FY 2013
COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT IMPLEMENTATION REPORT*

ILLINOIS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH

***NARRATIVE REPORT OF PROGRESS AND ACHIEVEMENTS IN FY2013 TOWARD THE IMPLEMENTATION OF THE SFY2012-SFY2013 COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT APPLICATION AND PLAN WHICH WAS SUBMITTED ON SEPTEMBER 1, 2011**

FY2013 IMPLEMENTATION REPORT

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Introduction

This implementation report covers the second year of a two-year Mental Health Block Grant plan for FY2012-FY2013 which was submitted to SAMHSA on September 1, 2011. In general, this report describes our achievement and continuing progress in working on the 22 strategies related to DMH priorities and goals and supported by performance indicators submitted in the plan as well as the challenges encountered during FY2013.

In accordance with formatting requirements by SAMHSA, each strategy is presented separately in a table which provides information about the priority, the goal that is being addressed, the strategy itself, the performance measure to evaluate achievement and outcome, a description of how the data for the performance measure is collected and changes are measured, and, finally, the state's report as to whether or not the strategy was achieved. Following each table, a brief review of background information, a description of our progress in FY2013, and other pertinent data are provided.

Available Services and Resources in the Comprehensive System of Care

Table 2 .1 AVAILABLE SERVICES
Report Year: FY2013
State Identifier: IL
Priority Area: Adults-Assurance of an effective array of clinical and support services.
Goal: *Continue to assure that a comprehensive array of community-based services is available to adults in need of mental health services* (Criterion I.)
Strategy: Ensure that the following services are available: • Mental health assessment • Treatment plan development, review and modification: • Assertive community treatment, • Case management, • Community support (individual, group and residential), • Crisis intervention, mental health intensive outpatient, • Psychosocial rehabilitation • Psychotropic medication administration, monitoring, and training; • Short-term diagnostic and mental health services, • Therapy/counseling, • Transitional ACT, and • Oral interpretation and sign language Work with system partners to provide supportive services including: o Educational services, o Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA), o Substance abuse services (through DASA), o Services for co-occurring mental health and substance abuse disorders, o Medical and dental (through DHFS for Medicaid eligible individuals), and o Community Integrated Living Arrangements (CILA).
Performance Indicator: Number of adults who are (a) Medicaid eligible or (b) Not Medicaid eligible who receive mental health services.
Description of Collecting and Measuring Changes in Performance Indicator: 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 is submitted to the state Medicaid agency, Department of Healthcare and Family Services (HFS), and 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.
Report of Progress toward goal attainment in prior State Fiscal Year: **_X__ Achieved _____ Not Achieved (if not achieved, explain why)**

DMH successfully met this goal in FY2013. The array of services and the Service Benefit Packages described below have continued. DMH continues to work closely with partner agencies in implementing supportive services. It is noteworthy that for 71.4%

of everyone served in FY2013, services were either fully or partly paid through Medicaid during the course of the year, while more than one of every four consumers received services paid solely from Non-Medicaid sources, largely out of the DMH service benefit packages. The Table below provides the Medicaid Status information for everyone (Adults and Children) served in FY2013. Comparison of FY2012 and FY2013 shows very modest change.

Medicaid Status of Persons Served in FY2012 and FY2013

Medicaid Status	Total Served in FY2012	Percent of Total Served	Number Served in FY2013	Percent of Total Served	Change (%) FY12-FY13
Medicaid (Only Medicaid)	**91,111**	**67.0**	**89,233**	**65.7**	**(-2.06)**
Non-Medicaid Sources (only)	**37,139**	**27.3**	**38,857**	**28.6**	**4.62**
People Served by Both	**7,797**	**5.7**	**7,668**	**5.6**	**(-1.65)**
Medicaid Status Not Available	**0**	**-**	**0**	**-**	
Total Served	**136,047**	**100.0**	**135,758**	**100.0**	**0**

The Array of Core Mental Health Services

The array of core mental health services listed in Table 2.1 (above) are purchased on behalf of Medicaid Eligible Illinois citizens with mental illnesses. The services are described in the DMH Provider Handbook that is maintained by the Mental Health Collaborative and is posted on the DHS/DMH Website.

See: http://www.hfs.illinois.gov/assets/cmhs.pdf.

Service Packages for Persons Who Are Not Enrolled in Medicaid

Individuals enrolled in Medicaid continue to receive the listed array of services reimbursable through Medicaid, while those who are not Medicaid eligible receive limited service packages paid for with the minimal funding DMH has available. Service provision and coverage are based on clinical criteria and financial eligibility. Persons at or below 200% of the federal poverty level (FPL) are fully funded; those over 400% are not funded, and those between 200% and 400% receive partial funding based on their FPL, which is determined by household size and income. These eligibility groups are aimed at applying state funding for mental health services for individuals with limited resources (within financial eligibility requirements) who are in need of mental health

services for a serious mental disorder or a suspected mental disorder as indicated by their mental health diagnosis and functioning level.

DMH has prioritized four distinct service groups:

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.**

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 individuals between the ages 18 and 40 who present 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.**

The Service Benefit Packages for individuals who are not Medicaid eligible are described in detail on the DHS Website at: http://www.dhs.state.il.us/page.aspx?item=51784 .

Coordinated Support Services

Educational services in the form of stipends and scholarships for college, trade school, and vocational training are available through DRS and facilitated by mental health providers. Consumers also receive support in pursuing the completion of basic educational requirements (e.g., GED) and other available educational programs through local public school systems. **Under the Individuals with Disabilities Education Act (IDEA),** local school systems provide special education and a range of related support services to students with disabilities over the age of 18, including career and technical education, competitive and supportive employment, interagency linkages for social services, and supports for transition to post-secondary (college) education. A full continuum of **Substance Abuse Services** is funded through the DHS Division of Alcoholism and Substance Abuse (DASA) including outpatient and residential programs for persons addicted to alcohol and other drugs. Substance abuse has been a significant presenting problem for more than 15% of mental health consumers seeking services.. Research suggests that a high proportion of persons with mental illness also have substance use problems. DMH and DASA have consistently worked together to meet the needs of the dually diagnosed consumer and have implemented specialized treatment programs, training, and support programs when funding has been available. Adults with serious mental illnesses can access the **medical and dental care services** available to the general population through the service coordination functions provided in case management and therapeutic services. As adults with mental illnesses often have neither the insurance nor the financial means to cover their healthcare costs, they require

navigation and assistance in accessing health care and are receiving support in applying for Medicaid, or accessing affordable insurance programs through Get Covered Illinois – the Illinois Marketplace. Those who are Medicaid eligible benefit from the medical services and programs provided through the Department of Healthcare and Family Services (DHFS).

Evidence-Based Practices

Three Evidence-Based Practices: Supportive Employment (EBSE), Assertive Community Treatment (ACT), and Permanent Supportive Housing (PSH) are currently implemented statewide.

Evidence Based Supportive Employment

Table 2.2 SUPPORTIVE EMPLOYMENT
Report Year: FY2013
State Identifier: IL
Priority Area: Adults-Promote Provision of Evidence Based Practices
Goal: *Promote Evidence Based Practices for individuals for whom DMH purchases services within the context of service benefit packages established by DMH for the Medicaid and non-Medicaid populations in need of mental health services.*
Strategy #1: During FY2012 and FY2013, maintain the implementation of Evidence Based Supportive Employment.
Performance Indicator: Number of consumers receiving supported employment in FY2012 and FY2013. (National Outcome Measure)
Description of Collecting and Measuring Changes in Performance Indicator: Data for this indicator are generated through a special web-based database created specifically for the DMH SE initiative. Fidelity and outcomes data are submitted to the DMH SE coordinator. As always, DMH has developed specifications for reporting that DMH funded providers must use when submitting data. DMH only reports data for teams that have been found to exhibit fidelity to the evidenced based practice model.
Report of Progress toward goal attainment in prior State Fiscal Year: **_X_ Achieved _____ Not Achieved (if not achieved, explain why)**

This strategic objective has been successfully accomplished. Evidence Based Supportive Employment has been successfully maintained throughout FY2012 and FY2013. In FY2013, a total of 27 IPS sites with fidelity to the model served 1,890 unduplicated consumers. An additional six sites that had not yet met fidelity standards served 216 consumers. In all, 2,106 consumers received supported employment services.

Background

Since 2007, DMH and DHS/Division of Rehabilitation Services (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. Supported Employment Services in Illinois are based on the integration of DHS Division of Rehabilitation Services (DRS) funded vocational services/resources with DMH funded mental health treatment and supportive services.

Accomplishments in expanding and improving implementation of evidence based supportive employment in the past three years have included:

- Consumer participation in all fidelity reviews and in crafting recommendations.
- Establishment of a specialized IPS site in FY2013 designed to serve justice-involved consumers (NGRI). This site provides IPS services as part of the service package that also includes housing and other recovery services for NGRI consumers released from the inpatient forensic program at Elgin MHC into a Community Conditional Release Program located in Rockford.
- Technical assistance to increase fidelity to the IPS Supported Employment Model has increased from 1695 hours provided to the IPS sites in FY2010 to approximately 5176 hours provided to 200 staff and support personnel in IPS sites across the State in FY2013. IPS technical assistance and training was provided on a variety of subjects including IPS principles and practice, IPS Supervisor training, job development, billing Medicaid for medically necessary mental health services related to IPS, vocational assessment, best practices for persons who are justice-involved, and training in the DMH IPS Web-Based System. The IPS technical assistance team also developed a CY2013 curriculum for Monthly State-wide Technical Assistance Calls with topics that focused on improving employment outcomes. The TA team worked with the Recovery Services Development Group (RSDG) to improve integrated Recovery support, IPS/WRAP, and the quality of peer support at IPS Agencies.
- DMH sponsored the 2013 Illinois IPS Conference in Springfield on June 17th and 18th which was attended by over 150 people. The conference included guest speakers, consumer IPS panel discussions, a half day session on foundations in IPS, and breakout sessions which addressed a range of relevant topics and issues.
- Education and training on the role of employment in recovery continues to be provided by NAMI IL in the NAMI Family-to-Family curriculum and is included in the training for new Family-to-Family facilitators.
- To prepare staff of community IPS teams to serve as certified IPS fidelity reviewers, DMH and DRS established a Certified IPS Fidelity Reviewer Training module that includes one day of training and participant observation in an actual fidelity review.
- DMH continues to expand and improve the IPS/EBSE Web-based Data System currently being used by all IPS fidelity sites to gather better and more accurate employment data from IPS agencies.
- In FY2013 the federal vocational rehabilitation rate for IPS cases was above 0.72%, up from 0.63% in FY2012 which had been hailed as above the average rehabilitation rate for all DRS cases and an unusually high rate for the population of persons with severe mental illness served by DRS. The rehabilitation rate is viewed by the federal rehabilitation agency as one of the most important measures

of the success of a state VR system and represents the percentage of consumers who successfully maintained employment for 90 days compared to those who were closed and were not successfully employed.

