finding and developing the resources to support IDDT. (See *Framework for Continuing Collaborative Planning- Mental Health and Substance Abuse Prevention and Treatment in Section II-A of this FY2012-2013 Application*)

## **PATH**

**Objective A4.1- PATH in FY2011: Utilizing an anticipated increase of \$264,000 in the Illinois Federal PATH allocation, continue to enhance existing PATH programs, expand specialized services to PATH eligible consumers who are ex-offenders or veterans, and increase the number of PATH eligible consumers served in FY 2011.**

### **Indicators:**

- **Number of persons receiving case management services under the PATH initiative by the end of FY 2011.**
- **Number of ex-offenders who are homeless with serious mental illness served by the end of FY 2011.**

***This objective has been successfully accomplished. In FY2011, \$264,000 was utilized to increase allocations to providers and enhance PATH programming in the State. PATH Providers report that case management services were delivered to 2,150 PATH eligible individuals and families. The PATH Ex-Offenders Re-Entry Initiative programs served 73 ex-offenders.***

The PATH Ex-Offenders Re-Entry Initiative began in December 2009 and reported having served 17 ex-offenders by the end of October 2010. This year PATH Providers reported serving a total of 73 ex-offenders in the period from July 1, 2010 through June 30, 2011 at two sites: Rockford (53) and Chicago (20).

PATH Providers have also been encouraged to use the funds to cultivate relationships with Illinois Department of Veterans Affairs, Veteran Administration Hospitals, centers, agencies and programs to increase the location (of) and services (to) Veterans encountered during the process of outreach who are in need of emergency assistance, linkage with appropriate services, and benefit assistance (if needed) when the individual is not connected with public entitlement programs/VA Benefits.

**Objective A4.2 – PATH : In FY 2011, convene a PATH Provider’s Conference: "Creating a Clear PATH-With Unlimited Connections".**

**Indicators:**

- **Number of attendees at the Conference who represent mental health and homeless interests outside the PATH service system.**
- **Number of PATH Providers in attendance.**
- **Number of Conference Evaluations showing successful scores.**

***This objective was successfully accomplished.***

**The second bi-annual Illinois PATH Provider’s Conference: "Creating a Clear PATH-With Unlimited Connections" was held at the Wedeberg Conference Center, Springfield , in September 2010. The event was a two-day conference for Illinois PATH providers and other service providers. 64 people attended on the first day and 49 people attended on the second day. A total of 73 unduplicated people attended the conference. Conference attendees were: 37 PATH providers representing 18 PATH service agencies; 18 individuals representing mental health and homeless interests outside the PATH system; 16 presenters; and two consumers. Conference presentations received high evaluative ratings from the attendees and the conference was considered to be highly successful in increasing collaboration and effectiveness in PATH service provision.**

The “Creating a Clear PATH – with Unlimited Connections”: 2010 Illinois PATH Conference took place September 09-10, 2010, in Springfield, Illinois. The conference initiated the development of a statewide PATH Providers support network, and provided trainings requested by administrative and front-line staff to increase access to current innovative strategies and multiply opportunities for cross-pollination: (a) Housing Resources for Individuals who are Homeless, (b) From Outreach to Data: PATH Eligibility and Enrollment Criteria – Process, (c) Working with Families with Serious

Mental Illness (SMI), (d) Learning to Listen: Practical Takeaways for Case Managers, (e) Trauma-Informed Services, (f) From Data to Outcomes: Tracking Data/Using Data to Support Programs (g) An Introduction to Cognitive and Behavioral Treatment, (h) Consumer Involvement: Normalizing Disclosure in the Workplace, (i) Harm-Reduction Strategies, and (j) An Overview of the Mental Health Court System.

## **SIGNIFICANT EVENTS AND CHANGES- ADULT**

### **Fiscal Challenges Facing Illinois**

Beginning in FY2009, economic conditions in Illinois significantly deteriorated. The Illinois Department of Revenue (IDOR) reports that the Total Revenue Collected (not including taxes collected for local governments) dropped from \$29,150,982,929 for SFY2008 to \$26,831,571,515 in SFY2009 resulting in a deficit to the state in excess of \$2.3 billion due to a 7.9% drop in revenue. Concurrently, the Illinois Department of Employment Security (IDES) reported that the state's Unemployment Rate (Seasonally Adjusted) steadily increased from 6.6 in July, 2008 to 8.1 in January, 2009 and reached 11.1 by the end of December, 2009. The number of persons employed dropped from 6,237,500 to 5,863,200 during the same period. The Annual Average of Unemployment rose dramatically from 6.4 in CY2008 to 10.0 in CY2009 reflecting an increase in the average number of Unemployed persons from 425,500 in CY2008 to 659,900 in CY2009. The decline of fiscal resources and growing gap between revenues and funding needs has continued since FY2009. Cash flow to providers has been impeded. As of this writing, the Department of Human Services is facing a total of \$694 million in reductions to the DHS budget unless the shortfall can somehow be reduced by the Illinois General Assembly. In addition to painful and detrimental cuts in direct service programs, DHS is also facing deep reductions in the "operations" portion of the budget which includes drastic cuts to state operated facilities, telecommunications, and contractual line items. These operations reductions threaten DHS' ability to provide needed services to customers and – without additional dollars - will force the closure of three state-operated psychiatric hospitals as well as two State Operated Developmental Centers (SODCs). Even with closures, the Division of Mental Health (DMH) and Division for Developmental Disabilities (DDD) budgets still face a shortfall of more than \$75 million because of shortages in the line-item appropriations bill approved by the General Assembly.

Illinois is on an annual budget cycle. Budget reductions are occurring in FY2012 and are expected to continue into FY2013. This year, a 20% to 25% statewide reduction in community services is anticipated unless the General Assembly restores some or all of the \$40 million taken from this year's budget. The outlook for any new funding for mental health services remains extremely bleak. In this constricted environment, DMH is making every effort to maintain essential mental health services for persons with the most serious mental illnesses through reallocation existing funds and has developed a very limited set of service packages to carry individuals who are not enrolled in Medicaid through this fiscal year.

#### *FY2011 Service Packages For Persons Who Are Not Enrolled in Medicaid*

The vast majority of individuals served in the Illinois public mental health system are unable to pay for their behavioral health care. They are either Medicaid-eligible or their services have been supported through DMH capacity grants. Beginning in FY2011, economic hardship necessitated a demarcation of those adult consumers who are enrolled in Medicaid and those who are not. Medicaid recipients will continue to receive the

normal array of services while those who are not Medicaid eligible will receive limited service packages to be paid for with the minimal funding DMH has available. Service provision and coverage will be based on clinical criteria and financial eligibility. Persons at or below 200% of the federal poverty level (FPL) will be fully funded; those over 400% will not be funded, and everyone between 200% and 400% will receive partial funding based on their FPL, which is determined by household size and income.

Providers now need to obtain definitive information from clients regarding their household income and family size. As the data system integrates the updated financial information, DMH will be able identify the size of the currently uninsured consumer group and address capacity needs in a focused manner. As additional funding becomes available due to the ACA, mental health providers anticipate being able to enhance their clinical programs and increase their capacity to provide the necessary quantity and quality in services to more consumers. Every effort is currently being undertaken to support consumers who qualify to apply for Medicaid eligibility.

DMH prioritized four distinct service groups in FY2011. These are:

**Eligibility Group 1:** Individuals who are **Medicaid Eligible** and in need of mental health services for a mental disorder or suspected mental disorder;

**Eligibility Group 2:** Individuals who are **not Medicaid eligible** but are in need of mental health services as indicated by a diagnosis, functioning level or treatment history that meets the clinical criteria for the **DHS/DMH Target Population (Adults with Serious and Persistent Mental Illness)**. This eligibility group is aimed at applying state funding for mental health services for an individual with limited resources who meets financial eligibility requirements and who is experiencing a serious mental illness.

**Eligibility Group 3:** Individuals who are **not Medicaid eligible** but are in need of mental health services as indicated by their diagnosis, treatment history and age and meet the clinical criteria for the **DHS/DMH First Presentation of Psychosis Population**. This eligibility group is aimed at applying state funding for mental health services for an individual with limited resources between the ages 18 and 40 who meets financial eligibility requirements and is presenting to the mental health service system for the first time as experiencing a serious mental illness.

**Eligibility Group 4:** Individuals who are **not Medicaid eligible** but are in need of mental health services as indicated by their diagnosis and functioning level that meets the clinical criteria for the **DHS/DMH Eligible Population**. This eligibility group is aimed at applying state funding for mental health services for an individual with limited resources (within financial eligibility requirements) who is in need of mental health services for a mental disorder or suspected mental disorder as indicated by their mental health diagnosis and functioning level.

The Service Benefit Packages for individuals who are not Medicaid eligible (Groups 2, 3, and 4) which became effective on October 1, 2010 are described in detail on the DHS Website at: <http://www.dhs.state.il.us/page.aspx?item=51784> .

## **Williams vs. Quinn Consent Decree**

A Class Action Court Settlement was finalized in FY2011 that requires additional financial resources available to the Department for mental health services. The Williams' Suit targeted individuals who are residents of Institutes for Mental Disease (IMD), Nursing Facilities in which more than 50% of the population is diagnosed with Serious Mental Illness. As such, an IMD cannot bill for federal Medicaid reimbursement and are 100% funded out of State General Revenue Funds. The premise of the Williams' suit is that individuals with serious mental illness have not been afforded due process to move out of these facilities when they no longer require or desire this level of nursing care. There are 4,500 class members involved in this suit.

Key terms in the Consent Decree include the following:

- Development of community capacity. This requires the State to ensure the availability of services, supports, and other resources to meet its obligations under the Decree.
- Development of a service plan. For individuals currently residing in IMDs who do not oppose moving to a community-based setting and who are otherwise appropriate for community placement, the State will develop a service plan specific to each person.

The Consent Decree was entered by the Court in September 2010 and requires that all class members will be assessed and given the choice to transition to the most appropriate integrated community based options with support services over the course of 5 years. The ultimate goal is to transition them into independent living/permanent supportive housing. The Implementation Plan detailing the steps to be taken by the State and the timelines towards reaching this goal was approved by the Court in June 2011. Additional financial resources are anticipated by the Department to meet these mental health service needs. As all the class members may not be ready for independent living at the initial stage of transitioning, the service system is required to develop an array of housing options and clinical support services to best accommodate members' immediate transition needs. Concurrently, the state will have to ensure that transitioning consumers, who do qualify, based on clinical and functional criteria, for independent living can afford to live in community based housing. Expanding funding resources to ensure the availability of Bridge Subsidies (until permanent rental subsidies or Section 8 housing choice vouchers can be secured) for those who do qualify for Permanent Supportive Housing will be paramount.

However, to assure success, all parties in the Consent Decree recognized that an array of available Community Services, including some non-Medicaid services, will be critical in achieving and sustaining the successful community placement of *Williams* Class Members. The existing infrastructure of services in the Illinois Medicaid State Plan is inclusive of mental health rehabilitation services, substance abuse and co-occurring services, services for persons with developmental disabilities and physical healthcare services that will be beneficial for Class Members. Twenty-five to 50% of Class Members seeking community placement are likely to have a co-occurring substance use disorder. Thus, coordination with DHS/Division of Alcohol and Substance Abuse

Services (DASA) is critical for these individuals. DHS/DASA and DHS/DMH have a foundation in collaborating in the development and implementation of services for individuals with these co-occurring disorders.

During FY2011, a parallel Class Action Suit, Colbert, was being developed which targets nursing facilities that are not IMDs in the City of Chicago boundaries, only, and across disability populations. The total class for Colbert is 10,000. Potentially, there are an additional 5,000 individuals with mental illness in this Class. Like Williams, mental health services (including residential supports) and affordable housing will be necessary to ensure seamless and safe transitioning for this population. Accommodating the residential and support service needs of these legal settlements will necessitate extensive enhancement to the existing public mental health service delivery system.

The Implementation Plan firmly asserts that Recovery Principles, a set of fundamental beliefs that persons with mental illness can recover and live purposeful lives, is expected to guide all system reform efforts and frame the development and expansion of all services. The Implementation Plan proposes not only to expand the current system of care, but to create a number of recovery-oriented system enhancements in both services and housing, designed to assure that each person choosing to move from an IMD has the best opportunity for a successful transition to community living.

In FY2012, the state is continuing to build the infrastructure for transitioning Williams Class Members and to support the development of 256 permanent supportive housing units and service supports necessary for successful transitions. The development of an Integrated Behavioral-Medical Health Model is being initiated in FY2012 by convening key stakeholders for input and advice. The model will draw from experiences from early outreach, transition and community placement activities. In FY2013, it is anticipated that the Integrated Behavioral-Medical Health model will be piloted and that quality assurance monitoring will be fully implemented. The goal is to successfully transition 640 class members by the end of 2013. The Implementation Plan may be accessed at: <http://www.dhs.state.il.us/page.aspx?item=56446>

### **Transformation Transfer Initiative.**

The Transformation Transfer Initiative (TTI) has been instrumental in facilitating regional and statewide collaboration on Mental Health and Justice Issues in Illinois. Most noteworthy in the collaboration was the involvement of judiciary in providing leadership for regional and statewide planning. Despite an ongoing severe state budget crisis and continual cutbacks in mental health services in the community, the TTI partners and stakeholders continued to forge ahead with planning, problem solving, and initiative development. Although, the TTI process identified more issues and service needs than it could ever fix in our current economic climate, it did raise the level of awareness of the needs of justice involved consumers. Also as important to transformation was the initiation of strategies through the TTI process that could become system wide approaches such as peer to peer support, and the development of a Mental Health and Justice Center of Excellence that can continue to support regional and statewide

initiatives with consultation, training, technical assistance, and information dissemination.

In FY2009 DMH was awarded a second SAMHSA Transformation Transfer Initiative grant for \$105,450 which was completed and reported upon to NASMHPD in FY2011. The grant supported three initiatives which will positively impact Mental Health and Justice in Illinois:

*(1) Statewide Mental Health and Justice Advisory Group Strategic Planning -*

- This Advisory Group completed the TTI strategic planning process and issued a Strategic Planning Report that identified priority initiatives for MHJ transformation for the next two years.
- Medicaid application training was provided to 120 provider staff.
- The Jail Data Link project was expanded to Macon county, with four more counties targeted for expansions in the next year (Kane, Mclean, Sangamon, and Vermillion)
- Planning for the establishment of a Illinois Mental Health and Justice Center of Excellence was initiated and start-up support for it was identified.