However, EBSE has faced several challenging issues:

- The depletion of DMH capacity grants resulted in the inability of most IPS programs to serve persons who are not Medicaid-enrolled as resources have not been available to provide and integrate the mental health treatment portion of the IPS model. To offset this development, DRS increased their milestone payment amounts in FY2012 and have added post-employment milestones payments in FY2013.

- 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. If the person who has been successfully working for 90 days continues to need intensive follow-along support, two additional post-employment milestone payments can now be paid to providers at 120 days and 150 days.

- Program sustainability has been challenged by frequent turnover of employment specialists and IPS Supervisors and the extensive training effort and time needed for staff to learn to implement the EBP.

FY2013 IPS Activity Report

	7/1 –9/30, 2012	**10/1 –12/31, 2012**	**01/1–3/31, 2013**	**4/1-6/30, 2013**
Number of locations at fidelity	27	27	27	27
Number of consumers receiving supported employment	1,167	1,185	1,277	1,241
Number employed in competitive jobs	401	429	447	476
Number of working people transitioned off the IPS Caseload successfully employed*	20	34	33	30

*While the number of working people transitioned off the IPS Caseload successfully employed decreased in FY2013, it was neither due to less consumers working, nor less consumers enrolled in IPS. From fidelity review interviews with IPS Supervisors and Mental Heath Treatment Team Supervisors, IPS agencies are providing better and longer follow-along supports that are more focused on the needs of each individual working consumer, thus consumers are using IPS follow-along supports longer.

Assertive Community Treatment

Table 2.3 ACT
Report Year: FY2013
State Identifier: IL
Priority Area: Adults-Promote Provision of Evidence Based Practices
Goal: *Promote Evidence Based Practices for individuals for whom DMH purchases services within the context of service benefit packages established by DMH for the Medicaid and non-Medicaid populations in need of mental health services.*
Strategy #2: During FY2012 and FY2013, continue provision of Assertive Community Treatment that meets national fidelity model requirements.
Performance Indicator: Number of persons with SMI receiving Assertive Community Treatment in FY2012 and FY2013 (National Outcome Measure).
Description of Collecting and Measuring Changes in Performance Indicator: 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.
Report of Progress toward goal attainment in prior State Fiscal Year: **__X__ Achieved _____ Not Achieved (if not achieved, explain why)**

This strategic objective was successfully achieved and exceeded in FY2013. Not only did DMH continue to provide Assertive Community Treatment that met national fidelity model requirements, but was also successful in increasing the number of ACT teams that meet fidelity requirements by 40%- from 15 teams at the end of FY2012 to 21 teams by the end of FY2013. The number of consumers receiving ACT increased 33.6% from 733 in FY2012 to 979 by the end of FY2013, reflecting an overall increase of 44.4% since FY2011 when 678 consumers received ACT services.

During FY2012 and FY2013, in response to the Williams Consent Decree, Illinois expanded ACT services in areas of the state where Class Members were most likely to seek services. This included funding to expand existing teams by adding additional team members, the creation of additional teams by providers already providing ACT, and the creation of new ACT teams by providers who did not previously have an ACT team. DMH has remained closely involved with these agencies as teams were developed or expanded to ensure fidelity to the ACT model.

In order to ensure this fidelity, DMH negotiated contracts with providers that were consistent with the model, provided opportunities for training, and conducted fidelity reviews. The training was provided through the SAMHSA Olmstead Policy Academy, utilizing technical assistance, guidance and training from Advocates for Human Potential (AHP), a nationally recognized contracted vendor with SAMHSA.

As a part of this AHP technical assistance and training, Dr. Carol VanderZwaag, a Clinical Professor of Psychiatry at UNC School of Medicine, and an Assertive Community Treatment Psychiatrist at Orange/Person/Chatham Mental Health in North Carolina, was identified to provide consultation and training to state staff and providers. To date, this has included teleconferences, surveys that she developed and administered to the ACT teams, and site visits to several ACT teams. This technical assistance and training will continue throughout FY14.

At the end of FY2013 there were 21 ACT teams in Illinois. Both the existing and new teams were reviewed for fidelity in FY2013, using a tool with standards based on the Dartmouth tool and the state Medicaid rule. Teams generally met full fidelity standards, and where they did not, were required to develop and implement plans of improvement which are monitored by DMH Regional Contract Managers. Enhancing access and availability of ACT as a means of serving additional Williams Consent Decree Class Members transitioning into the community continues. Contracts that ensure sufficient capacity to meet the needs of Class Members to be transitioned throughout FY2014 have been negotiated with community provider agencies.

Background:

Illinois adopted and began to implement the Assertive Community Treatment (ACT) model in 1992. ACT is the most intensive specialized model of outpatient community mental health care in which a team of mental health professionals takes responsibility for a small group of program participants' day-to-day living and treatment needs. Often these consumers have a history of repeated admission to psychiatric inpatient services or excessive use of emergency services and typically require assertive outreach and support to remain connected with necessary community mental health services. Usually, previous efforts to provide linkage to necessary services have failed and their 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.

Permanent Supportive Housing

Table 2.4 PERMANENT SUPPORTIVE HOUSING
Report Year: FY2013
State Identifier: IL
Priority Area: Adults-Promote Provision of Evidence Based Practices
Goal: *Promote Evidence Based Practices for individuals for whom DMH purchases services within the context of service benefit packages established by DMH for the Medicaid and non-Medicaid populations in need of mental health services.*
Strategy #3: By the end of FY 2013, 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.
Performance Indicator: Number of consumers who acquire appropriate permanent supportive housing. (National Outcome Measure)

Description of Collecting and Measuring Changes in Performance Indicator: Individuals receiving permanent supported housing were not previously required to be registered for mental health treatment services. Therefore, it was necessary to create a special database to track access to and receipt of permanent supportive housing. The data for this indicator will be generated from permanent supportive housing applications which are stored in the special database, as well as a special PSH outcomes database.
Report of Progress toward goal attainment in prior State Fiscal Year: **__X__ Achieved _____ Not Achieved (if not achieved, explain why)**

This strategy was successfully achieved in FY2013. The target of 300 consumers was exceeded. As of 11/30/2013, 2,115 consumers have been subsidized through the Bridge Program in the past five years. A year earlier, as of 10/25/12, the DMH Permanent Supportive Housing Bridge Subsidy Initiative had approved subsidizing 1,622 consumers. Thus, in the course of 13 months, 493 additional consumers have been served and placed -exceeding the target of 300 by 193 with attainment at 163%.

PSH has been adapted and utilized to meet the needs of class members in the Williams Consent Decree. By the end of FY2012, 258 members of the class were approved and placed. In FY2013 DMH worked on the goal of transitioning a cumulative total of 640 class members to decent, safe, and affordable housing and support services by the end of the fiscal year. As of June 30, 2013, 643 class members had been transitioned into permanent supportive housing utilizing Bridge subsidies funded through specially designated funds to meet the requirements of the Consent decree. As of 11/30/2013, an additional 144 class members have since been subsidized into PSH housing for a cumulative total of 787.

PSH continues to be utilized to meet the needs of the other consumers targeted by DMH (see below). As of 11/15/2013, a cumulative total of 1,328 consumers have been subsidized and obtained housing since FY2008.

Individuals Approved and Eligible for PSH Housing by Priority Population Group in FY2013

All Approved Applications by DMH Priority Population Grouping (As of November 30, 2013)	
Priority Population	**Total**
Resident of long term care	985
Resident of DMH funded residential	548
Experiencing homelessness	509
At risk of placement in long term care	39
Extended long term patient at state hospital	11
Aging out DCFS ward	15
Aging out ICG recipient	8
Grand Total	**2,115**

The number of consumers benefitting from this initiative has steadily grown. DMH has utilized approximately $8.5 million of dedicated funding to this Permanent Supportive

Housing expansion. DMH partners with six (6) 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. By the conclusion of FY2013 112 agencies had applied for access to this Initiative on behalf of the consumers they represented. During FY2012 DMH also partnered with the Department of Healthcare and Family Services (DHFS) for PSH subsidies and services to meet the needs of 377 consumers.

Background:

Since FY2009 Illinois has implemented DMH Permanent Supportive Housing (PSH), a specific Evidence Based program model in which a consumer lives in a house, apartment or similar setting, alone or with one other consumer upon mutual agreement. The goal has been to promote and stabilize consumer recovery by providing decent, safe, and affordable housing opportunities linked with voluntary DMH-funded community support services. The criteria for supportive housing include: housing choice, functional separation of housing from service provision, and the consumer's right to tenure, choice of services, service individualization, and service availability. PSH housing is integrated with housing for persons who do not have mental illness and must be affordable (consumers pay no more than 30% of their income on rent). Ownership or lease documents are maintained in the name of the consumer, so tenant-landlord relationships are maintained. The DMH provides tenant-based rental assistance designed to act as a "bridge" from the time the consumer is ready to move into his or her own housing unit until the time he or she can secure a permanent rental subsidy. Consumers who have a serious mental illness or a co-occurring mental illness and substance abuse disorder whose household income is at or below 30% of Area Median Income (AMI) as defined by HUD are eligible to apply to the program. DMH targets 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.

PSH and the Williams Consent Decree

A Class Action Court Settlement was finalized in FY2011 that required additional financial resources to be available to DHS for mental health services. The Williams' Suit targets 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.

The settlement 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. As all the class members will not be ready for independent living when transitioning, the service system will be required to develop an array of residential options with onsite supports to best accommodate members' immediate transition needs. Concurrently, the state had to ensure that transitioning consumers, who do qualify, based on clinical and functional criteria, for independent living can obtain affordable permanent supportive housing by expanding funding resources to ensure the availability of Bridge Subsidies (until permanent rental subsidies or Section 8 housing choice vouchers can be secured).

The Illinois Housing Development Authority (IHDA), in partnership with DHS, has worked with developers and landlords to increase housing stock. In transitioning interested Class Members to a community placement, it is expected that the chosen community service provider will assure the provision of a number of transition coordination services including assistance with the housing search, developing comprehensive individualized service plans for each Class Member that include a risk mitigation plan and a 24 hour emergency back-up plan, assuring entitlements are in effect, assistance with purchasing furniture and supplies and, most importantly, assuring linkages are completed for requisite services, including all needed mental health services as well as medical and other necessary services and supports.

In FY2013, the state invested $20,000,000 to build the infrastructure for transitioning Williams Class Members and to support the development of 640 permanent supportive housing units and service supports necessary for successful transitions. With hard work and a strong sense of determination of the DMH staff and providers statewide serving the needs of transitioning Williams Class Members, the goal to successfully transition 640 class members by the end of FY2013 was achieved and exceeded.
The Williams Implementation Plan may be accessed at:
http://www.dhs.state.il.us/page.aspx?item=56446

Bi-directional Integration of Primary Health Care and Behavioral Health Care

Table 2.5 BI-DIRECTIONAL INTEGRATION OF PRIMARY HEALTH CARE AND BEHAVIORAL HEALTH CARE.
Report Year: FY2013
State Identifier: IL
Priority Area: Adults/Children and Adolescents- Bi-directional Integration of Primary Health Care and Behavioral Health Care.
Goal: *Work with system partners to identify next steps in planning for bi-directional integration of primary health and behavioral health care.*
Strategy: Review evaluations of bi-directional health care summit held in June 2011 and meet with system partners to continue planning efforts for bi-directional integration of primary health and behavioral health care.
Performance Indicator: Follow-up meeting with system partners to continue planning efforts.
Description of Collecting and Measuring Changes in Performance Indicator: Minutes of meetings held with system partners.

Report of Progress toward goal attainment in prior State Fiscal Year:
__X__ Achieved _____ Not Achieved (if not achieved, explain why)

This strategy has been substantively addressed in FY2012 and FY2013.

- ***During FY2012 the evaluations of the Summit held in June 2011 were reviewed. Participants clearly issued a call to continue the discussions needed to further activate behavioral health and primary healthcare collaboration across the State and discussions continued in a number of interagency venues.***
- ***Early in FY2013, the issue was formally and substantively addressed as part of the statewide interagency planning process for the Illinois Mental Health 2013-2018 Strategic Plan.***
- ***After several months of planning and coordination, DMH, DASA, SAMHSA, and HRSA convened a Statewide Conference on Primary and Behavioral Healthcare Integration on June 12, 2013. Presenters from the National Council for Community Behavioral Healthcare and a panel of presenters from five community mental health and Alcohol and Substance Abuse Agencies covered the following topics: Policy Considerations for Integrated Care; Best Practices in Integration; Lessons learned from the field; and Using IT to Support Integrated Care. A description of the conference with links to all of the presentations may be accessed at:*** **http://www.dhs.state.il.us/page.aspx?item=66831**

- ***DMH is working with DHFS on the Care Coordination Innovations Project which seeks to integrate primary health care and behavioral health care under Medicaid through a managed care approach during FY2015.***
- ***The accomplishment of key tasks required in order to move forward in bi-directional integration of primary health care and behavioral health will continue to be addressed by the working partnership between DMH, DASA, DPH, and DHFS.***

Additionally, DMH has maintained a Website since the Summit in June 2011 as a means of continuing to share information and developments and build participation. This Website may be accessed at: http://www.dhs.state.il.us/page.aspx?item=55312

Background:

A working partnership between DMH, DASA, DPH, and DHFS aimed at accomplishing key tasks required to move forward in bi-directional integration of primary health care and behavioral health has continued. These tasks include: (1) Assisting in needs assessments, (2) Formulating recommendations on reforming the delivery system for chronic disease prevention and health promotion, (3) Ensuring adequate funding for infrastructure and delivery of programs, (4) Addressing health disparities, and, (5) Considering the role of health promotion and chronic disease prevention in support of state spending on health care.

Care Coordination Innovations Project: Public Act 96-1510 enacted in 2011, requires that at least 50% of recipients eligible for comprehensive medical benefits in all medical assistance programs or other health benefit programs administered by the Department of Healthcare and Family Services (DHFS), including the Children's Health Insurance Program Act and the Covering ALL KIDS Health Insurance Act, be enrolled in a care coordination program by no later than January 1, 2015. The 50% goal is to be achieved by enrolling persons from each medical assistance enrollment category to include parents, children, seniors, and people with disabilities. DHFS must ensure:

- Consumer choice of systems and of primary care providers within the systems;
- Quality care in a culturally and linguistically appropriate manner; and
- Coordinated care programs that meet the diverse needs of enrollees with developmental, mental health, physical, and age-related disabilities.

State funding is to be contingent on performance related to health care outcomes, the use of evidence-based practices, the use of primary care delivered through comprehensive medical homes, the use of electronic medical records, and the appropriate exchange of health information electronically. DMH has been working closely with DHFS to assure that the mental health components are properly addressed.

Additional activities in this arena are:

- DMH continues to explore and emphasize options for more extensive collaboration with Health Resources and Services Administration (HRSA) funded Federally Qualified Health Centers (FQHCs) in Illinois. CMHC'S in rural areas have been particularly interested in this collaboration as a means of integrating services in order to provide greater access for rural residents. At the June 2013 conference noted above, examples of successful collaborative and joint work were presented.

- DMH continues to emphasize the importance of assisting adult consumers in the completion of applications for Medicaid benefits as one means of assuring that access to health services are available. Individuals with serious mental illnesses who are Medicaid recipients are entitled to the range of health services covered in the Illinois Medicaid plan.

- DMH is a charter member of the Illinois Department of Public Health's Chronic Disease Prevention Task Force and is actively collaborating with other member agencies in developing management strategies to address issues relevant to individuals with behavioral health needs who also suffer with chronic diseases.

Advancement of Recovery

The advancement of the recovery vision for Illinois and the provision of mental health care that is consumer and family driven are important priorities of the Division of Mental Health. Consumer participation objectives for FY 2012/2013 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. To support

consumer participation, consumer education is provided through a variety of venues in the state.

Regional Recovery Conferences

Table 2.6 REGIONAL RECOVERY CONFERENCES
Report Year: FY2013
State Identifier: IL
Priority Area: Adults-Advancement of the Recovery vision.
Goal: *Establish a comprehensive system of care based upon principles of Recovery and Resilience in which consumers are knowledgeable and empowered to participate and provide direction at all levels of the system.*
Strategy #1: Educate consumers of mental health services in leadership, personal responsibility and self-advocacy, through participation in regional Recovery Conferences.
Performance Indicator: Number of regional Recovery Conferences held each year.
Description of Collecting and Measuring Changes in Performance Indicator: Document each regional recovery conference event. Aggregate the data across regions by year to enable comparisons across years.
Report of Progress toward goal attainment in prior State Fiscal Year: **__X__ Achieved _____ Not Achieved (if not achieved, explain why)**

This strategic objective has again been accomplished. Five regional recovery conferences have been held at five strategic locations in the State and attracted 1,490 participants. The conference dates, locations and number of participants are listed below:

Date	Location	Number Attended
September 20, 2012	**Peoria**	**325**
October 26, 2012	**Belleville**	**390**
June 12, 2013	**Chicago**	**275**
August 8, 2013	**Carterville**	**200**
September 19, 2013	**Springfield**	**300**

Background

DMH Recovery Support Specialists work with stakeholders to design, plan and convene annual recovery conferences in each DMH region. Through participation in regional Recovery Conferences, consumers of mental health services receive education in leadership, personal responsibility and self-advocacy. Often a well-known and /or national speaker delivers the keynote address and sets the "tone of recovery" for the conference. Consumers, family members, providers, staff from state agencies, and other stakeholders attend these conferences. This effort is continuing in FY2014.

Wellness Recovery Action Plan (WRAP)

Table 2.7 WRAP TRAINING
Report Year: FY2013
State Identifier: IL
Priority Area: Adults-Advancement of the Recovery vision.
Goal: *Establish a comprehensive system of care based upon principles of Recovery and Resilience in which consumers are knowledgeable and empowered to participate and provide direction at all levels of the system*
Strategy #2: Enhance the recovery orientation of mental health services through continuing education of certified WRAP Facilitators**.**
Performance Indicator: Number of regional WRAP continuing education/refresher trainings conducted each year
Description of Collecting and Measuring Changes in Performance Indicator: Each training event will be documented when held. Data will be aggregated by fiscal year for comparison across years.
Report of Progress toward goal attainment in prior State Fiscal Year: **__X__ Achieved _____ Not Achieved (if not achieved, explain why)**

This strategy was successfully accomplished in FY2013. Eight (8) training events were held during the fiscal year. At least two events occurred in each DMH region. More than 200 WRAP Facilitators participated.

Background

The Wellness Recovery Action Plan (WRAP) model is well established in Illinois. WRAP classes in community agencies and presentations of the principles of WRAP at consumer forums and conferences have benefited thousands of consumers throughout the state. 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. The continuing education of certified WRAP Facilitators has enhanced the recovery orientation of mental health services. Refresher/Continuing Education courses are held in each region bi-annually for Certified WRAP Facilitators. This effort continues in FY2014.

Consumer Education and Support Initiative

Table 2.8 CONSUMER EDUCATION TELECONFERENCING
Report Year: FY2013
State Identifier: IL
Priority Area: Adults-Advancement of the Recovery vision.
Goal: *Establish a comprehensive system of care based upon principles of Recovery and Resilience in which consumers are knowledgeable and empowered to participate and provide direction at all levels of the system*
Strategy #3: Conduct a series of statewide teleconferences designed to disseminate important information to consumers across the State.

Performance Indicator: Number of statewide teleconferences held each year.
Description of Collecting and Measuring Changes in Performance Indicator: Document each teleconference event and aggregate by year for comparison across years.
Report of Progress toward goal attainment in prior State Fiscal Year: **__X__ Achieved _____ Not Achieved (if not achieved, explain why)**

This strategy was successfully achieved in FY2013 and is continuing in FY2014. Ten teleconferences were conducted in FY2013 with an aggregate attendance of 4,667 (duplicated). The dates, topics, and number of participants of each teleconference are detailed in the table below.

Consumer Education Teleconferences in FY2013

Date of Teleconference	Topic	Number of Participants
July 26, 2012	Living Well through Self Education	495
August 23, 2012	Living Well through Career Building	427
September 27, 2012	Living Well through Integrated Healthcare	451
October 25, 2012	Living Well through Action Plans for Wellness and Recovery	468
January 24, 2013	Building Bridges from Sobriety to Wellness	479
February 28, 2013	Building Bridges toward Health & Wellness	532
March 28, 2013	Building Bridges toward Personal Independence	405
April 25, 2013	Building Bridges from Peer to Peer	543
May 23, 2013	Building Bridges from Symptoms to Solutions	415
June 27, 2013	Building Bridges to Healthy Relationships	452

DMH recognizes the need for providing consumers with the tools they need to cogently and effectively participate in the development and evaluation of the service system. The primary focus of the Consumer Education and Support Initiative has been to ensure that consumers of mental health services receive current, accurate, and balanced information regarding changes in the service delivery system, empowering them to take an active, participatory role in all aspects of service delivery. In FY2013 **ten** statewide consumer education calls were held with an average of 467 participants for each consumer education teleconference. These calls provided the forum for discussion of information about a range of services and approaches including integrated health care, crisis planning, and personal wellness, new developments such as changes in service policies and procedures, and emerging issues such as thriving in challenging economic times, all designed to promote consumers' awareness and knowledge. In FY2014 DMH is continuing to conduct a series of statewide teleconferences designed to disseminate important information to consumers across the State.