*(2) Integrated Database Pilots*

- The process of piloting the Integrated Mental Health Court Database was completed. Data was collected on 463 participants at both pilot sites in Cook and Winnebago County. The chief pilot finding was that effectively capturing comprehensive participant data is dependent on the cohesiveness of the Mental Health Court Team. The pilot in Winnebago County showed more effective results in this respect with the data entry person having more efficient access to participant information. Both sites showed that the database is an effective tool for capturing information in a uniform but flexible manner.

*(3) Mental Health and Justice Consumer Conferences and the development of peer-to-peer support*

- Tonier Cain, a nationally recognized consumer expert on Trauma and Recovery provided keynote addresses at the DMH Region III and IV recovery conference, at the Mental Health Court Association and at the Mental Health and Justice Statewide Conference in Dupage Illinois.
- Consumer recommendations for the TTI strategic plan were prioritized with the highest priority given to expanding peer to peer support services in Illinois.
- Peer to peer support to 21 recovery specialists and their supervisors working with local jails and court systems in their communities in Macon, McLean, and Sangamon counties was provided by a specialized consumer consultant funded through TTI.

### **Consumer Programs**

An additional noteworthy development in FY2011 is the fact that Peer-Run Living Room Programs have opened in three sites in Illinois. This is considered a most positive outcome in the midst of a very challenging time.



## **REPORT ON BLOCK GRANT ACTIVITIES AND EXPENDITURES**

### **Expenditure Of Block Grant Dollars In FY2011- Adults**

The Illinois expenditure of the FY 2011 Community Mental Health Services Block Grant was directed at providing services in community settings for adults with serious mental illness and children and adolescents with serious emotional disturbances. Administrative expenses are capped at 5%. For adults, the allocation of block grant dollars continued to be directed toward psychiatric leadership with a small amount for special projects related to community consumer support. Psychiatric leadership services include training and supervision of clinical staff as well as the provision of some services. 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 has been 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. As DMH does not currently apply a special code to specific services funded using Mental Health Block Grant dollars, detailed tracking is not available at the service or the individual consumer level. Approximately 26% of block grant funds are allocated to C&A Services.

A table that details the allocation of dollars to agencies providing services to adults and children is included in the Uniform Reporting System (URS) Illinois Report and in Appendix B of this Report.

## FY2011 SYSTEM PERFORMANCE INDICATORS –ADULT REPORT

**Name of Performance Indicator: A-1:(NOM) Increased Access to Services (Number)**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009	FY 2010	FY 2011	FY 2011	FY 2011
	Actual	Actual	Target	Actual	Percentage Attained
Performance Indicator	129,419	126,883	131,575	111,929	85%
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

---

<b>Goal:</b>	To monitor access to services.
<b>Target:</b>	Maintain or increase access to services for adults with mental illnesses at the FY2010 level.
<b>Population:</b>	Adults with mental illnesses.
<b>Criterion:</b>	2:Mental Health System Data Epidemiology
<b>Indicator:</b>	Increased access to services
<b>Measure:</b>	Number of adults receiving services from DMH-funded community-based providers.
<b>Sources of Information:</b>	DMH ASO Community Reporting System and data warehouse. This indicator is generated from URS Table 2A excluding those whose age is unknown
<b>Special Issues:</b>	
<b>Significance:</b>	Adults with mental illnesses should have access to treatment.
<b>Activities/strategies:</b>	The DMH Fiscal Year 2012 community mental health services budget has been cut by 40 million dollars. The impact on programs/services was described in the mental health block grant plan narrative. Although DMH is striving to maintain access to care by utilizing service benefit packages and utilization management strategies, it was anticipated that there might be reduced access to services. In FY2011, DMH continued to collect data to track the number of persons receiving services from DMH-funded community-based providers. DMH funded providers by contract must submit demographic, clinical information and claims data for all individuals receiving services funded using DMH dollars. The DMH provides data specifications to assure consistency of reporting. Registration data is submitted directly to the DMH information system which is operated by the DMH's Administrative Services Organization (ASO). Claims data, which is submitted to the state Medicaid agency Healthcare and Family Services (HFS), is returned to the ASO after processing where it is stored with registration information in the DMH data warehouse. This information is used as a basis for developing reports and for analytic purposes, and is the basis for reporting the data used to populate the majority of the URS tables.
<b>Target Achievement</b>	Not Achieved; Budget reductions have impacted access to services by individuals with mental illnesses.

---

**Name of Performance Indicator: A-2:(NOM) Reduced Utilization of Psychiatric Inpatient Beds -30 days (Percentage)**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	13.19	13.24	12.39	13.0	95.16%
Numerator	1,353	1,368	--	1,268	--
Denominator	10,256	10,330	--	9,736	--

Table Descriptors:

---

<b>Goal:</b>	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.
<b>Target:</b>	Maintain or decrease readmissions within 30 Days to state hospitals.
<b>Population:</b>	Adults with serious mental illnesses.
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems
<b>Indicator:</b>	Reduced Utilization of Psychiatric Inpatient Beds – 30 Days.
<b>Measure:</b>	Numerator: Number of adult civil readmissions to any state hospital within 30 days of discharge. Denominator: Total number of civil discharges from state hospitals in a fiscal year.
<b>Sources of Information:</b>	Admission, discharge and transaction information for individuals receiving inpatient services in DMH state hospitals are submitted to the DMH Inpatient Clinical Information System (CIS). Data specifications are utilized to assure consistency of reporting by staff. The data used for this indicator is generated from this dataset, and in turn is used to populate URS Table 20A.
<b>Special Issues:</b>	
<b>Significance:</b>	Individuals with mental illnesses should receive treatment in the least restrictive setting possible. DMH will continue to monitor the number of adults readmitted to state hospitals within 30 days of discharge with the goal of decreasing the level of re-hospitalization by providing services in the community that are alternatives to hospitalization. However, there are times when access to inpatient services is required. Treatment provided in these settings should not result in an individual's return to the inpatient setting within a short period of time. Budget reductions for community services may impact readmission rates.
<b>Activities/Strategies:</b>	
<b>Target Achievement:</b>	Not Achieved.

**Name of Performance Indicator: A-3 (NOM): Reduced Utilization of Psychiatric Inpatient Beds -180 days (Percentage)**

(1)	(2)	(3)	(4)	(5)	(7)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	22.86	22.27	22	22	100%
Numerator	2,345	2,301	--	2,231	--
Denominator	10,256	10,330	--	9,736	--

Table Descriptors:

<b>Goal:</b>	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.
<b>Target:</b>	Maintain or decrease the percentage of readmissions within 180 Days to state hospitals.
<b>Population:</b>	Adults with Serious mental illnesses.
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems
<b>Indicator:</b>	Reduced Utilization of Psychiatric Inpatient Beds-180 Days.
<b>Measure:</b>	Numerator: Number of civil readmissions to any state hospital within 180 days. Denominator: Number of civil discharges in the year.
<b>Sources of Information:</b>	DMH Inpatient Clinical Information System.
<b>Special Issues:</b>	
<b>Significance:</b>	Individuals with mental illnesses should receive services in the least restrictive settings possible.
<b>Activities/Strategies:</b>	DMH will continue to monitor the number of adults readmitted to state hospitals within 180 days of discharge with a FY2012 goal of maintaining or decreasing the level of re-hospitalization by maintaining services in the community that provide alternatives to re-hospitalization. DMH continues to implement initiatives that provide community-based alternatives to inpatient hospitalization. However, individuals with serious mental illnesses may still require access to inpatient treatment. Treatment provided in these settings however, should not result in an individual's return to the inpatient setting within a short period of time. Budget reductions in Community Services may lead to an increase in readmissions.
<b>Target Achievement:</b>	Target was Achieved.

**Name of Performance Indicator: A-4 (NOM):-Evidence Based-Number of Practices (Number)**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	3	3	3	3	100%
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

---

<b>Goal:</b>	To maintain the availability of EBPs within the state
<b>Target:</b>	Maintain/increase the number of EBPs available within the state.
<b>Population:</b>	Adults with serious mental illnesses.
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems
<b>Indicator:</b>	Number of EBPs Implemented in Illinois
<b>Measure:</b>	Number of EBPs Implemented in Illinois
<b>Sources of Information:</b>	DMH ASO Community Reporting System and structured program reports collected by DMH staff from community agencies.
<b>Special Issues:</b>	During the past few years, DMH has focused on Supported Employment (SE), Assertive Community Treatment (ACT) and Permanent Supported Housing despite major budget reductions.
<b>Significance:</b>	Adults with serious mental illnesses should have access to evidence-based practices.
<b>Activities/Strategies:</b>	DMH will strive to maintain the number of EBPs available within the state despite major funding reductions for community services. EBPs are very difficult to implement requiring the dedication of many resources, however DMH will work with providers to continue to determine the fidelity with which EBPs that have been implemented are provided. It is unlikely that there will be an increase in the number of EBPs implemented in FY2012.
<b>Target Achievement:</b>	Target Achieved.

**Name of Performance Indicator: A-5 Evidenced Based- Adults with SMI Receiving Permanent Supported Housing (Percentage)**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator			300		54%
Numerator	303	396	--	163	--
Denominator			--		--

Table Descriptors:

<b>Goal:</b>	Provide Permanent Supported Housing (PSH) to adults needing these services.
<b>Target:</b>	Increase the number of individuals with SMI receiving permanent supportive housing by 300 FY2011.
<b>Population:</b>	Adults with serious mental illnesses.
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems
<b>Indicator:</b>	Number of adults with SMI residing in Permanent Supported Housing
<b>Measure:</b>	Number of adults with SMI residing in permanent supportive housing.
<b>Sources of Information:</b>	This data will be generated from the DMH ASO community reporting system and a web-based database created especially for this initiative.
<b>Special Issues:</b>	Measure uses CMHS definition of SMI.
<b>Significance:</b>	Adults with serious mental illnesses who are in need of supported permanent housing should have access to it .
<b>Activities/Strategies:</b>	Work to increase the number of individuals with SMI residing in permanent supportive housing. The DMH has implemented a Permanent Supportive Housing initiative. Bridge subsidy dollars have been identified and allocated to support this goal.
<b>Target Achievement</b>	Target not achieved. DMH had to delay the opening of Round 5 in its permanent supported housing initiative. This resulted in fewer individuals transitioning to permanent supportive housing than anticipated.

**Name of Performance Indicator A-6: Evidence Based-Number of Persons Receiving Supported Employment (Number)**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	1,200		166%
Numerator	2,026	1,988	--	1,993	---
Denominator	N/A	N/A	--		---

**Table Descriptors:**

---

<b>Goal:</b>	Provide Supported Employment to individuals with SMI who want to receive this service.
<b>Target:</b>	Maintain the availability of SE to those individuals receiving it.
<b>Population:</b>	Adults with serious mental illnesses
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems
<b>Indicator:</b>	Number of adults with SMI receiving supported employment
<b>Measure:</b>	Number of adults with SMI receiving supported employment
<b>Sources of Information:</b>	Reports submitted by the DMH Central Office coordinator of supported employment by agencies providing this service.
<b>Special Issues:</b>	All SE data has not yet been integrated into DMH ASO Community Reporting System. Data is being collected through a special database designed for this purpose.
<b>Significance:</b>	Adults with serious mental illnesses who want to work should be able to secure competitive employment. Supported employment supports adults with SMI in their recovery.
<b>Activities/Strategies</b>	DMH staff have been working with DMH funded 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. DMH Decision Support staff are working to develop a web-based reporting system to collect this data.
<b>Target Achievement:</b>	Target Achieved and Exceeded.

**Name of Performance Indicator:#A-7: Evidence Based –Adults with SMI Receiving Assertive Community Treatment (Number)**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	653	678	103.8%
Numerator	653	707	--	678	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

---

<b>Goal:</b>	Provide access to assertive community treatment
<b>Target:</b>	
<b>Population:</b>	Adults with serious mental illnesses with multiple psychiatric hospitalizations
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems
<b>Indicator:</b>	Number of adults with SMI receiving ACT
<b>Measure:</b>	Number of adults with SMI receiving ACT
<b>Sources of Information:</b>	DMH ASO Community Reporting System
<b>Special Issues:</b>	
<b>Significance:</b>	ACT should be available to individuals who will benefit from this service. DMH will strive to maintain access to ACT for adults who need this service. DMH will also continue to undertake efforts to ensure that evidence-based assertive community treatment is being provided by conducting bi-annual fidelity assessments. The last assessment was conducted in FY11.
<b>Activities/Strategies:</b>	
<b>Target Achievement:</b>	Target achieved and exceeded



**Name of Performance Indicator:A-8: Evidenced Based- Adults with SMI Receiving Family Psycho-education (Percentage)**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

**Table Descriptors**

<b>Goal:</b>	Not Applicable: Not currently implementing this EBP.
<b>Target:</b>	Not Applicable.
<b>Population:</b>	Adults with mental illnesses.
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems
<b>Indicator:</b>	Number of adults with SMI receiving family psychoeducation.
<b>Measure:</b>	Number of adults with SMI receiving family psychoeducation.
<b>Sources of Information:</b>	Not currently implemented.
<b>Special Issues:</b>	
<b>Significance:</b>	
<b>Activities/Strategies</b>	Planning is ongoing.
<b>Target Achievement:</b>	Not Applicable

**Name of Performance Indicator:A-9: Evidenced Based- Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders (MISA) (Percentage)**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:** Not Applicable: DMH is currently undertaking planning to continue implementation of Integrated Dual Diagnosis Treatment (IDDT).

**Target:** Not Applicable.

**Population:** Adults with co-occurring serious mental illnesses and substance abuse disorders.

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

**Indicator:** Number of adults with SMI receiving IDDT services.

**Measure:** Number of adults with SMI receiving IDDT services.

**Sources of Information:** Not Applicable.

**Special Issues:** IDDT is one of the more difficult EBPs to implement. Although 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.