Certified Recovery Support Specialist (CRSS)

Table 2.9 CERTIFIED RECOVERY SUPPORT SPECIALISTS
Report Year: FY2013
State Identifier: IL
Priority Area: Adults-Advancement of the Recovery vision.
Goal: *Establish a comprehensive system of care based upon principles of Recovery and Resilience in which consumers are knowledgeable and empowered to participate and provide direction at all levels of the system*
Strategy #4: Support the role of Certified Recovery Support Specialists and their deployment statewide by hosting webinars for providers to help increase agencies' understanding of the role, value, function, and advantages of hiring CRSS professionals and by providing competency training events for individuals interested in the CRSS credential.
Performance Indicator: Number of training events held each year to increase stakeholder understanding of the CRSS credential and to increase competency in CRSS domains.
Description of Collecting and Measuring Changes in Performance Indicator: Document each training event and aggregate by year for comparison across years.
Report of Progress toward goal attainment in prior State Fiscal Year: **__X__ Achieved _____ Not Achieved (if not achieved, explain why)**

This objective was substantively accomplished. A statewide forum was held for agencies providing or interested in providing CRSS services. A total of 106 individuals attended, representing 43 different provider agencies from all 5 DMH regions. Five provider workgroups were subsequently developed to continue the effort to assist agencies to effectively utilize CRSS professionals, implement peer programs, and advance agency culture toward a recovery oriented system.

Additionally, three competency training events were held for individuals interested in the CRSS credential. The training was attended by a total of 265 individuals.

The Certified Recovery Support Specialist (CRSS) is a credential for those persons with lived experience who provide mental health or co-occurring mental illness and substance abuse peer support to others using unique insights gained through personal recovery experience. The CRSS credential assures competence in advocacy, professional responsibility, mentoring, and recovery support. Certified Recovery Support Specialists have the ability to infuse the mental health system with hope and empowerment, and improve opportunities for others to:

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

In collaboration with the Illinois Certification Board (ICB), the Divisions of Mental Health (DMH), Rehabilitation (DRS), and Alcoholism and Substance Abuse (DASA)

developed the Illinois Model for Certified Recovery Support Specialist (CRSS). This credential has been accessed through the ICB since July 2007. Individuals are certified as having met specific predetermined criteria for essential competencies and skills. 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.

As of October 4, 2013:

- **107 individuals with CRSS certification were active in the State, and all were in good standing with the Illinois Certification Board (ICB).**
- **36 applications had been approved and the applicants were in the process of completing their testing with the ICB.**
- **21 individuals had applied to the ICB for the credential and their applications were in process.**

The DMH Office of Recovery Support Services continues to work with other system partners, including the ICB and the Mental Health Collaborative for Access and Choice (MHCAC), to:

- Disseminate public information about the credential;
- Develop training curricula, and study materials for those seeking to obtain their CRSS credential;
- Plan and conduct Webinars and other training events for provider agencies to help increase agencies' understanding of the role, value, function, and advantages of hiring CRSS professionals.

The aim of DMH is to steadily increase the number of agencies that hire CRSS professionals.

Use of Data

The DMH utilizes data to support decision making in a wide variety of areas including utilization management, quality improvement activities, resource allocation and planning efforts. Information is analyzed and disseminated to a wide variety of entities in different formats that have been designed to be user-friendly. The use of quantitative measures of organizational functioning permits comparisons to be made against a standard over extended time or between organizational units. Target levels for the performance indicators provide the focus for evaluation and planning. Two major indicators for monitoring the system are access to care and consumer perception of care.

Access to Services

Table 2.10 USE OF DATA: ACCESS TO CARE
Report Year: FY2013
State Identifier: IL
Priority Area: Adults and Children/Adolescents- Advancement of the use of data to support decision-making
Goal: *Use quantitative data to assess access to care and perception of treatment outcomes to provide data for decision support.*

Strategy #1: Assess access to care by tracking the number of individuals who received treatment partitioned by race, gender and age.
Performance Indicator: Number of adults and number of children/adolescents receiving services from DMH-funded community-based providers.
Description of Collecting and Measuring Changes in Performance Indicator: 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 is submitted to the state Medicaid agency, Healthcare and Family Services (HFS), and 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.
Report of Progress toward goal attainment in prior State Fiscal Year: **__X__ Achieved _____ Not Achieved (if not achieved, explain why)**

This strategy was again effectively accomplished in FY2013. DMH used quantitative data to evaluate access to care by tracking the number of individuals who received treatment during the fiscal year partitioned by race, gender and age. The community mental health services budget has been substantially reduced sinceFY2011. Although DMH strived 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. It is noteworthy at this time that in the past three years, while the number of adults served has decreased by 14%, the number of children and adolescents served has increased by 17%. In FY2013, DMH services reached just 289 persons less than the number served in FY2012. The tables below provide access data for adults and children for the past three fiscal years.

Number of Adults Receiving Services from DMH-funded Community-based Providers

(1)	(2)	(3)	(4)
Fiscal Year	**FY 2011 Actual**	**FY 2012 Actual**	**FY 2013 Actual**
Performance Indicator	**111,929**	**100,377**	**96,259**
Numerator	**N/A**	**N/A**	**N/A**
Denominator	**N/A**	**N/A**	**N/A**

Number of Children/Adolescents Receiving Services from DMH-funded Community-based Providers

(1)	(2)	(3)	(4)
Fiscal Year	**FY 2011 Actual**	**FY 2012 Actual**	**FY 2013 Actual**
Performance Indicator	**33,610**	**35,670**	**39,499**
Numerator	**N/A**	**N/A**	**N/A**
Denominator	**N/A**	**N/A**	**N/A**

DMH funded community providers are contractually required to register all individuals funded with any DMH dollars in the DMH/ASO Community Reporting Information System. All claims are submitted directly to the Illinois Medicaid agency, the Department of Healthcare and Family Services MMIS. Processing of claims is subject to business rules established by DMH, thus the linkage between registrations of individuals for services and claims submission is being maintained. DMH reporting standards require full reporting of consumer and service data by community providers. DMH receives claims data on a weekly basis after it is processed and adjudicated by DHFS.

Assessing Consumer Perception of Care

Table 2.11 USE OF DATA: CONSUMER PERCEPTIONS OF CARE
Report Year: FY2013
State Identifier: IL
Priority Area: Adults and Children/Adolescents- Advancement of the use of data to support decision-making
Goal: *Use quantitative data to assess access to care and perception of treatment outcomes to provide data for decision support.*
Strategy #2: Conduct a consumer survey to assess perception of care to determine the extent to which consumers and caregivers report positive outcomes that are attributable to treatment received.
Performance Indicator: Percentage of: (a) adult consumers and (b) caregivers of youth reporting positively about outcomes.
Description of Collecting and Measuring Changes in Performance Indicator: The DMH utilizes the MHSIP Adult Consumer Perception of Care Survey and the Youth Services Survey for Families to collect this data. Each year, a random stratified sample of adults receiving treatment the previous June is selected for the survey and disseminated via mail in October with the goal of data collected by early November. Similarly a random stratified sample of caregivers of children and adolescents receiving services is also selected every year to receive the survey. The indicator values are compared with data collected in succeeding years.
Report of Progress toward goal attainment in prior State Fiscal Year: **____ Achieved _X__ Not Achieved (if not achieved, explain why)**

This strategic objective was achieved in FY2012 but was not achieved in FY2013. Due to the abrupt departure of key staff members who were experienced in conducting the survey, and knowledgeable in its requirements, process, and data analysis, DMH was unable to conduct the Survey in FY2013, but still plans to do so. Efforts have been and are currently underway to recruit and train replacements. We fully expect to be able to report the data.

During FY2012 DMH surveyed 2600 adult consumers and 2600 Caregivers of Children who received services at DMH funded community mental health centers during FY2011. Most adult respondents reported being generally satisfied with: Services (87%), Access to services (86%), Participating in their own treatment planning (85%), and Quality and Appropriateness of the services (85%). However, they were generally less satisfied with the results of their treatment: Treatment outcomes (65%), Daily functioning as a result of treatment (66%), and Social experiences (72%). DMH also conducted its annual perception of care survey of caregivers of children and adolescents aged 0-17 who received DMH funded MH services. Caregivers of children under twelve reported most positively about the cultural sensitivity of their providers (91%) and their participation in treatment planning (86%) and least positively about the child's post treatment functioning (57%) and treatment outcomes (55%)

Background

The Adult Consumer Survey and the Youth Services Survey for Families are part of the Mental Health Statistics Improvement Program (MHSIP) Quality Report performance measures. The surveys address two goals of the Division: (1) data-based decision-making in a continuous quality improvement environment and (2) to enhance and expand the involvement of consumers, families and caregivers in the review, planning, evaluation and delivery of mental health services. Variables included in the analysis are: severity of emotional disturbance, race/ethnicity, and length of time in treatment. Although a decrease in access to services due to budget constraints was anticipated, DMH desired to maintain the previous level of positive reporting by consumers in the Adult Consumer Survey through FY2013. The Performance Measurement Indicator for Adults is: 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

DMH annually surveys a stratified random sample of 2600 adult consumers who received services at DMH funded community mental health centers. Participants are chosen at random and the survey is sent to their home address. All surveys are confidential. Consumers are asked to rate their experiences on a scale of 1 to 5 whether they agree or disagree with 26 statements. Of the 2600 surveys sent out to consumer's homes in FY2012, 582 were completed and returned. This number of responses at nearly 25% was more than sufficient for statistical purposes to grade services that were offered.