**Activities/Strategies** DMH will continue planning to implement IDDT.

**Target Achievement:** Not Applicable.

**Name of Performance Indicator: A-10: Evidenced Based- Adults with SMI Receiving Illness Self-Management (Percentage)**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

---

**Goal:** NOT APPLICABLE: Currently this EBP is not available in Illinois.  
**Target:** No target; continuing efforts to implement this EBP.  
**Population:** Adults with serious mental illnesses.  
**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
**Indicator:** Number of individuals receiving Illness Self-Management..  
**Measure:** Number of individuals receiving Illness Self-Management..  
**Sources of Information:** Not currently collected.  
**Special Issues:**  
**Significance:** Illness self-management should be accessible to individuals with serious mental illnesses.  
**Activities/Strategies:** Not Applicable.  
**Target Achievement:** Not Applicable

**Name of Performance Indicator:**A-11 *Evidenced Based-* Adults with SMI Receiving Medication Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

---

**Goal:** Not Applicable - Currently this EBP is not available in Illinois.

**Target:** No target; continuing efforts to strengthen work in this area.

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

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

**Indicator:** Number of individuals receiving Medication Management.

**Measure:** Numerator: Number of individuals receiving Medication Management.  
Denominator: Total unduplicated number of adults with SMI served by DMH funded care.

**Sources of Information:** Not Applicable.

**Special Issues:**

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

**Activities/Strategies:** This EBP is not currently being implemented.

**Target Achievement:** Not Applicable.

**Name of Performance Indicator: A-12 (NOM) Client Perception of Care (Percentage)**

(1)	(2)	(3)	(5)	(6)	(7)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	67.98	67.33	61.40	67.2%	109.5%
Numerator	327	369	--	320	--
Denominator	481	548	--	476	--

Table Descriptors:

---

<b>Goal:</b>	Provide services that increase consumer perception of positive treatment outcomes.
<b>Target:</b>	Increase percentage of consumers with perception of positive treatment outcomes by 1%.
<b>Population:</b>	Adults with mental illnesses receiving mental health treatment
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
<b>Indicator:</b>	Percentage of adult consumers reporting positively about outcomes.
<b>Measure:</b>	Numerator: Number of adults reporting positively about outcomes using the MHSIP Adult Survey Denominator: Total number of adult responses regarding perception of outcomes completing the MHSIP Adult Survey
<b>Sources of Information:</b>	MHSIP Adult Consumer Survey – Reported in Table 11 URS Tables.
<b>Special Issues:</b>	
<b>Significance:</b>	Mental health services should result in positive outcomes.
<b>Activities/Strategies:</b>	As in previous fiscal years, the DMH selected a random stratified sample of individuals receiving treatment in June 2011 for this year’s survey. This sample was disseminated via mail in October 2011 with a goal of all data collected by early November. The data from the survey will be used to populate portions of table 11 and 11A.
<b>Target Achievement:</b>	Target achieved and exceeded

**Name of Performance Indicator: A-13 (NOM): Increase/Retained Employment**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	23.81	22.71	24	19.08	N/A
Numerator	26,172	23,760	--	18,092	--
Denominator	109,924	107,172	--	94,819	--

Table Descriptors:

**Goal:**

Increase in competitive employment status by adults with mental illnesses receiving treatment. General goal and target is to increase competitive employment rate of individuals receiving treatment. However, 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 established when we begin reporting data at T1 and T2.

**Target:**

**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 the 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.

**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.

**Activities/Strategies:**

Employment status is currently reported at case opening or admission. Assessing 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. DMH has implemented a policy to require 6 month updates of employment status for consumers. Once the quality of data is ascertained through a data integrity plan which is in 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.

**Target**

**Achievement:**

Not Applicable.

**Name of Performance Indicator: A-14 (NOM) -Decreased Criminal Justice Involvement (Percentage)**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	74.65	74.19	N/A	67.86	N/A
Numerator	53	23	--	19	--
Denominator	71	31	--	28	--

Table Descriptors:

---

<b>Goal:</b>	Decreased involvement with the justice system by adults with serious mental illnesses.
<b>Target:</b>	No target established as this measure is a developmental measure.
<b>Population:</b>	Adults with serious mental illnesses who have had involvement with the justice system
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems
<b>Indicator:</b>	Percent of adult consumers arrested in Year 1 who were not rearrested in Year 2. Numerator: Number of adult consumers arrested in T1 who were not rearrested in T2 (new and continuing clients combined)
<b>Measure:</b>	Denominator: Number of adult consumers arrested in T1 (new and continuing clients combined)
<b>Sources of Information:</b>	This indicator was collected using the MHSIP Survey.
<b>Special Issues:</b>	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 appropriateness of this measure.
<b>Significance:</b>	
<b>Activities/Strategies</b>	Data for this indicator was collected using the Adult MHSIP Survey However, due to the low response rate and the developmental nature of the measure NO targets were established for FY2011.
<b>Target Achievement:</b>	Not Applicable.

**Name of Performance Indicator: A-15: (NOM) -Increased Stability in Housing (Percentage)**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009	FY 2010	FY 2011	FY 2011	FY 2011
	Actual	Actual	Target	Actual	Percentage Attained
Performance Indicator	4.58	4.63	N/A	4.90	N/A
Numerator	5,554	5,368	--	5,197	--
Denominator	121,392	115,843	--	106,116	--

**Table Descriptors:**

<b>Goal:</b>	Improve stability of housing for adults with serious mental illnesses
<b>Target:</b>	Decrease the number of individuals in treatment who are homeless. However, since currently this data is collected only at intake prior to treatment we do not expect change to occur. Therefore no target is projected. Once we begin to track data at T1 and T2 we will specify a target. The data reported simply reflects status at intake.
<b>Population:</b>	Adults with serious mental illnesses
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems
<b>Indicator:</b>	Percent of adult consumers who are homeless or living in shelters.
<b>Measure:</b>	Numerator: Number of adult consumers who are homeless or living in shelters. Denominator: All adult consumers with living situation excluding persons with Living Situation reported as "Not Available". Measure excludes those whose age is unavailable.
<b>Sources of Information:</b>	DMH ASO Community Reporting System;
<b>Special Issues:</b>	Assessing 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. As with the collection of the employment indicator, the DMH has implemented a policy that requires 6 month updates of living arrangement status for consumers. Once the quality of data is determined, DMH will be able to report change in living arrangement status across time. This data will be used to generate information for URS Table 15.
<b>Significance:</b>	Adults with serious mental illnesses should have access to stable living environments.
<b>Activities/Strategies</b>	DMH funded providers by contract must submit demographic, clinical information and claims data for all individuals receiving services funded using DMH dollars. The DMH provides data specifications to assure consistency of reporting. Registration data is submitted directly to the DMH information system which is operated by the DMH's Administrative Services Organization (ASO). Claims data, which is submitted to the state Medicaid agency Healthcare and Family Services (HFS), is returned to the ASO after processing where it is stored with registration information in the DMH data warehouse. This information is used as a basis for developing reports and for analytic purposes, and is the basis for reporting the data used to populate the majority of the URS tables.
<b>Target Achievement:</b>	Not Applicable. Target is not specified as data reports only on consumers' status upon admission to treatment.



**Name of Performance Indicator: A-16 (NOM) Adult -Increased Social Supports/Social Connectedness**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	72.11	72.23	N/A	72.0%	N/A
Numerator	362	411	--	344	--
Denominator	502	569	--	478	--

**Table Descriptors:**

---

<b>Goal:</b>	Increased perception of social support/connectedness by individuals participating in treatment.
<b>Target:</b>	No target specified.
<b>Population:</b>	Adults with serious mental illnesses
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems
<b>Indicator:</b>	Percent of adult consumers reporting positively about social supports/social connectedness.
<b>Measure:</b>	Numerator: Number of adult consumers reporting positively about social connectedness. Denominator: Total number of family responses regarding social connectedness.
<b>Sources of Information:</b>	This information is being collected as a component of the FY2011 Adult MHSIP Survey.
<b>Special Issues:</b>	This indicator is developmental and still being refined.
<b>Significance:</b>	Availability of social support may be related to support for recovery.
<b>Activities/Strategies:</b>	The DMH utilizes the MHSIP Adult Consumer Perception of Care Survey to collect this data. As in previous fiscal years, the DMH selected a random stratified sample of individuals receiving treatment in June 2011 for this year's survey. This sample was disseminated via mail in October 2011 with a goal of all data collected by early November. The data from the survey will be used to populate portions of table 11 and 11A.
<b>Target Achievement:</b>	Not Applicable. Due to the developmental nature of this indicator no target was projected.

**Name of Performance Indicator: A-17: (NOM) Adult -Improved Level of Functioning (Percentage)**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	65.06	65.53	N/A	65.15	N/A
Numerator	324	367	--	316	--
Denominator	498	560	--	485	--

Table Descriptors:

---

<b>Goal:</b>	Improved functioning for adults with mental illnesses receiving services
<b>Target:</b>	None-Developmental Measure – No basis on which to set target
<b>Population:</b>	Adults with mental illnesses receiving treatment
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems 4:Targeted Services to Rural and Homeless Populations
<b>Indicator:</b>	Percent of adult consumers reporting positively about functioning.
<b>Measure:</b>	Numerator: Number of adults receiving services reporting positively about functioning Denominator: Total number of adult consumer responses regarding functioning
<b>Sources of Information:</b>	MHSIP Consumer Survey. This indicator is reported in URS Table 11.
<b>Special Issues:</b>	
<b>Significance:</b>	Mental health services should result in improved functioning and reduction in symptoms.
<b>Activities/strategies:</b>	DMH will continue to strive to purchase high quality services for individuals that result in positive perception of functional outcomes. Continue working with the NRI, CMHS and the states to refine/develop this indicator.
<b>Target Achievement</b>	<u>Not Applicable</u> . Due to the developmental nature of this indicator, no target was projected for FY2011.

---

**Name of Performance Indicator: A-18: ACT Service Hours In Community**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	68	72	63	80.60	127.9%
Numerator	42,651	48,517	--	46,953	--
Denominator	62,302	67,088	--	58,251	--

**Table Descriptors:**

---

<b>Goal:</b>	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.
<b>Target:</b>	63% of ACT services will be provided in community settings.
<b>Population:</b>	Adults with serious mental illnesses.
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems
<b>Indicator:</b>	Percentage of ACT service hours provided in community settings for adults being served by the DMH-funded Assertive Community Treatment (ACT) Programs.
<b>Measure:</b>	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.
<b>Sources of Information:</b>	DMH ASO Community Reporting System
<b>Special Issues:</b>	
<b>Significance:</b>	The ACT model emphasizes provision of services outside of traditional service settings.
<b>Activities/Strategies:</b>	DMH will continue to monitor service provision of ACT programs in order to maintain current levels of services delivered in community settings.
<b>Target Achievement</b>	Target Achieved and exceeded.

**Name of Performance Indicator: A-19: Co-Occurring Substance Abuse Disorders –Adults**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	9.50	12.30	N/A	*15.6%	N/A
Numerator	12,575	15,591	--	*17,452	--
Denominator	131,702	126,883	--	111,929	--

Table Descriptors: \*These numbers are correct. The numbers reported on the Webbgas version were incorrect.

**Goal:** To maintain community-based mental health services for persons who have co-occurring mental illness and substance abuse disorders.

**Target:** No target specified. Tracking access to services by individuals with co-occurring disorders.

**Population:** Adults with mental illness.

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

**Indicator:** Percentage of adults with co-occurring disorders based on diagnostic category receiving services.

**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:** 16% of DMH consumers were identified at intake as having a substance abuse and a mental health diagnosis in FY2011. This is likely to be an under-estimate given national statistics and demonstrates the importance of ongoing training in identifying and treating persons with dual disorders (MISA).

**Activities/Strategies** DMH continues to encourage and support increased training for community mental health professionals in the identification, reporting and treatment of co-occurring disorders. This data is collected at intake or admission. DMH will continue to track the number of individuals reported with co-occurring disorders.

**Target Achievement:** Not Applicable. The figures displayed simply reflect consumer status at intake.

**Name of Performance Indicator: A-20 Eligible Population -Adults**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	95.20	94.70	95.0	93.7	99%
Numerator	123,175	120,196	--	104,889	--
Denominator	129,419	126,883	--	111,929	--

Table Descriptors:

<b>Goal:</b>	To maintain access to services for individuals meeting the DMH eligible population criteria.
<b>Target:</b>	Maintain/increase the percentage of individuals meeting DMH eligibility criteria receiving Services from DMH community-based providers.
<b>Population:</b>	Adults with mental illnesses.
<b>Criterion:</b>	2:Mental Health System Data Epidemiology
<b>Indicator:</b>	Percent of adults receiving services from DMH-funded community-based providers who meet the established criteria for “eligible population” at the time of entry into services.
<b>Measure:</b>	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.
<b>Sources of Information:</b>	DMH ASO Community Reporting System. DMH funded providers by contract must submit demographic, clinical information and claims data for all individuals receiving services funded using DMH dollars. The DMH provides data specifications to assure consistency of reporting. Registration data is submitted directly to the DMH information system which is operated by the DMH’s Administrative Services Organization (ASO). Claims data, which is submitted to the state Medicaid agency Healthcare and Family Services (HFS), is returned to the ASO after processing where it is stored with registration information in the DMH data warehouse. This information is used as a basis for developing reports and for analytic purposes, and is the basis for reporting the data used to populate the majority of the URS tables.
<b>Special Issues:</b>	The DMH FY11 budget reductions may have had an impact on the number of individuals receiving treatment in FY 11.
<b>Significance:</b>	State mental health resources and services should be provided to the priority populations of the public mental health system.
<b>Activities/Strategies:</b>	DMH aims to maintain or increase the proportion of persons served who meet the established criteria for “eligible population” at the time of entry into services.
<b>Target Achievement</b>	Target not achieved.

**Name of Performance Indicator: A-21: Employment**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	23	18.70	N/A	16.2%	N/A
Numerator	26,172	23,760	--	18,092	--
Denominator	129,419	126,883	--	111,929	--

Table Descriptors:

---

<b>Goal:</b>	Continue tracking employment status of consumers at case opening
<b>Target:</b>	Track number of individuals employed at case opening
<b>Population:</b>	Adults with mental illnesses
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems
<b>Indicator:</b>	Percentage of adults engaged in full or part time employment that is unsubsidized at case opening
<b>Measure:</b>	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.
<b>Sources of Information:</b>	DMH ASO Community Reporting System.
<b>Special Issues:</b>	
<b>Significance:</b>	Employment is a key issue relating to recovery and resilience. In FY2011, employment rates were at 16% at the 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 developing employment and supportive employment services to assist individuals with mental illnesses in attaining competitive employment.
<b>Activities/Strategies Target Achievement</b>	Not Applicable.

**Name of Performance Indicator: A-22: Forensic Outpatient**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	1.10	1.10	N/A	.14	N/A
Numerator	1,442	1,438	--	167	--
Denominator	129,419	126,883	--	111,929	--

Table Descriptors:

---

<b>Goal:</b>	To track forensic status of adult clients served by the Mental Health System.
<b>Target:</b>	Track the forensic status of consumers accessing mental health treatment through the DMH ASO Community Reporting System.
<b>Population:</b>	Adults with mental illnesses.
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems
<b>Indicator:</b>	Percentage of adult consumers who had been court ordered into treatment due to a finding of Not Guilty by Reason of Insanity (NGRI), or Unfit to Stand Trial (UST), or by criminal court at the time of case opening
<b>Measure:</b>	Numerator: Number of adults reported as unfit to stand trail, 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.
<b>Sources of Information:</b>	DMH ASO Community Reporting System.
<b>Special Issues:</b>	Percentages reported for prior years included non-applicable categories. Hence the greatly reduced count reported for FY11.
<b>Significance:</b>	Community mental health staff track forensic outpatient status at the time of case opening.
<b>Activities/Strategies:</b>	Track the forensic status of consumers accessing DMH funded mental health services. DMH efforts to link mental health databases with county jails are ongoing and provide another means of identifying persons involved in the criminal justice system, as well as facilitating service provision. DMH plans to continue tracking forensic outpatient information at intake
<b>Target Achievement</b>	Not Applicable. Numbers reported reflect status at intake.

**Name of Performance Indicator: A-23: History Of Involvement With The Criminal Justice System**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	1.93	1.88	N/A	1.91	N/A
Numerator	2,497	2,382	---	2,142	---
Denominator	129,419	126,883	---	111,929	---

Table  
Descriptors:

**Goal:** To track justice system involvement of adult consumers served by the Illinois Mental Health system.

Track the justice system involvement of consumers accessing mental health services.

**Target:**

**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:**  
**Special Issues:**

DMH ASO Community Reporting System.

**Significance:**

Identifying individuals involved with the justice system at time of case opening can increase coordination of services that increase the chances of recovery from mental illness and reduce the rate of recidivism and involvement with the criminal justice system. Slightly less than 2% of all persons served due to mental illness have had some involvement with the justice system.

**Activities/strategies:**

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.

**Target Achievement:**

Not Applicable.



**Name of Performance Indicator: A-24: Living Independently (Percentage)**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	78.20	77.50	79	80%	N/A
Numerator	101,199	98,352	--	89,740	--
Denominator	129,419	126,883	--	111,929	--

Table Descriptors:

---

<b>Goal:</b>	To track demographic information on living arrangements of adult clients.
<b>Target:</b>	Track number of individuals living independently at case opening. No increase is projected as this data is collected at intake prior to treatment.
<b>Population:</b>	Adults with mental illness.
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems
<b>Indicator:</b>	Percentage of adults living in private residences, unsupervised, and considered to be living independently at the time of case opening.
<b>Measure:</b>	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.
<b>Sources of Information:</b>	DMH ASO Community Reporting System.
<b>Special Issues:</b>	
<b>Significance:</b>	The proportion of individuals reported as living independently at intake has increased from 78% to over 80% over the past several years.
<b>Activities/Strategies:</b>	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.
<b>Target Achievement:</b>	Not applicable. There is no established target for this indicator.

**Name of Performance Indicator: A-25: Rural Residents Served –Adults**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	28,166	26,046	27,000	22,034	81.6%
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	---	N/A	--

**Table Descriptors:**

---

<b>Goal:</b>	To assure that individuals with mental illnesses who reside in rural areas are accessing the DMH-funded community-based mental health service system.
<b>Target:</b>	Although the geography of rural areas adds challenges to the timely and consistent access to services for both service providers and persons with mental illness, DMH aims to maintain or expand access to community mental health services for persons residing in rural areas.
<b>Population:</b>	Adults with mental illnesses.
<b>Criterion:</b>	4:Targeted Services to Rural and Homeless Populations
<b>Indicator:</b>	Number of individuals being served by DMH-funded community-based providers who are residents of rural areas at the time of entry into services.
<b>Measure:</b>	Number of individuals reported by DMH-funded community-based providers who are residents of rural areas at the time of entry into services.
<b>Sources of Information:</b>	DMH ASO Community Reporting System.
<b>Special Issues:</b>	
<b>Significance:</b>	
<b>Activities/Strategies:</b>	DMH aims to expand access to community mental health services for persons residing in rural areas.
<b>Target Achievement</b>	Not Achieved. There was an overall decrease in individuals receiving services in FY2011.

**Name of Performance Indicator: A-26: Target Population –Adults**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	61.30	58	61	63.29	103.3%
Numerator	79,321	73,501	--	70,847	--
Denominator	129,419	126,883	--	111,929	--

Table Descriptors:

---

<b>Goal:</b>	To assure resources and services are provided to the DMH priority population.
<b>Target:</b>	Maintain access to services for individuals with serious mental illnesses.
<b>Population:</b>	Adults with serious mental illnesses.
<b>Criterion:</b>	2:Mental Health System Data Epidemiology
<b>Indicator:</b>	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.
<b>Measure:</b>	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.
<b>Sources of Information:</b>	DMH ASO Community Reporting System.
<b>Special Issues:</b>	
<b>Significance:</b>	The target group of adults with serious mental illnesses (SMI) is the priority population for the delivery of community mental health services.
<b>Activities/Strategies:</b>	DMH will continue to monitor service provision to assure that individuals with severe mental illnesses receive priority services.
<b>Target Achievement:</b>	Target was achieved and exceeded.

**Name of Performance Indicator: A-27: Vocational Placement (Percentage of adults engaged in full or part-time employment in subsidized, supported or sheltered employment)**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009	FY 2010	FY 2011	FY 2011	FY 2011
	Actual	Actual	Target	Actual	Percentage Attained
Performance Indicator	2.0	2.0	N/A	1.7	N/A
Numerator	2,675	2,468	--	1,947	--
Denominator	129,419	124,231	--	111,929	--

**Table Descriptors:**

---

<b>Goal:</b>	To track demographic information on vocational placement for adult consumers.
<b>Target:</b>	Track vocational status of consumers as reported at intake.
<b>Population:</b>	Adults with mental illnesses.
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems
<b>Indicator:</b>	Percentage of adults who have a vocational placement at the time of case opening.
<b>Measure:</b>	Numerator: Number of adults reported as having a vocational placement at case opening Denominator: Total number of adults served in the fiscal year.
<b>Sources of Information:</b>	DMH ASO Community Reporting System.
<b>Special Issues:</b>	
<b>Significance:</b>	
<b>Activities/Strategies</b>	DMH plans to continue tracking this data while developing specialized employment services.
<b>Target Achievement:</b>	Not applicable. DMH has not established a target for this indicator.

## CHILD AND ADOLESCENT REPORT

### **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 with activities directed toward increasing family voice and participation in the provision of C&A services statewide and in DMH Regions. Planning is currently underway to develop and establish a statewide family organization to support parents and caregivers of children with Serious Emotional Disturbance.*

**Objective C1.1- Family Peer Supports:** Continue 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 FY2011.
- Number of FRD's hired in System of Care grant-funded programs.
- By the end of FY 2011, maintain five Family Consumer Specialists and convene the Family Advisory Councils, 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.

*This continuing objective has been excellently accomplished in FY2011.*

The number of FRDs hired by SASS programs to facilitate parent-to-parent support exceeded expectations. A total of 53.5 FRDs were employed in SASS agencies statewide in FY2011 exceeding the target of 44 FRD positions employed statewide by over 21%. Of the 44 SASS agencies across the State required to have at least one FRD position, only 2 (5%) did not employ an FRD in FY2011 while 16% (7 agencies) employed more than one.

19 Family Resource Developers are employed by the two current System of Care Grant projects. There are 10 FRDs (called "family partners" and "access coordinators") at the ACCESS Initiative in Champaign County (East Central Illinois) and 9 are employed in Project Connect in White, Saline, and Gallatin Counties in Southern Illinois.

The five Family Consumer Specialist positions have been successfully maintained throughout the fiscal year and are currently functional, one in each region, and activities with Family Advisory Councils, coordination of family participation efforts, and consultation to DMH are continuing in all five DMH regions.

#### ***Family Resource Developers***

DMH has required that Family Resource Developers (FRDs) be hired in SASS agencies. Increasing value has been placed on the expertise FRDs bring to the SASS teams and

their support role has expanded. To increase family participation and provide family peer supports, DMH continues to:

- Provide training for FRDs and facilitate monthly FRD regional meetings in order to provide education, resource development, and support for the positions.
- Employ Family Consumer Specialists (FCS) as C & A staff members of DMH in each region of the state. All five of the DMH regions have a Family Consumer Specialist actively involved.
- Increase family participation in Regional Planning Councils, and the IMHPAC. The Child and Adolescent sub-committee of the Illinois Mental Health Planning and Advisory Council which convenes bi-monthly by video and teleconference consists of more than 100 members representing a broad range of stakeholders all across the State. It is successfully co-chaired by a parent who exhibits strong leadership and advocacy skills and a community mental health agency director. This committee has become increasingly influential within the IMHPAC
- Partner with and provide technical assistance and logistical support to the ICG parent group that is concerned with the enhancement of the quality of services in the Individual Care Grant (ICG) program and continues to be a robust voice in developing child services in Illinois.

### **The Family Driven Care Initiative**

*Illinois was one of six states that received a SAMHSA award that paid expenses to participate in a policy academy focused on Family Driven Care. This project has supported collaboration with other child serving systems and stakeholders to address the extent to which systems serving children and adolescents are family driven. The project involved surveys 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. The expectation is that moving the system to truly family driven care will require ongoing effort for several years.*

**Objective C1.2- Family Driven Care: In FY2011 advance Family Driven Care in Illinois by (1) developing the competency requirements and curriculum for the certification of parent providers as Family Partner Professionals. (2) Continuing to educate family members and caregivers through monthly parent empowerment teleconferencing. (3) Developing a virtual classroom to provide access to information for parents.**

#### **Indicators:**

- **A proposal of a protocol for certification and an established curriculum are completed by the end of the fiscal year.**
- **Number of statewide parent empowerment calls completed and the number of parents participating in the calls.**
- **A virtual classroom system that provides information for parents is operational by the end of the fiscal year.**

*This objective was fully achieved. During FY2011, Family Driven Care was actively and successfully advanced and expectations have been exceeded.*

**In addition to the establishment of competency requirements and a curriculum, the examination for the Certified Family Partner Professionals (CFPP) was piloted (“beta tested”) in Chicago by 14 people on May 10<sup>th</sup> and in Springfield by 22 people on May 12<sup>th</sup>. The Study Guide for the CFPP has been completed and will be posted on both the Illinois Certification Board (ICB) Website and on the Project Educare Website (the virtual classroom described below). A workshop on the CFPP was included in ICB Annual Conference in November. Those 36 individuals who took the pilot examination and passed are now preparing to submit evidence of their qualifications which includes a 100-hour training requirement and supervised work experience. Although an official examination date for new applicants has not as yet been set, it is anticipated that the first exam for the CFPP credential will occur in the next six months.**

**Eleven Parent Empowerment Conference Calls were held in FY2011. The number of lines accessing these calls ranged from 20 to 35 for each call.**

**A virtual classroom system that provides information for parents and child-serving clinicians was fully operational by the end of the fiscal year. Project Educare was developed and instituted by Northern Illinois University and is currently fully operational with a separate home page for families and caregivers and one for providers. Once registered, parents and clinicians can regularly log in and participate in a variety of course modules designed for their needs and obtain posted information about resources and events which may be of interest to them. It is estimated that an average of 100 family members are accessing the classroom each month and benefitting from educational modules specifically designed for families.**

**The Project Educare Website may be accessed at: <http://weblog.niu.edu/educare/>**

The Family Driven Care Commission led the development of the Certified Family Partner Professional (CFPP) credential. The CFPP will assist in ensuring the quality of care that is provided to client families by peer parents in many of the child-serving systems. Certification will be accomplished through a mandatory training and experience protocol and the successful completion of a written examination. The goal for this credential is that it will be recognized in Illinois Medicaid Rule (Rule 132), and CFPP's will be authorized to provide services at the Mental Health Practitioner (MHP) level.

Northern Illinois University has developed a virtual classroom that can be used by all the community mental health providers serving children, and another that will support information for families. Currently, fifteen clinical modules in Evidence-Informed Practices have been introduced and are available in the classroom. So far, 127 clinical providers have registered, and it is estimated that an average of 100 family members are accessing the classroom each month.

FY2011 Parent Empowerment Calls:

07/01/10	Cancelled
08/05/10	Taking Care of Yourself (20 lines)
09/02/10	Say It Out Loud-How Much? (Advocacy) 23 lines
10/07/10	Alike But Different (Cultural Competence)
11/04/10	Who's Who on My Child's Treatment Team (Defining Roles)
12/02/10	Tips For Handling the Holidays
01/06/11	Leadership Development (32 lines)
02/03/11	The Value of Measuring Outcomes (29 lines)
03/03/11	Overview of Special Education – Parents' Rights and Responsibilities (25 lines)
04/07/11	Parental Resilience (27 lines)
05/05/11	Building a Natural Support System – Developing Supports With-in Communities (35 lines)
06/02/11	The Sibling Balance (20 lines)

Parent Empowerment Calls have continued in FY2012 with similar participation ranging from 27 to 34 lines each month with discussions on crisis planning, Social Emotional Learning (SEL), advocacy, and what parents should know about trauma.

**Evidence-Informed and Evidence-Based Practices**

*DMH has an evidence based practice committee 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”.*

**ObjectiveC1.3- Evidence Informed Practice: Continue to advance the implementation of evidence-informed practices in the child and adolescent service system:**

- **Implement 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**

**Indicators:**

- **Number of training events provided in FY2011 that 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.

*This continuing objective has been largely accomplished.*

Recent work has been done on identifying and distilling the common elements in Cognitive Behavioral Therapy (CBT) and Behavioral Parent Training (BPT). Training in these elements was piloted with the training cohort in FY2011. Cohort V on “The Common Elements” had 10 all day (6 hour) trainings and 24 (2 times a month) one hour supervisions by phone conference for a total of 84 hours of training. The outcomes in terms of clinician experience and improvement of clients demonstrated through measurement tools (see Objective C2.1) will be evaluated in FY2012 and FY2013.