The Division has adapted the MHSIP: Youth Services Survey for Families to annually collect feedback from caregivers of children ages 0 – 17 who are receiving community mental health services funded by the DMH. In past years, 2600 participants were chosen at random and the survey was sent to their home address. Adolescents aged 12-17 who had fewer than 9 service-days were excluded to protect the privacy of those seeking care before letting their caregiver know. Caregivers who receive the survey are asked to rate on a scale of 1 to 5 whether they agree or disagree with 26 statements. In FY2012, 411 caregivers responded to the survey providing a large enough sample for a statewide evaluation. As with Adults, DMH is seeking to maintain the percentage of parents/caregivers reporting positive outcomes through the Youth Services Survey for Families. The Performance Measurement Indicator is: Percentage of parents/caregivers reporting positively about outcomes with reference to the following National Outcome Measures:

- Client Perception of Care (Outcomes Domain)
- Increased Social Supports/Social Connectedness
- Improved Level of Functioning

Forensic Services

Table 2.12 FORENSIC SERVICES- JAIL DATA LINK (JDL)
Report Year: FY2013
State Identifier: IL
Priority Area: Adults- Maintain a comprehensive system to serve the forensic needs of court-involved consumers.
Goal: *Maintain a system of care to address the mental health needs of consumers with criminal justice involvement.*
Strategy: Monitor and maintain linkages to community services for individuals with serious mental illness released from Illinois jails.
Performance Indicator: Percentage of eligible individuals released from jail who are linked to community-based services.
Description of Collecting and Measuring Changes in Performance Indicator: A daily cross match of individuals receiving mental health services with individuals in jails in selected jurisdictions is used to identify individuals participating in the jail data linkage project. Data will be collected to track the number of individuals who are linked with community based mental health service providers. Data will be aggregated across the year for comparison with data from succeeding years.
Report of Progress toward goal attainment in prior State Fiscal Year: **__X__ Achieved ___ Not Achieved (if not achieved, explain why)**

This strategic objective has been accomplished in both FY2012 and FY2013. Linkages to community services for individuals with serious mental illness released from Illinois jails were monitored and maintained. In FY2013, however, there appears to have been some erosion in comparison to FY2012 as indicated in the data below:

Fiscal Year	Eligible for Jail Linkage	Actual Linkage	30 day longevity	60 day longevity
2012	**6175**	**1018**	**559**	**84**
2013	**7447**	**1005**	**452**	**50**
	State-wide	**State-wide**	**State-wide**	**State-wide**

The FY2013 data reflected that 13.5% of those eligible for linkage were indeed linked. Of those, 44% were still linked and engaged at the 30 day level and that the level of engagement dropped to 5% at the 60 day level. Compared to FY2012, the number eligible for Jail Linkage in FY2013 increased by 20% but actual linkage decreased by 3%, and the percentages of those engaged at the 30 day and 60 day levels also decreased. It should be noted that many clients who are engaged in medication monitoring may not revisit during this 60 day interval.

This data reflects that the system lacks agency involvement in linkage of individuals identified by JDL. Lack or loss of Medicaid benefits is a key factor along with the need to fund additional JDL case managers to support current and expanded county jail participation. Some current JDL involved agencies have reduced case management services due to overall agency funding reductions. Additional financial support for JDL is critically needed.

Background

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). In addition to service responsibilities mandated by Illinois forensic statutes, DMH has also collaborated on initiatives with key stakeholders to address the service needs of non-mandated individuals with mental illness who are involved with the criminal justice system.

The Jail Data Link Project began in 1999 when the Bureau of Justice Assistance and other national experts published findings that 6.1% of male and 15% of female detainees in the Cook County Jail, suffered from mental illness. Phase I of the Project was limited to Cook County and 14 pilot mental health community providers. Since then, the Project has expanded to ten counties in Illinois. The 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 an automated technology basis and is performed on a daily basis, based on the jail's current census.

Dedicated case managers to facilitate and follow linkage arrangements continue to be a critical need in the program. Despite its high volume of individuals eligible for linkage, Cook County Jail Linkage has very limited case management, mainly through one

provider. Also, consideration needs to be given to funding dedicated case managers for other counties that wish to join Jail Data Link. Will, Mclean, Peoria, St Clair, Winnebago and Rock Island counties continue to link individuals to community services. Planning is currently under way to include Champaign, Du Page, and Macon counties in the program.

A major linkage obstacle for many of the consumers identified by Jail Data Link is the loss of Medicaid funding or the closure of their cases by the community agency providing services. As of August 1, 2012 Illinois has introduced Public Act 96-0872, which has allowed (in certain instances) detainees to maintain their Medicaid Benefits for 30 days and possibly longer depending on benefit packages. It is hopeful that with the expansion of Medicaid under ACA in 2014, agencies will engage more justice involved consumers identified by Jail Data Link and improve linkage and maintained linkage percentages. This will also necessitate access to a range of Medicaid approved (Rule 132) services, DASA services, and evidenced based practices necessary for meeting the service needs of a population with persistent and chronic mental illness, high rates of co-morbidity with substance abuse, and medical conditions. In addition, this population presents a tremendous need for recovery supports, including housing and employment.

Uninsured and Underinsured Consumers

Table 2.13 UNINSURED/UNDERINSURED CONSUMERS
Report Year: FY2013
State Identifier: IL
Priority Area: Adults/Child and Adolescent- Planning, within budgetary constraints, to address the needs of uninsured and underinsured consumers.
Goal: *Identify resources to purchase mental health services for uninsured and under-insured consumers.*
Strategy: Use financial resources from the state general revenue fund, Federal Fund Participation (FFP), and grants as a basis to fund the purchase of mental health services. Enhance human resources of the public mental health system through continued support of public/academic linkages, mental health and law enforcement training, and the training and coordination of providers of emergency and disaster services.
Performance Indicator: No indicators for this goal.
Description of Collecting and Measuring Changes in Performance Indicator: No indicators are identified for this goal.
Report of Progress toward goal attainment in prior State Fiscal Year: **__X_ Achieved _____ Not Achieved (if not achieved, explain why)**

Efforts to identify new resources and maintain levels of service to uninsured and underinsured consumers have continued in a climate of budget limitations. New financial resources have become available for a limited service population through the Williams vs. Quinn Consent Decree which have resulted in the expansion of some components of the service system that will benefit the broader range of consumers. DMH is evaluating the impact of significant developments related to the implementation of ACA on the consumer population currently being served.

Consumers who do not qualify for expanded Medicaid or are unable to purchase affordable health plans in the Marketplace-GetCovered Illinois- will continue to be served through the limited GRF funds available. DMH will continue to provide a safety net for persons who are not enrolled in Medicaid or an insurance plan within budgetary constraints.

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. 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 of existing funds and the prioritization of distinct service groups to receive a limited set of service packages to carry individuals who are not enrolled in Medicaid. See text of Table 3.1 (Available Services) above, for a description of service provision and coverage based on clinical criteria and financial eligibility.

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 and to participate advantageously in the insurance programs now being developed through Affordable Care.

Financial resources for adult and child/adolescent community mental health services come from the General Revenue Funds (GRF) appropriated by the Legislature, dollars generated through federal fund participation (FFP), Block Grant funds, and the redirection of dollars accrued from the reduced utilization of state hospital services and annualized income from previous initiatives. Through Medicaid Rule (Rule 132) revisions, DMH has been able to improve and clarify the documentation requirements to enhance provider and state compliance with federal and state Medicaid regulations and expectations. These activities have permitted greater flexibility in generating Medicaid funds for community mental health programs.

Child – Available Services

Table 2.14 CHILD – AVAILABLE SERVICES
Report Year: FY2013
State Identifier: IL
Priority Area: Child and Adolescent- Assurance of an effective array of clinical and support services for children and adolescents
Goal: *Continue to assure that a comprehensive array of community-based services is available to children and adolescents in need of mental health services (Criterion I.)*
Strategy: Ensure that the following services are available: • Mental health assessment, • Treatment plan development, review and modification: • Screening, Assessment and Support Services (SASS), • Case management, • Community support (individual, group and residential), • Crisis intervention, • Mental health intensive outpatient, • Psychotropic medication administration, monitoring, and training; • Short-term diagnostic and mental health services, • Therapy/counseling, • Individual Care Grant for Children with Mental Illness (ICG/MI) and • Oral interpretation and sign language Work with system partners to provide supportive services including: o Educational services, o Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA), o Substance abuse services (through DASA), o Services for co-occurring mental health and substance abuse disorders, o Medical and dental services (provided through DHFS for youth who are Medicaid eligible), and, o Wraparound services.
Performance Indicator: Number of youth who are (a) Medicaid enrolled or (b)non-Medicaid eligible who receive mental health services.
Description of Collecting and Measuring Changes in Performance Indicator: 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. Data will be collected by fiscal year to compare change across years.
Report of Progress toward goal attainment in prior State Fiscal Year: **___X__ Achieved _____ Not Achieved (if not achieved, explain why)**

DMH successfully met this goal in FY2012 and FY2013. This array of services has been provided through Medicaid and Service Benefit Packages for consumers not

enrolled in Medicaid. DMH continues to work closely with partner agencies in implementing support services. The Table below provides the Medicaid Status information for everyone (Adults and Children) served in FY2013. Comparison of FY2012 and FY2013 shows modest change.

Medicaid Status of Persons Served in FY2012 and FY2013

Medicaid Status	Total Served in FY2012	Percent of Total Served	Number Served in FY2013	Percent of Total Served	Change (%) FY12-FY13
Medicaid (Only Medicaid)	**91,111**	**67.0**	**89,233**	**65.7**	**(-2.06)**
Non-Medicaid Sources (only)	**37,139**	**27.3**	**38,857**	**28.6**	**4.62**
People Served by Both	**7,797**	**5.7**	**7,668**	**5.6**	**(-1.65)**
Medicaid Status Not Available	**0**	**-**	**0**	**-**	
Total Served	**136,047**	**100.0**	**135,758**	**100.0**	**0**

Background

The array of core mental health services purchased on behalf of Illinois citizens with mental illnesses are based on the tenets of the Community Support Program (CSP) and Child and Adolescent Support Services (CASSP) models. The core services provided to children and adolescents in Table 2.14 are aimed at providing acute care services during a crisis and longer term mental health treatment services intended to reduce psychiatric symptoms and promote adaptive functioning. An individual's mental health service needs are evaluated and an individual treatment plan (ITP) must be formulated that is monitored, reviewed, and modified as needed on an ongoing basis. Youth with serious emotional disturbances and their families may receive specialized services including Screening, Assessment and Support Services (SASS); Child and Adolescent Wraparound Services; and services through the Individual Care Grant Program for Children with Mental Illness (ICG/MI).

Screening, Assessment and Support Services (SASS) programs have been in operation for over two decades. The primary objectives of SASS are to develop community-based screening and assessment capability, intensive home-based services, and crisis intervention services. The philosophy of service is short-term intervention that is child-centered, family-focused and community-based. Parents are involved in service provision and evaluation. Since FY2005, the DMH has participated in a significant effort to deliver SASS services collaboratively with the Department of Children & Family Services (DCFS) and the Department of Healthcare & Family Services (DHFS).

Wraparound Services The Wraparound Approach is essential to the provision of case management services. DMH has defined the way these services are to be provided to families, offering both traditional and non-traditional supports by using the local network of community providers and associations. In this approach, there is a definable planning process involving the child and family which results in an individualized plan for that

child and family that focuses on strengths and needs across multiple settings**.** The Wraparound approach strengthened the collaboration needed to serve these youth and promoted an important shared agenda for community mental health providers and schools.

Individual Care Grant For Children with Mental Illness The DMH Individual Care Grant (ICG) Program provides funds for residential treatment or intensive community treatment for children and adolescents with serious emotional disturbances who meet the criteria of severe mental illness and impaired reality testing. If the funding is awarded for a community grant, parents and providers work together to provide highly individualized services in the community. These individualized services include intensive home-based support, treatment and respite care which allow the child to remain at home. A parent, along with the community mental health center may also decide that residential treatment is the appropriate option. Families are encouraged to place their children close to home to optimize parental involvement in treatment.

Service Packages for Persons Who Are Not Enrolled in Medicaid

The overwhelming majority of children served by DMH funded providers are enrolled in Medicaid. Medicaid recipients continue to receive the normal array of services while those who are not enrolled in Medicaid receive limited service packages to be paid for with the minimal funding DMH has available. DMH has prioritized four distinct service groups. ***Descriptions of these groups and the service benefit packages available to them are provided under Table 3.1 (Adult Available Services) above and at:*** http://www.dhs.state.il.us/page.aspx?item=51784 .

Support Services

The DMH has pursued a model of service provision that is organized around the needs of the families, schools and communities and addresses the needs of children served through the **Individuals with Disabilities in Education Act (IDEA).** The school-based model includes universal, selected and targeted strategies while also addressing cultural factors, stigma, outreach and other barriers to engagement. Students experience school wide behavioral interventions which promote learning and integrate mental health services in a positive way. **Substance Abuse Services** are provided through the IDHS Division of Alcoholism and Substance Abuse (DASA), which administers funding to a network of community-based substance abuse treatment programs. DMH and DASA continue to explore the need for staff training and increasing program capacity to address the clinical needs of youth with co-occurring (Substance Abuse/Mental Health) Disorders. DASA has funded the Illinois Co-Occurring Center for Excellence (ICOCE) to provide training, technical assistance, and consultation and has collaborated with DMH in providing trainings on trauma informed prevention, treatment and recovery as well as adolescent and family co-occurring disorders and their treatment. Essential **medical and dental services** are available to children and youth with SED regardless of income and are accessed through case management or referral. Mental health providers actively assist families to process their medical bills through Medicaid and to obtain health insurance coverage for their children under the All Kids program. Mental health providers may facilitate access to subsidized health care clinics that provide medical and dental services at minimal cost.

The State of Illinois provides access to health care for children and adolescents through **All Kids,** a program administered by the Illinois Department of Health Care and Family Services (DHFS). Funded by the Illinois Legislature since 2006, this state program has offered comprehensive, affordable health insurance for children in Illinois. Every uninsured child may be eligible regardless of income, current health condition or citizenship. Information is available on the All Kids Website at: http://www.allkids.com
All Kids also has two programs for pregnant women: Medicaid Presumptive Eligibility (MPE) that offers immediate, temporary coverage for outpatient healthcare for pregnant women and Moms & Babies which covers healthcare for women while they are pregnant and for 60 days after the baby is born. Moms & Babies covers both outpatient healthcare and inpatient hospital care including delivery. See: http://www.**allkids.com**/pregnant.html
Family Care extends healthcare coverage to parents living with their children 18 years old or younger and also covers relatives who are caring for their children in place of their parents. See: http://www.familycareillinois.com

Family Resource Developers (FRDs)

Table 2.15 FAMILY DRIVEN CARE/SYSTEM OF CARE PARENT SUPPORT
Report Year: FY2013
State Identifier: Il
Priority Area: Child and Adolescent - Advancement of family-driven care.
Goal: *Establish a system of care that is family driven and emphasizes services that are evidence-based.*
Strategy #1: Facilitate parent-to-parent support through the use of Family Resource Developers in system of care grants.
Performance Indicator: Number of Family Resource Developers hired in System of Care grant-funded programs.
Description of Collecting and Measuring Changes in Performance Indicator: The number of parents hired as system family resource developers for system of care grants will be aggregated across the year for comparison with data collected for subsequent years.
Report of Progress toward goal attainment in prior State Fiscal Year: **__X__ Achieved _____ Not Achieved (if not achieved, explain why)**

This strategic objective has been achieved. Parent to Parent support has been effectively facilitated statewide and in System of Care projects. As of the end of FY2013, there were 55 Family Resource Developers working throughout the state of Illinois. A number of them are working with families in Illinois System of Care projects where they are identified as "family partners" and "access coordinators". As of the end of FY2013, 14 Family Resource Developers were employed by the two current System of Care Grant projects. There were three Family Resource Developers at the ACCESS Initiative in Champaign County (East Central Illinois) and eleven Family Resource Developers were employed in Project Connect in White, Saline, and Gallatin Counties in Southern Illinois.
Additionally, Family Consumer Specialists, persons having personal experience with the caretaking of children with SED, are employed by DMH in the five regions of the state. Family Consumer Specialists continue to host monthly statewide 'Parent Empowerment Calls' to provide parents with information that allows them to more

effectively drive and evaluate their children's care and the system at large. Eleven (11) Parent Empowerment Calls were held in FY2013. Over 375 lines were utilized on the calls, with parents sometimes meeting together to participate.

DMH has continued to facilitate parent-to-parent support through the use of Family Resource Developers and is working with parents and parent-led organizations to encourage substantive feedback on enhancing the quality of services at all levels of care in FY2014.

Background:

DMH requires that Family Resource Developers (FRDs), parents and caregivers of children with SED, be hired in SASS agencies and that they be participating members of teams that provide services to youth and their families. Increasing value has been placed on the expertise FRDs bring to the SASS teams and their support role has expanded. Continuous training and monthly regional meetings provide education, resource development and support for the positions.

FRD's have also had an integral and valuable role in the development and implementation of Systems of Care (SOC) projects in Illinois. SOC grants are federal grants usually awarded to the state and local governments for five year periods to develop and build systems of care for children, youth, and their families. Two SOC grants are currently active in Illinois:

- The ACCESS Initiative in Champaign County, a SOC grant awarded in FY2010, is aimed toward transforming the county's services into an integrated network of community-based services and supports that are family-driven, youth-guided and culturally competent. This initiative is community-based, using a public health facility located in close proximity to at-risk neighborhoods as a means of reducing stigma and promoting linkage between physical and behavioral health services. African American youth with SED, ages 10-17 who are involved with (or at risk of involvement with) the juvenile justice system are the priority group being served.
- Project Connect in White, Saline, and Gallatin Counties was also awarded in FY2010. Project Connect is a collaborative initiative for youth with serious emotional disturbances and their families in these three rural, southeastern Illinois counties that have high poverty rates, low levels of adult education, high levels of disability, high Medicaid enrollment, and are substantially underserved for mental health. Project Connect works with schools and has prioritized youth transitioning to adulthood (age 16-21); youth receiving special education services, and youth undergoing major developmental transitions (into grade school, into middle school, and into high school). The initiative is implementing universal screening of youth through the schools at three points in their K-12 education; hiring Family Resource Developers and Care Managers to work in concert with school-based social workers and mental health service providers in the community; and offering evidence-based practices to support youth and family development (such

as Wraparound services, parent skills training, and services focused on transitioning to adulthood).

Certification of Parent Providers

Table 2.16 FAMILY DRIVEN CARE/FAMILY PARTNER PROFESSIONALS
Report Year: FY2013
State Identifier: Il
Priority Area: Child and Adolescent - Advancement of family-driven care.
Goal: *Establish a system of care that is family driven and emphasizes services that are evidence-based.*
Strategy #2: In FY2012 and FY2013 advance Family Driven Care in Illinois by certification of parent providers as Family Partner Professionals.
Performance Indicator: The number of individuals who are credentialed as CFPPs by the end of each fiscal year.
Description of Collecting and Measuring Changes in Performance Indicator: The number of parents certified as Family Partner Professionals will be aggregated across the year for comparison with data collected for subsequent years.
Report of Progress toward goal attainment in prior State Fiscal Year: **__X__ Achieved _____ Not Achieved (if not achieved, explain why)**

This strategic objective was initialized in FY2012. In FY2013, DMH continued to advance the certification of parent providers as Family Partner Professionals and to monitor the extent of their statewide deployment. As of 10/1/13, there were 15 Certified Family Partnership Professionals (CFPP'S) deployed in the State and 12 applicants were scheduled to take the next CFPP examination before the end of December.

Certified Family Partnership Professionals (CFPPs) are individuals trained to incorporate the unique life experiences they gained through parenting a child whose emotional and/or behavioral challenges required them to access resources, services, and supports from multiple child-serving systems as they progressed toward the achievement of their family's goals. Family peer-to-peer support is vital for families overcoming the challenges of raising and supporting a child with emotional, mental, or behavioral disorders. The Illinois Model identifies the functions, responsibilities, knowledge, and skill bases required by the professional CFPP in the performance of his/her job, regardless of the treatment setting in which the work is performed or through which previous professional training and orientation has been received. The CFPP credential assists by ensuring that quality of care is provided to client families by peer parents in many of the child-serving systems. Certification is accomplished through a mandatory training and experience protocol and the successful completion of a written examination. Evidence of qualifications includes a 100-hour training requirement, supervised work experience, and passing the examination. As of the end of FY2012, 9 individuals had received the CFPP certification and 5 individuals had passed the exam and certification was pending. 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. (Further information on the CFPP credential may be obtained

from the Website of the Illinois Mental Health Collaborative. The direct link is: http://www.illinoismentalhealthcollaborative.com/consumers/consumer_cfpp.htm

Mental Health and Juvenile Justice

Table 2.17 SERVICE INTEGRATION/Mental Health & Juvenile Justice
Report Year: FY2013
State Identifier: Il
Priority Area: Child and Adolescent- Enhancement of collaborative efforts with state and local partners to address the mental health needs of youth.
Goal: *Integrate services for children/adolescents across service systems and the developmental stages from early childhood through young adulthood. (Criterion 3-Juvenile Justice)*
Strategy #1: In FY2012 and FY2013, increase the number of youth receiving services through the Mental Health Juvenile Justice Initiative (MHJJ).
Performance Indicator: Number of youth served by the MHJJ program statewide**.**
Description of Collecting and Measuring Changes in Performance Indicator: Aggregate the number of youth receiving services from the mental health juvenile justice program across the year that will be compared with data from subsequent years.
Report of Progress toward goal attainment in prior State Fiscal Year: **__X__ Achieved _____ Not Achieved (if not achieved, explain why)**

This strategic objective has been substantively addressed. The program has been impacted by budget related issues and provider instability due to financial challenges. Although the numbers served in the program modestly decreased in FY2012, outcome measures (re-arrest rate and percent of successful linkages) showed some improvement. In FY2013, Northwestern University, the program's contractor and evaluator, spearheaded the complete overhaul of its data warehousing website which has resulted in a significant delay in reconciling data entered into the old website and revised website. It is anticipated that as the overhaul is completed, the data reported for FY2013 will change. As of November 15th, the data shows that a total of 616 youth were referred to the program during the fiscal year and 276 of them were found to be eligible. Outcome data is still not available.