As noted above (Objective C1.2) Northern Illinois University has developed a virtual classroom that can be used by all the community mental health providers serving children, and another that will support information for families. Currently, fifteen clinical modules in Evidence-Informed Practices have been introduced and are available in the classroom. So far, 127 clinical providers have registered, and it is estimated that an average of 100 family members are accessing the classroom each month. EIP education topics are also presented and discussed in the Parent Empowerment Conference Calls noted above.

Recruitment of a fourth university to provide a Masters level training program in the southern part of the state continued actively during FY2011. DMH C&A Services approached Southern Illinois University to establish the graduate certificate in their social work program but negotiations were not successful. Three Masters level training programs across the state have continued to provide graduate students with certifications in evidence based child and adolescent services. During FY2011, two of these programs, Northern Illinois University at DeKalb and University of Illinois in Urbana Champaign, have begun to incorporate the evidence based training in all the graduate training for human services so that it is no longer something separate. The University of Illinois at Chicago (UIC) Jane Addams Graduate School of Social Work is continuing to offer the separate certification. This initiative is increasing the ability of the workforce to provide evidence-based intervention to youth in Illinois in the long term.

*Provider Education and Training:*

The EBP Committee has provided guidance and oversight to several training initiatives designed to increase competence of providers in Evidence Informed Practices. As of the end of FY2011, 50 agency groups had participated in this EIP training series. An important note here is that 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. Although there were no Learning Collaborative groups in FY2011,, a Learning Collaborative on “Engaging Families in Evidence-based Group

Delivered Services” taught by Dr. Mary McKay is planned in FY2012 and will include 2 in person sessions with Dr. Mary McKay, 4 two hour teleconference/Net meetings and 6 monthly phone conferences.

#### *Virtual Classroom*

Project Educare is an e-Learning website through Northern Illinois University that has learning modules addressing social, emotional and behavioral issues of children and adolescents. The modules are prepared for both clinicians and caregivers. CEUs or Certificates of Participation may be earned.

### **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 (the Collaborative) 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.*

**Objective C1.4- ICG Community-Based Services:** In FY2011, continue to strengthen community service options in the DMH ICG program through increasing the number of youth served and implementation of outcome measures.

#### **Indicators:**

- Number of children served through ICG community service options in FY 2011.
- Evaluation of first year results of the implementation of outcome measures.

*This objective has been successfully accomplished and exceeded expectations. In FY2011, 318 youth were served in community-based care out of the 385 youth in the ICG Program, which represented 82.5% of the total population and greatly exceeded the percent served in previous years. Comparatively, in FY2010, 150 youth were served in community care out of 374 youth which represented 40% of the total served by the ICG program. This reflects the concerted effort of the DMH to serve children/adolescents with serious emotional disturbances in community settings.*

Community-based ICG services are coordinated through agencies funded to provide SASS services. 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. The SASS agencies work with families to identify appropriate support services, serve as a fiscal agent by purchasing the services specified in an approved plan, and monitor their effectiveness in meeting the youth's clinical needs. The program offers a number of supports, including child support services, case coordination services, behavior management services, and therapeutic stabilization services. In FY2010, 150 youth were served in Community-Based care out of the 374 youth in the ICG Program, which represented 40% of the total population and is consistent with the percent served in Community-Based care in previous years. Recently, the ICG program began to incorporate the assessment scales and outcome measures reported in Objective C2.1 in all ICG residential and community-based programs. ICG services are available across the state.

### ***The MHSIP Youth Services Survey for Families***

*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 National Outcome Measures (NOMS) measures reported through the survey are: Client Perception of Care, Increased Social Supports/Social Connectedness, and Improved Level of Functioning.*

### **Objective C1.5 (NOM) - Assessing Parent/Caregivers Perception of Care:**

**The percentage of parents/caregivers reporting positive outcomes through the Youth Services Survey for Families will increase in FY2011. (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**

**This objective is currently in process. During November 2011, the FY2011 Consumer Survey was mailed to a random sample of 2,600 families of children ages 11 and under receiving services in June 2011. It is anticipated that an analysis of the responses will be completed in February 2012. The FY2010 Consumer Survey was completed during FY2011 and serves as the baseline from which to track**

**consumer satisfaction with services and the newly developed national outcome measures for social connectedness and improved functioning.**

**The FY2010 survey results showed an increase in Client Perception of Care (Outcomes Domain) from responses in previous years (52% to 56%) and 44% of caregivers reported an improvement in school attendance as a result of services, an increase of 10% over FY2009. For Decreased Criminal Justice Involvement only one caregiver reported an arrest. Increased Social Supports/Social Connectedness changed very slightly (75% in FY2008, 76% in FY2009, and 77% in FY2010) but Improved Level of Functioning increased significantly from 53% in FY2009 to 58% in FY2010. Generally, six of the seven domains surveyed showed gains in percentage points and only one - Reporting Positively about Access - dropped very slightly from 71% in FY2009 to 70% in FY2010.**

### **The FY2010 MHSIP-YSS Survey**

In FY2010, DMH conducted its annual perception of care survey targeting caregivers of children 0-11 who received DMH funded MH services. The decision to exclude adolescents aged 12-17 was made because some adolescents seek help without their parent's knowledge and receiving a survey at home may compromise that decision. 2600 participants were chosen at random and the survey was sent to their home address. Caregivers were asked to rate on a scale of 1 to 5 whether they agreed or disagreed with 26 statements. All surveys were anonymous. The 26 questions comprising the survey were combined to create the results for the domains listed below.

Four hundred and eleven (411) caregivers responded to the survey which provided a large enough sample for a statewide evaluation. Of those: sixty-six percent of the children are male; 31% female. When asked about Medicaid, 90% of the caregivers reported that their children were receiving Medicaid. Eighty-three percent of respondents were currently receiving services; 44% received services for less than 1 year; 56% for 1 year or more.

Generally, most caregivers felt satisfied with their services but only a little more than half of caregivers surveyed agreed that their children functioned better in their lives as a result of services. The percent of positive responses to the 7 domains overall are listed below in descending order from the greatest number of positive responses (cultural sensitivity) to the least (Outcomes).

Reporting Positively About Cultural Sensitivity of Staff	88%
Reporting Positively about Participation in Treatment Planning	84%
Reporting Positively about Social Connectedness	77%
Reporting Positively about General Satisfaction	72%
Reporting Positively about Access	70%
Reporting Positively about Functioning	58%
Reporting Positively about Outcomes	56%

The FY2010 survey resulted in the following significant observations:

- Survey respondents felt the cultural sensitivity of staff providing services was very high. 88% felt positively about it.
- Survey questions related to functioning and outcome had the lowest percent of positive responses: 58% and 56% respectively.
- One out of four caregivers reported problems with access to services.
- Compared to previous years, responses are relatively stable, with a slight increase in reporting of positive Outcomes in FY2010.
- Nationwide average responses have generally been 10 percentage points higher than the Illinois average, except for Participation in Treatment Planning where the national score is only 3 points higher.

### **Decreased Rate of Readmissions**

**Objective C1.6 – State Hospital Readmissions (NOM): Continue efforts to decrease 30 day and 180 day rates of readmissions 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.**

*This objective continues to be addressed.*

**DMH continues 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 the goal of maintaining or decreasing the level of re-hospitalization through the use of community based services that provide alternatives to hospitalization. However, it is to be expected that children and adolescents with serious emotional disturbances and mental disorders, 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 Child Performance Indicators section for data and information about these indicators that are a National Outcome Measure (NOM)**

### ***Child and Adolescent Outcomes Analysis***

*The web-based Outcomes Analysis System began operating in July of 2008. 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. Implementation has gone well and has included training in the instruments and monthly Technical Assistance calls and Net meetings for users of the system.*

**Objective C2.1- C&A Outcomes: By the end of FY2011, fully integrate the Web-based system into treatment planning and agency decision-making. Implement 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 and able to include functional assessments in the billing process.**
- **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 FY2011.**

*This objective has been substantively accomplished.*

**The web-based outcomes analysis system is being utilized by 151 agencies with 2225 users in the system. A total of 26,790 unduplicated clients have been registered. Cumulatively, 52,819 assessments have been completed using the Ohio Scales; 46,788 using the Columbia Impairment Scales for Parents and 36,000 using the Columbia Impairment Scales for Youth.**

**Training on the use of the outcomes web-based system has been ongoing through a Technical Assistance Conference Call every month and bi-monthly conference calls on the clinical use of data. Training in the use of the DECA scales was conducted by Mary MacKrain in June/July 2011. The Ohio Scales Training and DECA training presentations are posted on the Project Educare Website as a resource for providers.**

**Seventy (70) agencies are reporting DECA assessments. A total of 1,074 DECA-Parent and 240 DECA-Clinical assessments were reported to have been completed.**

**Statewide Outcomes**

Statewide, the Ohio Scales showed a 22% reduction in scores over 90 days; the Columbia Impairment Scale for Parents- an 11.6% reduction, and the Columbia Impairment Scale for Youth, a 12.5% reduction. The results indicate significant 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 was 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 were added to the web system and trainings were held for providers on both use of the instruments and mental health work with young children.

***Mental Health and Juvenile Justice***

*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 to monitor the progress of each youth for a period of six months.*

**ObjectiveC3.1- MHJJ: In FY 2011, increase the number of youth receiving services through the Mental Health Juvenile Justice Initiative (MHJJ)**

**Indicators:**

- Number of youth served by the program statewide.
- Percentage linked to services, and
- Percentage of youth re-arrested

*The activities of this continuing objective were accomplished. A modest increase in the number of youth served was realized.*

**The number of those referred declined slightly from FY2010 and the number of those enrolled increased slightly in FY2011. In FY2011, 1185 youth were referred to the MHJJ Initiative, 551 were screened, 494 were determined eligible for program services, and 426 were actually enrolled. The initiative reported that 80.5% of the youth were linked to services and that 21.4% had been re-arrested in FY2011. Budget related issues and provider instability due to financial challenges have continued to negatively impact the program.**

*The data for the FY 2010 indicators and data for FY 2011 are detailed below:*

<b>FY '10</b>	Referred	Screened	Eligible	Enrolled
	1193	517	474	420

<b>FY '11</b>	Referred	Screened	Eligible	Enrolled
	1185	551	494	426

	<b>FY '10</b>	<b>FY '11</b>
Linked to services	71.9%	80.51%
Re-arrest rate	17.8%	21.36%

### **Evaluation and Progress**

Although the number of referrals decreased in FY2011, there were increases in youth screened, eligible and receiving services in MHJJ. The most recent data analysis also indicates 76.2% of youth had a previous history of mental illness with 47.1% on psychotropic medication. This represents a significant increase in the percentage of youth with mental illness compared to the two previous years.

In FY2010, for those youth actually served approximately 72% were male. 47% of the youth receiving services were White, 40% African-American and 9% Hispanic. In FY2011, 73.3% were male. 46.2% of youth enrolled in the program were White, 38.2% African-American and 9.7% were Hispanic. This represents the second year where the program saw a slight increase in the percentage of males with a slight decrease in African American youth, compared to the previous two years.

In FY2012 and FY2013, the overall mission of MHJJ will remain unchanged and liaisons will continue their efforts to intercept youth at the earliest stages of their justice involvement to further increase access to services. In response to the decrease in minority program participants, MHJJ will continue to place a high priority on the program's targeted outreach to, and education of, referral sources regarding minority youth with serious mental illnesses. Continuously increasing the percentage of minority youth referred and percentage of minority youth enrolled is a priority objective for the program particularly in light of the overrepresentation of minority youth in the juvenile justice system.

### **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) identified early childhood mental health as a priority in Illinois and collaborated in funding appropriate mental health services to children ages 0-5 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.*



**Objective C3.2:** During FY2011, 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. Implement 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 FY 2011.
- A description of services provided to children and their families/caretakers and the number of service hours provided for each service in FY2011
- 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.

*This objective was met in FY2011. However, the program terminated at the end of the fiscal year.*

In FY 2011 the initiative continued to provide Illinois families with array of clinical services. As of March, 2011 slightly more than 100 infants and children received clinical services not available prior to implementation of the initiative. However, due to budget reductions encountered by the Illinois Children's Mental Health Partnership, this program was discontinued at the end of FY2011.

During FY2009 and FY 2010, nearly 450 infants, young children and their families received clinical, case management and support services from providers funded by the initiative. More than 8,000 direct service hours were delivered and over \$100,000 was billed to Medicaid. 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.

**Objective C4.1 - Child Tele-psychiatry:** Continue to implement Tele-psychiatry services in six rural sites in Illinois. Explore possibilities for expansion through the support of recently approved Medicaid reimbursement for telemedicine services.

**Indicator:**

- Number of youth served FY 2011
- Number of psychiatry hours provided in FY2011.
- A plan for expansion of Tele-psychiatry services for rural youth is completed and proposed.

*This objective was substantively accomplished.*

In FY2011, 232 youth were served from seven community mental health agencies located in rural areas. In all, 1538 Tele-psychiatry sessions were provided, which

**included 1100 hours with a child psychiatrist. The most common diagnoses of children who received these services were: Bipolar Disorders (43%), Attention Deficit Hyperactivity Disorder (ADHD) (16%), Mood Disorders (16%), and Posttraumatic Stress Disorder (12%). Plans for the future expansion of this needed initiative are under active consideration.**

## **Background**

Since FY2008, DMH has 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. Services include assessment, treatment and ongoing monitoring of youth. By the end of FY2009, 168 children/adolescents and their families had benefited from Tele-psychiatry services and 939 psychiatry hours had been provided. Tele-psychiatry services were implemented in the six rural sites and an additional site was added in FY2010, bringing the number of sites to seven. In the beginning of FY2010, the project had to be put on suspension status, due to contractual freezes related to budget issues and the service was only available for eight months. In FY2010, 121 youth were served from seven community mental health agencies and 653 hours of Tele-psychiatry services were provided to these youth.

## **SIGNIFICANT EVENTS AND CHANGES-CHILD & ADOLESCENT**

### **Fiscal Challenges Facing Illinois**

Please see the Significant Events and Changes section in the Adult Report for a full description of the fiscal and service issues which impact both adults and children.

Additionally, the Illinois Children's Mental Health Partnership, which has been successful in garnering appropriations for furthering children's mental health in Illinois, also experienced a significant budget reduction for FY2012 which resulted in the termination or significant change to some initiatives and programs described in the FY2011 Block Grant Application and Plan and referenced in the previous section (Summary of Areas Needing Attention).

However, there have been some noteworthy programmatic accomplishments in FY2011 so far unmentioned in this Implementation Report:

- Work began on two new System of Care Grants awarded in FY2010. The Access Initiative in Champaign County and Project Connect in White, Saline, and Gallatin Counties in Southern Illinois. Work continued in the System of Care initiative in McHenry County.
- In addition to the three current SOC Grants, a new grant application was submitted to SAMSHA for a 12 month System of Care Expansion Grant. This one-year SOC Grant was subsequently awarded to Illinois in October and will provide approximately \$750,000 for planning a statewide system of care initiative. The Illinois United for Youth System of Care Expansion Planning Initiative (IUY) is expected to result in the development of a comprehensive strategic plan for integrating the system of care philosophy into the delivery of a full array of behavioral health services for youth with serious emotional disturbances statewide throughout Illinois. The objectives of IUY will build upon and reflect the goals of current system of care work including infrastructure development and sustainability, youth and family involvement, readiness for the adoption and implementation of core SOC principles across the state and the development of a statewide SOC blueprint including action steps that aim to create and sustain a statewide system of care. *Of highest priority will be the development of a statewide lead family organization and an SOC primer training opportunity for key stakeholders.* The collective experience acquired from the three current SAMSHA funded Systems of Care in Illinois and the work of the Interagency Child Serving Clinical Care Coordination Committee, which has been planning for statewide change since Fall 2010 will provide direction for initiating, planning and implementation of the Initiative. As with the current grants, the strategic planning will leverage the commitment of youth, their families, the child serving state agencies that serve them and a myriad of stakeholders.

- The Early Intervention For Children of Incarcerated Parents (EICIP) program located in Chicago's North Lawndale community, successfully piloted in the past few years, serves children of incarcerated parents. Utilizing a Multi-Family Group format, the 14-week curriculum of Strengthening Families for the Future model which is designed for at-risk families is employed to reconstruct relationships within the families. The program also provides case management, mentoring, tutoring, crisis counseling, individual/family therapy, career counseling and assessment as well as community education. Referrals to the program come from local elementary schools, social service agencies, Cook County Jail, and the state's corrections system. A total of 116 children and youth and 31 parents, totaling 147 families received direct service this year. The success of this project led to its replication in Southern Illinois, in Madison and St. Clair Counties during FY2011. This new EICIP program employs clinicians that are responsible for the clinical work and for outreach as well as stakeholder education. Family support, case management, individual and group therapy are provided. Children and youth are eligible if they have at least one parent incarcerated with a release date no further out than two years and an intention of returning to a primary parenting role. Upon the parents' release, they are reunified with their child and linked to the resources in the community. Currently there are twenty families being served.
- A new initiative in FY2011, Reaching Out To Help – Prevention and Early Intervention Services for Children and Youth (“Reaching Out To Help”) is a 3-tiered public health model. which is the DMH next generation of early intervention strategies. Tier 1 consists of universal health promotion/prevention activities which target an entire population to promote and enhance emotional wellness by increasing developmentally appropriate mental health skills. Tier 2 is early intervention targeting children at greater risk of developing risky behaviors and mental health concerns. Tier 3 are treatment activities targeting children identified as having significant mental health concerns that require referral and linkage to clinical mental health treatment. This next generation initiative is designed to be a set of interconnected interventions that will identify a specific population of children and/or adolescents at-risk for mental health concerns and provide interventions across a continuum of wellness from prevention to treatment. In FY2011, through DMH's competitive funding application process, seven mental health providers located throughout Illinois have been funded to: a) establish and nurture local systems of care, embedded in a public health model, consistent with core values and principles of CASSP and Family Driven Care; b) enhance the capacity of the community to design and implement protocols for prevention, early identification, early intervention, referral, and follow up; c) develop and implement an array of evidenced based or evidence informed services and practices across a continuum of need that address the promotion/prevention, early intervention, and treatment needs of the identified population; and, d) participate in evaluation, networking, and technical assistance activities designed to promote the development of effective systems of care

- models. Fully establishing and implementing the Reaching Out to Help initiative is an objective for FY2012 and FY2013.
- The DHS Division of Mental Health in partnership with the Illinois State Board of Education and the Illinois Children’s Mental Health Partnership developed the Interconnected Systems Model of School Based Mental Health (ISM). This three tiered model is designed to meet the universal (promotion/prevention), early intervention, and treatment needs of Illinois students through the development of a partnership between systems. ISBE and DMH coordinators work closely to further develop the infrastructure for integrating school systems and community mental health services in the ISM model. Concurrent funding of the Early Intervention Grants to school districts by ISBE and the Mental Health and School Collaboration grants through DMH and state level partnering has resulted in significant and rewarding opportunities for cross training with school staff, staff members of community mental health agencies, and supportive stakeholders. Regional Learning Collaboratives have sprung up in response to the need to share experience and knowledge regarding specific program areas, prevention and intervention issues, and concepts in clinical work and education. The sharing of the cumulative knowledge and experience of this integrative approach has been instrumental in garnering federal grants to two school districts in rural Illinois and a Safe Schools grant to Chicago Public Schools. During School Year 2010/2011, six Community Mental Health Providers offered services in 12 schools. A total of 7,118 individuals were served through the initiative, including 6,614 students and 504 adults who were school staff, parents, and community members. The following activities occurred:
    - a. 2747 students and 5 adults participated in classroom level skill building activities.
    - b. 322 students participated in small group interventions;
    - c. 163 students and 111 adults received family support, including linking family members to needed mental health services.
    - d. 313 adults received consultation and education to support
    - e. 774 students in the classroom

FY2011 has also been a year of transition for C&A Administrative staff with the departure of several key members and the appointment of a new full-time Director who is board certified in Child Psychiatry

## **REPORT ON BLOCK GRANT ACTIVITIES AND EXPENDITURES**

### **Allocation Of Block Grant Dollars In FY2011**

The Illinois plan for the expenditure of the FY 2011 Community Mental Health Services Block Grant was directed at providing services in community settings for children and adolescents with serious emotional disturbances. Administrative expenses are capped at 5%. Approximately 26% of block grant funds are allocated to C&A Services. For FY2011, block grant funds were 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. The DMH does not currently apply a special code to specific services funded using Mental Health Block Grant dollars, thus detailed tracking is not available at the service or the individual consumer level. *Allocations to specific agencies for service provision to Children and Adolescents are reported in the Uniform Reporting System (URS) tables and the Appendix.*

## CHILD-IMPLEMENTATION REPORT SYSTEM PERFORMANCE INDICATORS

**Name of Performance Indicator: C-1 (NOM) Increased Access to Services (Number)**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	36,768	36,242	36,768	33,610	91.41
Numerator	N/A	N/A	--		--
Denominator	N/A	N/A	--		--

**Table Descriptors:**

**Goal:** To monitor access to services.  
The DMH Fiscal Year 2012 community mental health services budget has been cut by 40 million dollars. The impact on programs/services was described in the mental health block grant plan narrative. Although DMH is striving to maintain access to care by utilizing service benefit packages and utilization management strategies, it is anticipated that

**Target:** there may be reduced access to services.

**Population:** Children and adolescents with emotional and serious emotional disturbances

**Criterion:** 2:Mental Health System Data Epidemiology  
3:Children's Services

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

**Measure:** Number of children/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. Excludes those whose age is unknown.

**Special Issues:**

**Significance:** Services should be accessible to children and adolescents with mental health needs. DMH funded providers by contract must submit demographic, clinical information and claims data for all individuals receiving services funded using DMH dollars. The DMH provides data specifications to assure consistency of reporting. Registration data is submitted directly to the DMH information system which is operated by the DMH's Administrative Services Organization (ASO). Claims data, which is submitted to the state Medicaid agency Healthcare and Family Services (HFS), is returned to the ASO after

**Activities/Strategies:** processing where it is stored with registration information in the DMH data warehouse. This information is used as a basis for developing reports and for analytic purposes, and is the basis for reporting the data used to populate the majority of the URS tables.

**Target Achievement:** Target Not Achieved. It is likely that DMH budget reductions have impacted access to treatment.  
:

**Name of Performance Indicator: C-2 (NOM) Reduced Utilization of Psychiatric Inpatient Beds- 30 day Readmissions (Percentage)**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	4.23	5.88	5	0	100
Numerator	3	4	--	0	--
Denominator	71	68	--	14	--

**Table Descriptors:**

<b>Goal:</b>	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.
<b>Target:</b>	Maintain or decrease readmission rates of children and adolescents to DMH state hospitals
<b>Population:</b>	Children and adolescents with serious emotional disturbances.
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
<b>Indicator:</b>	Decreased rate of civil readmissions to state psychiatric hospitals within 30 days.
<b>Measure:</b>	Numerator: Number of civil readmissions to any state hospital within thirty days of being discharged. Denominator: Total number of civil discharges in the year.
<b>Sources of Information:</b>	Admission, discharge and transaction information for individuals receiving inpatient services in DMH state hospitals are submitted to the DMH Inpatient Clinical Information System (CIS). The Illinois DMH contracts the majority of inpatient services for children and adolescents
<b>Special Issues:</b>	with 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.
<b>Significance:</b>	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 should not result in an individual's return to the inpatient setting within a short period of time.
<b>Activities/Strategies:</b>	DMH continues to monitor the number of children and adolescents readmitted to state hospitals within 30 days of discharge with a goal of maintaining or decreasing the level of re-hospitalization by maintaining services in the community that provide alternatives to re-hospitalization.
<b>Target Achievement:</b>	Achieved as no readmissions were reported. However, the numbers reported are so small that this information may not be meaningful.



**Name of Performance Indicator: C-3 (NOM):** Reduced Utilization of Psychiatric Inpatient Beds -180 day Readmissions (Percentage).

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	5.63	13.24	5.6	0	100
Numerator	4	9	--	0	--
Denominator	71	68	--	14	--

Table Descriptors:

---

<b>Goal:</b>	To decrease readmissions of individuals to state hospitals within 180 days by providing treatment that results in sufficient clinical stabilization so that subsequent treatment is provided in the least restrictive setting.
<b>Target:</b>	Maintain or decrease level of readmission rate to state hospitals.
<b>Population:</b>	Children and adolescents with serious emotional disturbances.
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
<b>Indicator:</b>	Decreased rate of civil readmissions to state psychiatric hospitals within 180 days.
<b>Measure:</b>	Numerator: Number of civil readmissions to any state hospital within 180 days. Denominator: Total number of civil discharges in the year.
<b>Sources of Information:</b>	DMH Inpatient Clinical Information System.
<b>Special Issues:</b>	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.
<b>Significance:</b>	Individuals with mental illnesses should receive services in the least restrictive settings possible. However, there are times when access to inpatient services is required.
<b>Activities/Strategies:</b>	DMH will continue to monitor the number of children and adolescents readmitted to state hospitals within 180 days of discharge with a goal of maintaining or decreasing the level of re-hospitalization by maintaining services in the community that provide alternatives to re-hospitalization. However, as should be noted, the number of children/adolescents hospitalized in state hospitals was extremely small (n=14) in FY2011.
<b>Target Achievement:</b>	Target Achieved. However, the numbers are so small that this indicator may not be meaningful.

**Name of Performance Indicator: C-4 (NOM) Evidence Based -Number of Practices (Number)**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

---

<b>Goal:</b>	DMH is not currently implementing the EBPs that are part of the National Outcome Measures
<b>Target:</b>	DMH is not currently implementing the EBPs that are part of the National Outcome Measures
<b>Population:</b>	Children with serious emotional disturbances
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
<b>Indicator:</b>	Number of Child/Adolescent EBPs implemented
<b>Measure:</b>	Number of Child/Adolescent EBPs implemented
<b>Sources of Information:</b>	DMH ASO Community Reporting System
<b>Special Issues:</b>	The DMH is focusing on an Evidence Informed Practice approach that is described in the narrative. As such, the EBPs identified as NOMS are not being implemented in Illinois.
<b>Significance:</b>	
<b>Activities/Strategies:</b>	DMH is not currently implementing the EBPs that are part of the National Outcome Measures
<b>Target Achievement:</b>	Not Applicable.

**Name of Performance Indicator: C-5 (NOM) Evidence Based -Children with SED Receiving Therapeutic Foster Care (Percentage)**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

---

<b>Goal:</b>	Not Applicable. Illinois is not implementing this EBP.
<b>Target:</b>	DMH is not currently planning to implement therapeutic foster care.
<b>Population:</b>	Children/adolescents with serious emotional disturbances
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
<b>Indicator:</b>	Number of children and adolescents receiving therapeutic foster care.
<b>Measure:</b>	Number of children and adolescents receiving therapeutic foster care.
<b>Sources of Information:</b>	
<b>Special Issues:</b>	Foster care is provided through the state welfare agency. The DMH does not anticipate that it will implement this EBP.
<b>Significance:</b>	
<b>Activities/Strategies:</b>	DMH has no current plans to implement therapeutic foster care as this service would be administered by the child welfare agency.
<b>Target Achievement</b>	Not applicable

**Name of Performance Indicator: C-6 (NOM) Evidence Based -Children with SED Receiving Multi-Systemic Therapy (Percentage)**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

---

<b>Goal:</b>	NOT APPLICABLE. DMH has no plans to implement MST in Illinois.
<b>Target:</b>	DMH is not currently providing this EBP.
<b>Population:</b>	Children/adolescents with serious emotional disturbances
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
<b>Indicator:</b>	Number of children and adolescents receiving multi-systemic therapy
<b>Measure:</b>	Number of children and adolescents receiving multi-systemic therapy
<b>Sources of Information:</b>	Not Applicable – DMH is not collecting or reporting data on this EBP.
<b>Special Issues:</b>	DMH is not currently implementing MST. Rather it is focusing on evidence-informed practices.
<b>Significance:</b>	
<b>Activities/Strategies:</b>	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.
<b>Target Achieved:</b>	Not applicable

**Name of Performance Indicator: C –7 (NOM) Evidence Based -Children with SED Receiving Family Functional Therapy. (Percentage)**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

---

<b>Goal:</b>	NOT APPLICABLE. DMH has no plans to implement this EBP.
<b>Target:</b>	DMH is not currently providing this EBP.
<b>Population:</b>	Children/adolescents with serious emotional disturbances
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
<b>Indicator:</b>	Number of children and adolescents receiving family functional therapy.
<b>Measure:</b>	Number of children and adolescents receiving family functional therapy.
<b>Sources of Information:</b>	
<b>Special Issues:</b>	DMH is focusing on evidence –informed practices and has no specific plans to implement family functional therapy at this time.
<b>Significance: Activities</b>	The DMH has no plans at this time to implement family functional therapy as it is focusing its effort on evidence –informed practices
<b>Target Achievement:</b>	Not Applicable.