Background

The Mental Health Juvenile Justice (MHJJ) program was designed to divert youth with serious emotional disturbances out of the juvenile justice system and into community-based care. Initially funded in 2000 as a pilot project in just seven counties, the project shortly expanded to 17 Illinois counties with detention centers and one county without a detention center. The MHJJ program currently covers 34 Illinois counties, involving 21 community agencies and including the efforts of an estimated 60 clinicians from provider agencies across the State. The program seeks to maintain the number of available providers. For example, MHJJ lost a significant provider in Region 1 and was able to place another active and well regarded provider, Metropolitan Family Services, in this role in the Region.

The MHJJ program aims to strengthen the linkages among the courts, probation, detention, schools, mental health, and other community-based services and recognizes that family engagement at all levels is vital to achieving best outcomes. 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 and a functional assessment is conducted to identify areas of functional impairment as well as 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. Access to flexible spending funds is available to supplement the youth's ancillary treatment services or family stabilization if no other source of funding is available. A number of MHJJ agencies have been able to offer parent to parent support through their Family Resource Developers.

In FY2012 and FY2013, the overall mission of MHJJ has remained unchanged and liaisons continue their efforts to intercept youth at the earliest stages of their justice involvement to further increase access to services. Youth served by MHJJ in FY2012 were: primarily male (65%); 46.1% were White; 37.8% were Black; and, 8.9% Hispanic. In light of the overrepresentation of minority youth in the juvenile justice system, increasing the percentages of minority youth referred and minority youth enrolled has been a Project priority. MHJJ continues to emphasize targeted outreach to, and education of, referral sources of minority youth with serious mental illnesses.

Research has shown that an estimated 75% of children in the juvenile justice system have experienced traumatic victimization. In FY2013, the MHJJ project has worked on shifting its focus on the impact of trauma on the youth it serves. The current assessment tool used for the project (the CANS) was modified to specifically assess trauma experiences and the extent to which those experiences have impacted the youth's current mental health and overall functioning. The MHJJ program is gradually and substantively moving into the delivery of Trauma Informed Care as a priority for the youth it serves.

In FY2013, Northwestern University spearheaded the complete overhaul of its data warehousing website. The aims of the overhaul are to make the website more user-friendly by streamlining data report processes and revise data entry procedures in order to enhance privacy protections and adherence to confidentiality guidelines set by Northwestern University's IRB. In doing so, there has been a significant delay in reconciling data entered into the old website and the revised website. This has resulted in some compromised accuracy of the data available and currently provided as well as a delay in obtaining and reporting significant data on enrollment and outcomes.

In sum, MHJJ continues to successfully identify youth in the juvenile justice system with mental illness, treat the youth in the community, improve the youth's overall functioning and support the youth from re-arrest. The annual evaluation and outcome analysis has consistently demonstrated that completion of the MHJJ project is associated with overall

clinical improvement, decreased functional impairment, and reduced rates of recidivism for youth.

MHJJ Data for the past three fiscal years:

FY '11	Referred	Screened	Eligible	Enrolled
	1185	551	494	426

FY '12	Referred	Screened	Eligible	Enrolled
	1044	461	410	364

FY '13	Referred	Screened	Eligible	Enrolled
	616	**194**	**276**	N/A

	FY '11	**FY '12**	**FY'13**
Linked to services	80.51%	87.62%	N/A
Re-arrest rate	21.36%	20.52%	N/A

Mental Health and Schools

Table 2.18 SERVICE INTEGRATION/Mental Health & Schools
Report Year: FY2013
State Identifier: IL
Priority Area: Child and Adolescent- Enhancement of collaborative efforts with state and local partners to address the mental health needs of youth.
Goal: *Integrate services for children/adolescents across service systems and the developmental stages from early childhood through young adulthood. (Criterion 3-Schools)*
Strategy #2: Provide technical assistance and implementation support to educators, parents, organization and other state agencies on the coordination of the Illinois Interconnected Systems Model of School Based Mental Health.
Performance Indicator: Number of Technical Assistance events in each fiscal year
Description of Collecting and Measuring Changes in Performance Indicator: Aggregate data on the number of technical assistance events held across each of the fiscal years for comparison with subsequent years.
Report of Progress toward goal attainment in prior State Fiscal Year: **__X__ Achieved _____ Not Achieved (if not achieved, explain why)**

This strategic objective was successfully achieved in FY2013. Thirteen (13) technical assistance events were provided statewide including one two-day conference and 12 monthly technical assistance teleconferences. During the 2012/2013 School Year, total of 5,185 students and 389 adults were served in 15 schools through the Initiative and

participated in at least ten mental health awareness activities. The initiative is gradually gaining both strength and sustainability.

Additionally,

- **As part of this year's planning and infrastructure development, community providers along with their school partners attended two days of training in April on the development of an individual Memorandum of Understanding for School-Community Guidelines and linkage agreements. Three agencies were subsequently able to develop and execute partnership agreements focused on implementing the Illinois Interconnected Systems Model of School Based Mental Health.**
- **In anticipation of the grant funding lasting only three years, three agencies have formulated preliminary sustainability plans.**
- **Grant sites have been collaborating with Positive Behavioral Intervention Supports (PBIS) in the schools which resulted in improved overall attendance and academic performance.**

The DHS Division of Mental Health in partnership with the Illinois State Board of Education (ISBE) 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. Six DMH Mental Health and School Collaboration grant sites were funded initially, one in each of the five DMH Regions, and an additional site in Region 3, in rural Central Illinois. State level partnering by ISBE and DMH and the concurrent funding of Early Intervention Grants to school districts by ISBE and the Mental Health and School Collaboration grants by DMH, has resulted in significant and rewarding opportunities for cross training with school staff, staff members of community mental health agencies, and supportive stakeholders.

During the 2012/2013 School Year, total of 5,185 students and 389 adults were served in 15 schools through the Initiative and participated in at least ten mental health awareness activities. Students, teachers, parents and community members who were served were also able to participate in the following prevention, promotion and early intervention activities that would not have been available without the collaborative partnership agreements:

- 1,995 students and 140 adults participated in classroom level skill building activities, including Social Emotional Learning Evidence Based Programs.
- 625 students and 101 adults participated in small group/skill building interventions
- 85 students and 77 adults received family support, including linking family members to needed mental health services.
- 242 adults received consultation and education to support 1420 students in the general education classroom setting.

In FY2014 DMH continues to advance the development of a statewide infrastructure to meet the mental health needs of Illinois students. Contingent on available funding, DMH is working to increase the number Community Mental Health Providers and Schools participating in the Mental Health and Schools Collaboration Project. Six new sites were funded to implement School Community Partnerships with 15 schools for the 2013/2014 school year. Technical assistance and implementation support to educators, parents, organization and other state agencies on the coordination of the Illinois Interconnected Systems Model of School Based Mental Health will continue to be provided.

Evidence-Informed and Evidence-Based Practices

Table 2.19 EVIDENCE INFORMED PRACTICES
Report Year: FY2013
Priority Area: Child and Adolescent- Child and Adolescent- Promotion of Evidence-Informed Practices
Goal: *Advance the implementation of evidence-informed practices in the child and adolescent service system through FY2013.*
Strategy: Implement video-based training methodologies and develop additional evidence-based content in an effort to increase and improve statewide EIP training**.**
Performance Indicator: The number of training events (including video-based) held to advance evidence-informed practices
Description of Collecting and Measuring Changes in Performance Indicator: Each training event will be documented and the data aggregated across the year for comparison with subsequent years.
Report of Progress toward goal attainment in prior State Fiscal Year: **___X_ Achieved _____ Not Achieved (if not achieved, explain why)**

This strategy was successfully and effectively accomplished in FY2013 and continues to be actively pursued in FY2014. Statewide, 8 training events were held in FY2013 either as in-person events or video webinars with ongoing follow-up phone consultations. These events were part of two separate Evidence Based/Informed Training initiatives:

1) ***Evidence Based Treatment Initiative – Cohort VI***
2) ***Evidence Based Treatment Initiative – Cohort VII***

A collaborative workgroup continues work on defining the core competencies needed by clinicians to sustain learning and the development of a strong Children's Mental Health System.

In FY2014 access to Practicewise and Project Educare was made available statewide to all clinicians in the children's mental health system using DAT-STAT, an Outcome Analysis System developed by DMH.

EIP strategies focus on: (1) Strengthening the capacity of community mental health agencies to utilize evidence informed practices in their children's mental health service system through the Evidence Informed Practice Initiative. (2) Assessing the

quality of mental health treatment services provided in community mental health agencies.

Strengthening agency capacity: Over the past seven years DMH has worked in collaboration with other state systems through the Evidence Informed Practice Initiative to build the capacity of community mental health agencies to utilize evidence informed practices in their children's mental health services system. A collaborative workgroup that includes families, community level practitioners and secondary education professionals from across the state continues to define the core competencies needed by clinicians in order to sustain individual learning and to further develop and strengthen the Children's Mental Health System in Illinois. Evidence Informed Practices have been identified and implemented that are culturally and linguistically appropriate to the needs of Illinois children and families, reflective of available research, and measureable to ensure that the selected practices lead to improved functioning at home, in school, in the community and throughout life. Additionally, eight (8) community mental health agencies have worked over the past six months to integrate the common elements of Cognitive Behavioral Therapy and Parent Behavioral Therapy into practice utilizing the *PracticeWise* online resources to facilitate the work.

Assessing the quality of services provided in community mental health agencies: Through an Outcomes Analysis System developed by DMH, DMH continues to utilize the online data based system to monitor treatment progress and individual child and adolescent outcomes. During FY 2013, 151 community mental health agencies consisting of 2,557 clinicians utilized the system to monitor the clinical outcomes of 35,868 children and adolescents. The clinical outcome scales available on this system include the Ohio, Columbia Impairment Scales Youth and Parent versions, and the Devereux Early Childhood Assessments (DECA). During FY 2013 there were a few changes to the system that will provide demographic information and inform the workgroup working to define a core set of competencies. The web-based database system (DAT-STAT) allows not only the tracking of treatment responses by individual client and allows provider agencies to track clinical outcomes per clinical provider, per clinical service, but now we will be able to track clinical outcomes per region, gender, ethnicity, and EBP (Evidenced-based Provider Certified).