**Name of Performance Indicator: C-8: (NOM): Client Perception of Care (Percentage)**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	52.27	56.51	60	N/A	
Numerator	196	230	--	N/A	--
Denominator	375	407	--	N/A	--

Table Descriptors:

<b>Goal:</b>	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
<b>Target:</b>	Increase the percentage of caregivers reporting positive outcomes for their children/adolescents.
<b>Population:</b>	Parents/caregivers of children/adolescents receiving DMH funded mental health services.
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
<b>Indicator:</b>	Percentage of families reporting positively about outcomes.
<b>Measure:</b>	Numerator: Number of caregivers reporting positively about outcomes of treatment Denominator: Total number of family responses regarding perception of outcomes.
<b>Sources of Information</b>	The DMH utilizes the MHSIP Youth Services Survey for Families Perception of Care Survey to collect this data. The data from the survey will be used to populate portions of table 11 and 11A
<b>Special Issues:</b>	
<b>Significance:</b>	Individuals receiving treatment should report positive outcomes for treatment.
<b>Activities/Strategies:</b>	As in previous fiscal years, the DMH selected a random stratified sample of individuals receiving treatment in June 2011 for this year's survey. This sample was disseminated via mail in November 2011. Data will be available by January 2012.
<b>Target Achievement:</b>	Not available until January 2012.

**Name of Performance Indicator: C-9 (NOM) -Return to/Stay in School (Percentage)**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	33.33	44	N/A	N/A	N/A
Numerator	58	69	--	N/A	--
Denominator	174	157	--	N/A	--

**Table Descriptors:**

<b>Goal:</b>	Monitor school attendance of children/adolescents with serious emotional disturbances receiving mental health treatment
<b>Target:</b>	No target set due to low response rate and developmental nature of the indicator.
<b>Population:</b>	Children with emotional and serious emotional disturbances aged 0-11.
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
<b>Indicator:</b>	Percent of parents/caregivers reporting improvement in child's school attendance Numerator: Number of parents reporting improvement in child's school attendance. (Both new and continuing clients.)
<b>Measure:</b>	Denominator: Total responses (excluding not available) new and continuing clients combined.
<b>Sources of Information:</b>	MHSIP Annual Youth Services Survey
<b>Special Issues:</b>	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 low response rate for this variable as well as the developmental nature of the indicator.
<b>Significance:</b>	Children/adolescents with ED/SED should benefit from receiving mental health services. The ability to regularly attend and perform in school is a tangible benefit of mental health services.
<b>Activities/Strategies:</b>	DMH has selected a random stratified sample of individuals receiving treatment in June 2011. This sample is the basis for the survey disseminated in November 2011. Data will be available in January 2012.
<b>Target Achievement:</b>	Data for this indicator has been collected using the YSS/F MHSIP Survey. However, given the developmental nature of the indicator and the small numbers used for reporting , no target was established for FY2011 . Data will be available in January 2012.

**Name of Performance Indicator: C-10: (NOM) Decreased Criminal Justice Involvement (Percentage)**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	27.27	43.95	N/A	N/A	N/A
Numerator	6	69	--	N/A	--
Denominator	22	157	--	N/A	--

Table Descriptors:

<b>Goal:</b>	Monitor Juvenile Justice Involvement for children/adolescents who have forensic issues and who are receiving mental health treatment
<b>Target:</b>	Data for this indicator was collected in FY2008 through FY2010. However, due to the developmental nature of the measure and the low response rate we elected not to set a target for FY2011.
<b>Population:</b>	Children/adolescents with serious emotional disturbances who are involved with the justice System and who are receiving mental health services
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
<b>Indicator:</b>	Percent of children/youth consumers arrested in Year 1 who were not rearrested in Year 2. Numerator: Number of children/youth consumers arrested in T1 who were not rearrested in T2.
<b>Measure:</b>	(new and continuing clients) Denominator: Number of children/youth consumers arrested in T1 (new and continuing clients combined).
<b>Sources of Information:</b>	Youth Services Survey for Families (Caregivers)
<b>Special Issues:</b>	This indicator is still developmental; as such DMH is not projecting targets.
<b>Significance:</b>	The provision of mental health services should have an impact on the outcomes for Children/adolescents involved in the justice system
<b>Activities/Strategies:</b>	DMH disseminated the FY2011 survey in November 2011. Data will be available for this indicator in January 2012.
<b>Target Achievement:</b>	Not Applicable. Data for this indicator will be collected using the YSS/F MHSIP Survey. However, given the developmental nature of the indicator and the small numbers used for reporting , no target was established for FY2011.



**Name of Performance Indicator: C-11 -Increased Stability in Housing (Percentage)**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	0.71	0.59	N/A	.56	N/A
Numerator	240	197	--	188	--
Denominator	33,996	33,604	---	33,610	--

Table Descriptors:

<b>Goal:</b>	Increase stability in housing by reducing the number of children who are homeless or living in shelters. Indicator specifies increase, however, it is currently only a snapshot of consumers' status at admission; thus we would not project an increase.
<b>Target:</b>	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.
<b>Population:</b>	Children/Adolescents with serious emotional disturbances who are homeless and living in shelters.
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
<b>Indicator:</b>	Percent of Child/Adolescent clients who are homeless and living in shelters.
<b>Measure:</b>	Numerator: Number of Child/Adolescent clients who are homeless and living in shelters. Denominator: All child/adolescent clients with known living situation (excluding persons with Living Situation Not Available).
<b>Sources of Information:</b>	DMH ASO Community Reporting System
<b>Special Issues:</b>	Assessing 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. As with the collection of the employment indicator, the DMH has implemented a policy that requires 6 month updates of living arrangement status for consumers. Once the quality of data is determined, DMH will be able to report change in living arrangement status across time.
<b>Significance:</b>	Children/Adolescents with serious emotional disturbances should have access to stable living environments.
<b>Activities/Strategies:</b>	DMH funded providers by contract must submit demographic, clinical information and claims data for all individuals receiving services funded using DMH dollars. The DMH provides data specifications to assure consistency of reporting. Registration data is submitted directly to the DMH information system which is maintained by the DMH's Administrative Services Organization (ASO). Once this data is processed, it is then transferred to the DMH Data Warehouse for storage. This information is then used to develop reports. Once it has been determined that the quality of the data is good, DMH will begin to report change data for this variable.
<b>Target Achievement:</b>	No target established (see above).

**Name of Performance Indicator: C-12: (NOM) Child -Increased Social Supports/Social Connectedness (Percentage)**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	76.41	76.98	N/A	N/A	N/A
Numerator	285	311	--	N/A	--
Denominator	373	404	--	N/A	--

**Table Descriptors:**

---

<b>Goal:</b>	Monitor caregivers' perception that their child's social connectedness has improved as a result of participating in treatment.
<b>Target:</b>	Developmental Measure – No Target established.
<b>Population:</b>	Children/adolescents with serious emotional disturbances aged 0-11.
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
<b>Indicator:</b>	Percent of caregivers responding positively about social connectedness.
<b>Measure:</b>	Numerator: Number of caregivers of child/adolescent consumers reporting positively about the social connectedness of their child. Denominator: Total number of family responses regarding social connectedness.
<b>Sources of Information:</b>	Annual Youth Services Survey for Families (Caregivers)  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.
<b>Special Issues:</b>	
<b>Significance:</b>	Treatment should result in positive outcomes for children. The DMH will utilize the MHSIP Youth Services Survey for Families Perception of Care Survey to collect this data. As in previous fiscal years, the DMH selected a random stratified sample of individuals receiving treatment in June 2011 for this year's survey. This sample was disseminated via mail in November 2011 with a goal of all data collected by early December. Data may not be readily available until January 2012. The data from the survey will be used to populate portions of table 11 and 11A
<b>Activities/Strategies:</b>	Data for this indicator is collected using the YSS/F MHSIP Survey.
<b>Target Achievement:</b>	However, given the developmental nature of the indicator and the small numbers used for reporting , no target was established for FY2011.

**Name of Performance Indicator: C-13: (NOM)-Improved Level of Functioning (Percentage)**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	53.48	58	N/A	N/A	N/A
Numerator	200	236	--	N/A	--
Denominator	374	404	--	N/A	--

**Table Descriptors:**

<b>Goal:</b>	Increase caregivers' perception of functioning as a result of treatment.
<b>Target:</b>	No target established.
<b>Population:</b>	Children and adolescents with emotional/serious emotional disturbances.
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services  4:Targeted Services to Rural and Homeless Populations
<b>Indicator:</b>	Percent of families reporting positively about functioning.
<b>Measure:</b>	Numerator: Number of families of child/adolescent consumers reporting positively about functioning. Denominator: Total number of family/caregiver responses regarding functioning.
<b>Sources of Information:</b>	MHSIP Annual Youth Services Survey for Families (Caregivers)
<b>Special Issues:</b>	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.
<b>Significance:</b>	Treatment should result in positive outcomes for children. DMH has selected a random stratified sample of individuals receiving treatment in June 2011. This sample is the basis for the survey that was disseminated in November 2011. Data will be available in January 2012.
<b>Activities/Strategies:</b>	
<b>Target Achievement</b>	Not Applicable. Data for this indicator is collected using the YSS/F MHSIP Survey. Given the developmental nature of the indicator and the small numbers used for reporting a target has not been established.

**Name of Performance Indicator: C-14 Corrections History -C&A**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	0.84	0.80	N/A	.43	N/A
Numerator	310	282	--	145	--
Denominator	36,768	36,242	---	33,610	--

Table Descriptors:

---

<b>Goal:</b>	To track forensic status of children and adolescents served by the Illinois mental health system
<b>Target:</b>	Track increase/decrease in individuals involved in the justice system who access services. This population is expected to remain relatively constant at approximately 1%.
<b>Population:</b>	Children and adolescents with serious emotional disturbances.
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems
<b>Indicator:</b>	Percentage of children and adolescent clients reporting involvement with the Department of Corrections/Juvenile Justice at the time of case opening.
<b>Measure:</b>	Numerator: Number of children and adolescent clients reported as Department of Corrections/Juvenile Justice clients (e.g. Probation, parole) at the time of case opening. Denominator: Total number of children and adolescents served in the fiscal year.
<b>Sources of Information:</b>	DMH ASO Community Reporting System
<b>Special Issues:</b>	Note: This year DMH used a narrower definition (NGRI and UST only) for this indicator which results in lower figures.
<b>Significance:</b>	Tracking this information helps to insure coordination of services between the mental health system and juvenile corrections.
<b>Activities/Strategies</b>	Community mental health staff track the number of children and adolescents who are forensic outpatients (0.8%) at the time of case opening. This data is collected as part of clinical assessments. DMH will continue to track these percentages.
<b>Target Achievement</b>	Not Applicable.

**Name of Performance Indicator: C-15: Co-Occurring Disorders-C&A**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	1	1.50	1	2.3	N/A
Numerator	390	543	--	766	--
Denominator	36,768	36,242	--	33,610	--

Table Descriptors:

---

<b>Goal:</b>	To maintain community-based mental health service for persons who have co-occurring disorders of mental illnesses and substance use.
<b>Target:</b>	Track the number of individuals with co-occurring disorders accessing services.
<b>Population:</b>	Children and adolescents with mental illness and a co-occurring substance use disorders.
<b>Criterion:</b>	3:Children's Services
<b>Indicator:</b>	Percentage of Child and Adolescents (C&A) served with a mental illness and substance use diagnosis receiving services.
<b>Measure:</b>	Numerator: Number of clients served in the community with a substance abuse diagnosis. Denominator: Total number of all child and adolescents receiving services.
<b>Sources of Information:</b>	DMH ASO Community Reporting System..
<b>Special Issues:</b>	It is likely that identification of these individuals is under-represented.
<b>Significance:</b>	Many individuals with serious mental illnesses and emotional disturbances have co-occurring substance abuse disorders
<b>Activities/Strategies:</b>	DMH will continue to track this information in FY2012-FY2013 with the goal of increasing the capacity for identification of dually diagnosed youth.
<b>Target Achievement:</b>	Not Applicable.

**Name of Performance Indicator: C-16: Eligible Population-C&A**

(1)	(2)	(3)	(4)	(5)	(7)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	95	96.20	95.0	97	102.1
Numerator	34,959	34,581	--	32,596	--
Denominator	36,768	36,242	--	33,610	---

Table Descriptors:

---

<b>Goal:</b>	To provide access to services to children and adolescents meeting the DMH eligibility for service criteria.
<b>Target:</b>	Maintain the percentage of children and adolescents receiving mental health services who meet eligibility requirements.
<b>Population:</b>	Children and adolescents with serious emotional disturbances
<b>Criterion:</b>	2:Mental Health System Data Epidemiology
<b>Indicator:</b>	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. 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.
<b>Measure:</b>	Denominator: All children and adolescents being served by DMH-funded community-based providers.
<b>Sources of Information:</b>	DMH ASO Community Reporting System
<b>Special Issues:</b>	
<b>Significance:</b>	This indicator is part of the monitoring process to insure that mental health services are accessible and are accessed by those individuals who need them most.
<b>Activities/Strategies:</b>	State mental health resources and services should be provided to the priority populations of the public mental health system. Because of the draconian nature of the cuts to the community services budget, DMH is not projecting an increase in access to programs. In FY2012-2013, DMH will continue to monitor access to services by these individuals. DMH has a goal of increasing the proportion of children and adolescents served who meet the criteria for eligible population.
<b>Target Achievement:</b>	Target achieved and exceeded.

**Name of Performance Indicator: C-17: Forensic Outpatient-C&A**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	0.55	0.43	0.55	0.33	60
Numerator	204	157	--	111	--
Denominator	36,768	36,242	--	33,610	--

Table Descriptors:

<b>Goal:</b>	To track forensic status of children and adolescents served by the Illinois Mental Health System.
<b>Target:</b>	Maintain access to services for children and adolescents who are involved with the juvenile justice system.
<b>Population:</b>	Children and Adolescents with serious emotional disturbances.
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems
<b>Indicator:</b>	Percentage of children and adolescent clients who have 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.
<b>Measure:</b>	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.
<b>Sources of Information</b>	DMH ASO Community Reporting System (See Below)
<b>Special Issues:</b>	
<b>Significance:</b>	The service needs of this small but high risk group require that assessment and adequate services are provided and tracked.
<b>Activities/Strategies</b>	Community mental health staff track the number of children and adolescents who are forensic outpatients as well as those on probation and parole at the time of case opening. This data is collected as part of clinical assessments. DMH will continue to track these percentages.
<b>Target Achievement</b>	Not Achieved. As noted previously, there has been an overall decrease in the number of individuals accessing services in FY2011. This may have had an impact on this indicator. However, DMH staff are further investigating issues related to this indicator.

**Name of Performance Indicator: C-18: Living Arrangements-C&A**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	96	89.70	N/A	92.15	N/A
Numerator	32,648	32,511	---	30,973	--
Denominator	36,768	36,242	---	33,610	--

**Table Descriptors:**

<b>Goal:</b>	To track demographic information on living arrangements for child and adolescent clients.
<b>Target:</b>	Track percentage of children and adolescents with mental and emotional disturbances who live in private residences. No target established as information is collected at intake prior to treatment.
<b>Population:</b>	Children and adolescents with mental illness.
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems
<b>Indicator:</b>	Percentage of children and adolescent clients living with parents or other relatives in private residences at the time of case opening.
<b>Measure:</b>	Numerator: Number of children and adolescents reported as living with parents or other relatives in private residence at the time of case opening. Denominator: Total number of children and adolescents served in the fiscal year with known living arrangements.
<b>Sources of Information:</b>	DMH ASO Community Reporting System.
<b>Special Issues:</b>	
<b>Significance:</b>	Community mental health staff report living arrangements at intake for children and adolescents to assess service needs. At the time of case opening in FY 2011, the vast majority of children and adolescents lived with parents or other relatives in a private residence (92%).
<b>Activities/Strategies:</b>	DMH funded providers by contract must submit demographic, clinical information and claims data for all individuals receiving services funded using DMH dollars. The DMH provides data specifications to assure consistency of reporting. Registration data is submitted directly to the DMH information system which is operated by the DMH's Administrative Services Organization (ASO). Claims data, which is submitted to the state Medicaid agency Healthcare and Family Services (HFS), is returned to the ASO after processing where it is stored with registration information in the DMH data warehouse. This information is used as a basis for developing reports and for analytic purposes, and is the basis for reporting the data used to populate the majority of the URS tables.
<b>Target Achievement</b>	Not Applicable.



**Name of Performance Indicator: C-19: Rural Residents Served -C&A**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	10,354	9,793	10,350	8,620	83.3
Numerator	N/A		---	N/A	---
Denominator	N/A		--	N/A	---

**Table Descriptors:**

---

<b>Goal:</b>	To assure that children with emotional disturbances who reside in rural areas are accessing the DMH-funded community-based mental health service system.
<b>Target:</b>	Maintain the number of children/adolescents residing in rural areas who receive services by using Tele-psychiatry and other strategies.
<b>Population:</b>	Children and adolescents with emotional disturbances who live in rural areas of the state.
<b>Criterion:</b>	4:Targeted Services to Rural and Homeless Populations
<b>Indicator:</b>	Number of children being served by DMH-funded community-based providers who are residents of rural areas at the time of entry into services.
<b>Measure:</b>	Number of children being served by DMH-funded community-based providers who are residents of rural areas at the time of entry into services.
<b>Sources of Information:</b>	DMH ASO Community Reporting System
<b>Special Issues:</b>	
<b>Significance:</b>	
<b>Activities/Strategies:</b>	Although the geography of rural areas adds challenges to the timely and consistent access to services for both service providers and persons with mental illness, DMH aims to maintain or expand access to community mental health services for persons residing in rural areas using strategies such as telepsychiatry. Despite the use of technology however, budget cuts will likely lead to a continuing reduction in the number of individuals seen for treatment in FY2012-2013.
<b>Target Achievement</b>	Not Achieved. As noted previously, the total number of individuals receiving services decreased in FY2011. This may have an impact on this indicator.

**Name of Performance Indicator: C-20: SASS Service Hours In Community**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	---	N/A	
Denominator	N/A	N/A	--	N/A	

Table Descriptors:

<b>Goal:</b>	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.
<b>Target:</b>	A target is not set because the data source does not capture complete information at this point in time.
<b>Population:</b>	Children and adolescents with serious emotional disturbances.
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems
<b>Indicator:</b>	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.
<b>Measure:</b>	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.
<b>Sources of Information:</b>	DMH ASO Community Reporting System.
<b>Special Issues:</b>	This data is no longer reported directly to the DMH. We will retain this indicator as a placeholder because of its importance. We hope to reacquire the information in FY 2012.
<b>Significance:</b>	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.
<b>ActivitiesStrategies:</b>	DMH has worked to retrieve this information and therefore retained this indicator as a place holder pending the reacquisition of this data as it is important to monitor delivery of these critical services. This indicator is being dropped in FY2012-2013.
<b>Target Achievement</b>	Not Applicable

**Name of Performance Indicator: C-21: Target Population -C & A (Percentage)**

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	40	38.50	40	43.15	107.9
Numerator	14,773	13,955		14,502	--
Denominator	36,768	36,242		33,610	--

Table Descriptors:

---

<b>Goal:</b>	To assure that resources and services are provided to individuals who are the most in need of services as evidenced by meeting the DMH’s criteria for serious mental illnesses.
<b>Target:</b>	To increase the percentage (by 2%) of child and adolescent mental health clients who have serious emotional disturbances receiving services
<b>Population:</b>	Children and adolescents with serious emotional disturbances.
<b>Criterion:</b>	2: Mental Health System Data Epidemiology
<b>Indicator:</b>	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.
<b>Measure:</b>	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.
<b>Sources of Information:</b>	DMH ASO Community Reporting System
<b>Special Issues:</b>	
<b>Significance:</b>	Children and adolescents with severe emotional disturbances (SED) are the priority target for mental health services.
<b>Activities/Strategies:</b>	DMH aims to maintain or increase the proportion of children and adolescents served who meet the criteria for the target population. However, the DMH Fiscal Year 2012 community mental health services budget has been substantially reduced. The impact on programs/services has been described in the mental health block grant plan narrative. Because of the extent of these cuts, DMH is not projecting an increase in access to programs. DMH will continue to monitor access to services by this population of individuals.
<b>Target Achievement:</b>	Target for FY2011 was achieved and exceeded!

Appendix A

**ILLINOIS MENTAL HEALTH PLANNING AND  
ADVISORY COUNCIL**

**Co-Chairs: Linda Denson  
John W. Shustitzky, PhD**

---

November 29, 2011

Ms. Virginia Simmons  
Grants Management Officer  
SAMHSA OPS  
Division of Grants Management  
1 Choke Cherry Road, Room 7-1091  
Rockville, MD 20850

Dear Ms. Simmons:

Together with the Co-Chair of the Illinois Mental Health Planning and Advisory Council, Linda Denson, I am pleased to add the Council's support for the 2011 Block Grant Implementation Report.

Our Council members, Planning Committee and our other committees work closely with the Illinois Division of Mental Health and stakeholders throughout our State to monitor the mental health services provided and to promote improvements wherever possible. Our Council Executive Committee met recently to review the attached report. While we appreciate the many positive accomplishments highlighted in the report, we are deeply concerned about the continuing decreases in services that result from the substantial cuts in funding at the state and federal level.

As reported in its November, 2011, report, "State Mental Health Cuts: The Continuing Crisis," The National Alliance on Mental Illness (NAMI,) reports that Illinois ranks fourth highest on the list of percentage reductions in state funding for mental health for the Fiscal Years 2009 through 2012, following only South Carolina, Alabama and Alaska. During that time, Illinois has reduced its mental health budget by \$187 million, or 31.7%. For the most recent year, FY 2012, Illinois had the highest percentage of cuts compared to the previous year: - 13.4%.

These cuts have had a devastating impact on the availability of services for those who rely on the public system of care. Staff positions at state-operated facilities

and in community-based organizations have been reduced, delays and waiting lists for care have increased and limitations have been placed on the services provided for some consumers. Our Council is particularly concerned about the significant delays in services for those court ordered for inpatient psychiatric care (see response to Objective A1.9.)

We join our colleagues from Planning Councils across the nation in hoping for and advocating on behalf of the restoration of funds for the much-needed and life-saving mental health services that have been reduced.

Please do not hesitate to contact me if you have any questions for our Council.

Sincerely,

John W. Shustitzky, Ph.D.  
Co-Chair

JWS/djw

**Appendix B**  
**Illinois Department of Human Services**  
**Division of Mental Health**

**FY 2011 Allocation of Mental Health Block Grant Funds**

VENDOR_NAME	SumOfAWARD	SUBPROG	SERVICE DESCRIPTION
ABRAHAM LINCOLN CENTER	\$100,000	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
ADVOCATE NORTHSIDE	\$354,868	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
ALEXIAN BROS CTR FOR MNTL HLTH	\$237,618	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
ASIAN HMN SVCS OF CHICAGO INC	\$162,633	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
ASSOCIATION FOR INDIVIDUAL DEV	\$135,696	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
ASSOCIATION HOUSE OF CHICAGO	\$195,558	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
BEN GORDON CENTER	\$70,672	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
BOBBY E WRIGHT CCMHC	\$343,288	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
BRIDGEWAY INC	\$659,777	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
CENTER FOR CHILDRENS SERVICES	\$36,526	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
CHESTNUT HEALTH SYSTEMS INC	\$868,652	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
CHICAGO CITY OF	\$70,650	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
CHILDRENS HOME ASSOCIATION OF	\$55,539	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
CHRISTIAN CNTY MNTL HLTH ASSN	\$36,390	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
CIRCLE FAMILY HEALTHCARE NTRWK	\$295,243	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
COLES CO MENTAL HLTH ASSN INC	\$88,342	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
COMMUNITY CNSLNG CTRS CHICAGO	\$438,262	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
COMMUNITY ELEMENTS INC	\$97,098	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
COMMUNITY MENTAL HLTH CNCL INC	\$344,707	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
COMMUNITY RESOURCE & COUNSELIN	\$87,996	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
COMMUNITY RESOURCE CENTER INC	\$133,525	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
COMPREHENSIVE BEHAVIORAL HLTH	\$208,517	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
COUNSELING CENTER OF LAKEVIEW	\$176,823	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
COUNSELING CENTER OF LAKEVIEW	\$8,228	HO61	PSYCHIATRIC MEDICATIONS
COUNTY OF WILL	\$227,015	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
COUNTY OF WILL	\$100,000	HO61	SPECIAL PROJECTS
CROSSPOINT HUMAN SERVICES	\$246,000	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
DE PAUL UNIVERSITY	\$27,891	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
DELTA CENTER INC	\$85,156	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
DUPAGE COUNTY	\$324,632	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
ECKER CTR FOR MENTAL HLTH INC	\$400,093	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
EGYPTIAN PUBLIC & MENTAL	\$47,953	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
FAMILY COUNSELING CENTER INC	\$46,800	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
FAMILY SERVICE & CMNTY MENTAL	\$627,028	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
FAMILY SERVICE & MENTAL HEALTH	\$82,400	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER

FAMILY SERVICE ASSOCIATION OF	\$52,191	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
GATEWAY FOUNDATION INC	\$10,862	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
GRAND PRAIRIE SERVICES	\$577,271	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
HABILITATIVE SYSTEMS INC	\$52,000	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
HEARTLAND HUMAN SERVICES	\$50,710	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
HELEN WHEELER CENTER FOR	\$309,382	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
HEPHZIBAH CHILDRENS ASSCTN	\$11,388	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
HERITAGE BHVRL HEALTH CTR INC	\$467,492	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
HUMAN RESOURCES CENTER OF	\$80,887	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
HUMAN SERVICE CENTER	\$120,027	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
HUMAN SERVICE CENTER	\$40,000	HO61	MENTAL HEALTH SPECIAL PROJECTS
HUMAN SUPPORT SERVICES	\$23,895	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
HUMAN SVC CTR S METRO EAST	\$60,173	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
JANET WATTLES CENTER	\$575,199	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
JEFFERSON COUNTY COMPREHENSIVE	\$120,166	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
JEFFERSON COUNTY COMPREHENSIVE	\$40,000	HO61	SPECIAL PROJECTS
JOSELYN CENTER FOR MENTAL	\$106,672	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
KENNETH YOUNG CENTER	\$89,015	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
LAKE COUNTY	\$215,353	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
LEYDEN FAMILY SVCS & M H CTR	\$129,014	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
LOCUST STREET RESOURCE CENTER	\$83,553	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
LORETTO HOSPITAL	\$64,480	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
LUTHERAN SOCIAL SERVICES OF IL	\$55,476	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
MAINE CENTER INC	\$69,964	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
MCLEAN COUNTY CTR HUMAN SRV IN	\$143,797	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
MENTAL HEALTH CENTERS OF	\$62,394	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
MENTAL HEALTH CTRS OF CNTRL IL	\$544,978	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
METROPOLITAN FAMILY SERVICES	\$296,252	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
MOUNT SINAI HOSP MEDICAL CTR	\$495,670	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
NORTH CENTRAL BEHAVIORAL	\$397,346	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
NORTHWESTERN MEMORIAL HOSPITAL	\$492,122	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
PERRY CNTY COUNSELING CTR INC	\$24,984	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
PILLARS COMMUNITY SERVICES	\$176,527	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
PILSEN-LITTLE VILLAGE COMMUNTY	\$103,910	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
PROVISO FAMILY SERVICES INC	\$102,575	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
ROBERT YOUNG CENTER FOR	\$654,787	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
SAINT MARY & ELIZABETH MED CTR	\$51,634	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
SINNISSIPPI CENTERS INC	\$107,594	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
SOUTHEASTERN IL COUNSELING	\$61,671	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
SOUTHERN IL REGIONAL SOCIAL	\$64,368	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
TAZWOOD MENTAL HEALTH CTR INC	\$82,436	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
THE H GROUP BBT INC	\$217,768	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
THE THRESHOLDS	\$102,871	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER

THRIVE COUNSELING CENTER	\$45,600	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
TRANSITIONS OF WESTERN IL INC	\$72,450	HO61	PSYCHIATRIST SERVICES IN THE MENTAL HEALTH CENTER
TRILOGY INC	\$52,212	HO61	PSYCHIATRIST SERVICES IN MENTAL HEALTH CENTER
<b>GRAND TOTAL</b>	<b>\$15,180,692</b>	-----	-----