As can be seen in the tables below, the data from DAT-STAT shows that there continues to be a significant improvement in clients who received treatment from clinicians using Evidence Based methods taught in cohorts VI and VII.

Evidence Based Training Initiative Cohort 6 and Statewide
FY2012 Score Averages for:
Ohio Problem/Functioning Scales
Columbia Impairment Scale – Parent &Youth

Scale	EBTI Cohort 6	Statewide
% Ohio Problem Improvement	19.86%	15.2%
% Ohio Function Improvement	10.7%	5.15%
% CIS- Parent Improvement	23.91%	12.1%
% CIS – Youth Improvement	36.74%	12.84%

Evidence Based Training Initiative Cohort 7 and Statewide
FY2013 Score Averages for:
Ohio Problem/Functioning Scales
Columbia Impairment Scale – Parent &Youth

Scale	EBTI Cohort 7	Statewide
% Ohio Problem Improvement	45%	15.1%
% Ohio Function Improvement	29.36%	4.76%
% CIS Parent Improvement	21.69%	13.5%
% CIS Youth Improvement	31.66%	12.5%

A new Resource Section has been added to the DatStat System with two website links, Project Educare and PracticeWise:

Project Educare is a web-based learning system for both provider and families. This system includes links to other mental health websites, family support and education websites, family education programs/modules. It also includes links to the Journal of Clinical Child and Adolescent Psychology (JCCAP), education modules; free Continuing Education Units (CEU's) for licensed clinicians and evidence-informed practices (EIP) resources for providers. The DECA and Ohio Trainings are also available on this website.

PracticeWise offers innovative tools and services to help clinicians and organizations improve the quality of health care for children and adolescents. The Datstat PracticeWise link will provide access to the following three elements of Practice Wise:

1. Practitioner Guides: PracticeWise has developed a set of treatment materials that summarize the most common elements of evidence-based treatments for youth. Each practice and process is summarized in a convenient handout format to guide therapists in performing the main steps.
2. MATCH-ADTC: is a bold redesign of evidence-based treatment of childhood anxiety, depression, trauma, and conduct problems. Extensively tested in community mental health settings as part of the Child STEPs clinical trials, this innovative system is the ultimate practitioner's toolbox: a wealth of well-organized resources that can be deftly adapted for a diverse array of children and problems. The program combines 33 procedures—drawn from the most

successful evidence-based treatments—into a single, flexible system. Comprehensive flowcharts guide the process of care, streamlining treatment to fit the child's needs while fostering individualization to address co-morbidity or therapeutic roadblocks. The system provides clear step-by-step instructions, activities, example scripts, time-saving tips, monitoring forms, and easy-to-read explanatory handouts and worksheets for children and their caregivers.

3. The PracticeWise database includes hundreds of randomized clinical trials of treatments for children's mental health problems, making it the most comprehensive dynamic decision-support tool available for reviewing the evidence base in children's mental health. Using this online searchable database, professionals can access summaries of the best and most current scientific research, and results can be customized to match an individual child's characteristics. The database currently covers research in the areas of childhood anxiety, attention problems, autistic spectrum, depression, disruptive behavior, eating, elimination, mania, substance use, suicide, and traumatic stress disorders.

A Public Health Model in Early Intervention:
The Reaching Out To Help Initiative

Table 2.20 REACHING OUT TO HELP:A Public Health Model Initiative
Report Year: FY2013
State Identifier: IL
Priority Area: Child and Adolescent -Encourage and facilitate the use of the Public Health Model
Goal: *Establish and nurture local systems of care, embedded in a public health model, consistent with the values and principles of CASSP and Family Driven Care to implement a prevention and early intervention initiative known as "Reaching Out to Help"*
Strategy: In FY2012 and FY2013, fully establish and implement the Reaching Out to Help initiative which is a 3-tiered public health model. 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. Develop a baseline for measurement of outcomes and the implementation of local systems of care for the Reaching Out to Help Initiative.
Performance Indicator: The number of children and adolescents participating in Tier 1, Tier 2, and Tier 3 in FY 2012 and FY2013**.**
Description of Collecting and Measuring Changes in Performance Indicator: Aggregate the number of children/adolescents participating in Tiers 1,2, and 3 of the "Reaching Out to Help" Initiative across the year for comparison with subsequent years of data.
Report of Progress toward goal attainment in prior State Fiscal Year: **__X__ Achieved _____ Not Achieved (if not achieved, explain why)**

This strategy was achieved. In FY2013 the DMH C&A Office continued work on establishing and implementing the Reaching Out to Help initiative, a 3-tiered public

health model now being implemented in seven agencies statewide. A baseline is being developed for measurement of outcomes and the implementation of local systems of care. The initiative served more than 5,700 children in the fiscal year.

Reaching Out To Help Initiative in FY2013
Number of Children Served at Each Tier

Tier	Number Served
Tier 1	5,100
Tier 2	620
Tier 3	52
Total	5,772

Literature supports the use of a public health model in the development of a comprehensive, integrated, continuum of interventions across systems. The Reaching Out To Help – Prevention and Early Intervention Services for Children and Youth ("Reaching Out To Help") initiative was designed to be a set of interconnected interventions that 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. Through DMH's competitive funding application process, seven mental health providers located throughout Illinois were funded to: a) establish and nurture local systems of care embedded in a public health model; 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. In FY2012 the Reaching Out to Help initiative served 4,219 individuals and provided 12,048 direct service hours.

Tele-Psychiatry: A Mental Health Service to Youth Residing in Rural Areas

Table 2.21 RURAL TELEPSYCHIATRY
Report Year: FY2013
State Identifier: IL
Priority Area: Child and Adolescent- Advancement and expansion of the use of video-conferencing and Tele-psychiatry
Goal: *Advance and expand the use of video-conferencing and Tele-psychiatry in clinical work and partner with universities and other stakeholders to plan initiatives to better align service delivery for children and adolescents in rural areas.*
Strategy: (use as many lines as needed for each strategy) Through FY2013, continue to implement Tele-psychiatry services in seven rural sites in Illinois and, contingent upon funding opportunities, plan for further expansion of the program.
Performance Indicator: Number of youth living in rural areas receiving services through Tele-psychiatry.

Description of Collecting and Measuring Changes in Performance Indicator: Aggregate data on the number of youth receiving Tele-psychiatry services in rural areas across each year for comparison with subsequent years of data.
Report of Progress toward goal attainment in prior State Fiscal Year: __X__ Achieved _____ Not Achieved (if not achieved, explain why)

This strategy was achieved! In spite of budget cutbacks in FY2011 and FY2012, DMH has continued to successfully implement Tele-psychiatry services at rural sites in Illinois. A total of 247 unduplicated clients were served during the fiscal year (an increase of 12.25% over FY2012) and 1,673 sessions were scheduled including 104 initial sessions and 1,569 return appointments. The most common diagnoses of children who received these services in FY2013 were: Bipolar Disorders (43%), Attention Deficit Hyperactivity Disorder (ADHD) (16%), Mood Disorders (16%), and Posttraumatic Stress Disorder (12%). Tele--psychiatry sessions for the past four years are depicted in the table below:

Year	Number of Psychiatric Encounters
FY2010	**1,527**
FY2011	**1,538**
FY2012	**1,659**
FY2013	**1,673**

Background:

For the first three years of the program, starting in FY2008, DMH had budgeted $300,000 for a pilot project which allowed six agencies to each purchase $50,000 of qualified psychiatric consultation time to be provided through a Tele-Psychiatry approach. By the end of FY2009, 168 children/adolescents and their families had benefited from Tele-psychiatry services and 939 psychiatry hours had been provided. Budgetary issues in fiscal years 2011 and 2012 forced a reduction in funding to $200,000. Prioritization of serving Medicaid eligible clients and the establishment of a process for billing telemedicine has allowed the program to continue despite the cut in funds. Currently, services are continuing at five sites which are utilizing the full amount of available psychiatric time. As a result of this project and other efforts, more rural mental health agencies are considering Tele-psychiatry as an option to address the shortage of qualified C&A psychiatric services.

Tele-psychiatry services include assessment, treatment and ongoing monitoring of youth. When using this service families typically travel to their local mental health agency for the appointment. The examining room contains a video camera, flat screen monitor, comfortable seating, and toys and such in case there are small children in the room. Mental health agency staff remains in the room to provide background information to the psychiatrist, reassure the family, and complete the requirements of making the session eligible for Medicaid reimbursement. As would be expected, it is the children who quickly adjust to the use of technology. Parents take a little longer. The psychiatrist at the remote location interviews both the child and family and is able to observe the child's behavior. Should medication be required, the doctor completes the prescription using a

software program and the family is able to immediately fill the prescription at their local pharmacy. Follow up appointments are made at the end of the session. They can be scheduled for two weeks or sooner if necessary.

Homeless Youth

Table 2.22 HOMELESS YOUTH
Report Year: FY2013
State Identifier: IL
Priority Area: Child and Adolescent- Address the mental health needs of children and adolescents who are homeless and those who reside in rural areas.
Goal: *Maintain and increase provision of mental health services to families and children who are homeless and to those who reside in rural areas.* (Criterion 4)
Strategy: (use as many lines as needed for each strategy) Track the number of youth with serious emotional disturbances who are homeless and receiving mental health services.
Performance Indicator: Number of individuals under age 18 who are homeless and who are receiving services. (National Outcome Measure)
Description of Collecting and Measuring Changes in Performance Indicator: 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.
Report of Progress toward goal attainment in prior State Fiscal Year: **__X__ Achieved _____ Not Achieved (if not achieved, explain why)**

This ongoing strategy was again accomplished in FY2013. The data reports that 183 youth were identified as homeless or residing in shelters when they first received mental health services. DMH is continuing to track the number of homeless youth served in FY2014.

A System Performance Indicator was created in FY1999 to track the number of homeless youth entering community-based services in the public mental health service system. This performance indicator is now a national outcome measure and is titled: **Increased Stability in Housing**-*Percent of Child/Adolescent Clients who are Homeless or Living in Shelters.* The measure permits an initial evaluation of the system's ability to provide access to mental health services for runaway youth and children in families who are homeless and who have serious emotional disturbances.

The number of homeless youth entering community-based mental health services has steadily declined in Illinois. From FY2007 through FY2013, the number of homeless youth served decreased by nearly 38% as shown in the table below.

Homeless Youth Served FY2007-FY2012
Number and Percent of Children Served

Fiscal Year	2007	2008	2009	2010	2011	2012	2013
Number of Homeless Youth	295	293	240	197	188	200	183
Percent of All Youth Served	0.78	0.73	0.65	0.54	0.56	0.56	0.46