# FY 2015
# COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT IMPLEMENTATION REPORT*

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

***NARRATIVE REPORT OF PROGRESS AND ACHIEVEMENTS IN FY2015 TOWARD THE IMPLEMENTATION OF THE SFY2014-SFY2015 COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT APPLICATION AND PLAN WHICH WAS SUBMITTED ON APRIL l, 2013**

## Introduction

This implementation report covers the second year of a two-year Mental Health Block Grant plan for FY2014-FY2015 which was submitted to SAMHSA on April 1, 2013. In general, this report describes our achievement and continuing progress in working on 18 strategies related to the DMH priorities and goals which were supported by performance measures as submitted in the plan and also documents the challenges we encountered during FY2015.

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 evaluating achievement and outcome, a description of how the data for the performance measure is collected and how 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 FY2015, and other pertinent data are provided.

# FY2015 IMPLEMENTATION REPORT

**Table 1.1 Available Mental Health Services**

| 1. Priority Area:<br>**Facilitation of an effective array of clinical and support services for adults and children.** | 2. Priority Type:<br>MENTAL HEALTH SERVICES |
|---|---|
| 3. Population(s) SMI, SED: | |
| 4. Goal of the priority area:<br>***Facilitate the array of community-based services available to adults and youth in need of mental health services*** | |
| 5. Strategies to attain the goal: Actively enhance and support the provision of the following core services for all consumers:<br>o Crisis intervention,<br>o Mental health assessment<br>o Oral interpretation and sign language<br><br>For Adults with SMI and Youth with SED not Medicaid eligible (in addition to the above)<br>o Treatment plan development, review and modification:<br>o Case management<br>o Psychotropic medication administration, monitoring, and training;<br><br>For Adults with SMI and Youth with SED who are Medicaid eligible (in addition to all the above services)<br>o Mental health intensive outpatient,<br>o Short-term diagnostic and mental health services,<br>o Therapy/counseling, and<br>o Assertive community treatment,<br>o Community support (individual, group and residential),<br>o Psychosocial rehabilitation<br><br>Work with system partners to provide supportive services including:<br>o Educational services,<br>o Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA),<br>o Substance abuse services (through DASA),<br>o Services for co-occurring mental health and substance abuse disorders,<br>o Medical and dental (through DHFS for Medicaid eligible individuals), and<br>o Community Integrated Living Arrangements (CILA) for Adults, and,<br>o Wraparound services (for Children and Adolescents) | |
| **6. Annual Performance Indicators to measure goal success:**<br>**Indicator: Number of individuals who receive mental health services.** | |
| a) Baseline measurement (Initial data collected prior to and during SFY 2014): | |
| b) First-year target/outcome measurement (Progress to end of SFY 2014): | |
| c) Second-year target/outcome measurement (Final to end of SFY 2015): | |
| d) **Data source:** DMH funded providers by contract must submit demographic, clinical information and claims data for all individuals receiving services funded using DMH dollars. The DMH provides data specifications to assure consistency of reporting. | |
| e) **Description of data:**<br>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 | |

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| 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. |
| f) **Data issues/caveats that affect outcome measures**: None |
| **7. Report of Progress toward goal attainment**<br>**Second year target: ___X__ Achieved_____Not Achieved (If not achieved, explain why)** |

***DMH successfully met this goal in FY2014 and FY2015. It is noteworthy that for more than 82% of everyone served in FY2015, services were either fully or partly paid through Medicaid during the course of the year, while nearly one of every six 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 FY2014 and FY2015. Comparison of FY2014 and FY2015 shows a 7.5% change overall. While the actual number of all persons served decreased by 6.8%, the number funded by Medicaid increased by 3.2%, the number served by both Medicaid and other sources dropped by 25%, and the number of clients served solely by Non-Medicaid sources decreased by nearly 30%. Medicaid enrollment assures the availability of the broad array of services enumerated above. DMH continues to work closely with partner agencies in implementing supportive services.***

**Medicaid Status of Persons Served in FY2014 and FY2015**

| Medicaid Status | Number Served in FY2014 | Percent of Total Served | Number Served in FY2015 | Percent of Total Served | Change in Number(%) FY14-FY15 | Percentage Change (%) FY14-FY15 |
|---|---|---|---|---|---|---|
| **Medicaid (Only Medicaid)** | **92,545** | **68.4%** | **95,581** | **75.9%** | **3.28%** | **7.5%** |
| **Non-Medicaid Sources (only)** | **31,894** | **23.6%** | **22,386** | **17.8%** | **-29.81%** | **-5.8%** |
| **People Served by Both** | **10,758** | **8.0%** | **7,992** | **6.3%** | **-25.71%** | **-1.7%** |
| **Medicaid Status Not Available** | **0** | | **12** | **0** | | |
| **Total Served** | **135,197** | **100.00** | **125,971** | **100.00** | **-6.8%** | |

### *The Array of Core Mental Health Services*

The array of core mental health services listed in Table 1.1 (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.

## *FY2015 Service Packages for Persons Who Were Not Enrolled in Medicaid*

Individuals enrolled in Medicaid continued to receive the listed array of services reimbursable through Medicaid, while those who were not Medicaid eligible received limited service packages paid for with the minimal funding DMH had available. **However, these service packages have not been included in the FY2016 budget.** Service provision and coverage were based on clinical criteria and financial eligibility. Persons at or below 200% of the federal poverty level (FPL) were fully funded; those over 400% were not funded, and those between 200% and 400% received partial funding based on their FPL, which is determined by household size and income. A description of the Service Benefit Packages for individuals who were not Medicaid eligible in FY2015 is provided on the DHS Website at: http://www.dhs.state.il.us/page.aspx?item=51784 .

## *Support Services for Adults*

**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. 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. 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. 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. Most individuals enrolled in Medicaid Managed Care programs under the Department of Health and Family Services (DHFS) are able to access these 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).

## *Special Services for Children & Adolescents*

The array of core services provided to children and adolescents 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. The overwhelming majority of children served by DMH-funded providers are enrolled in Medicaid. Youth with serious emotional disturbances and their families may also 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 almost 25 years. 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 has 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 **Recently enacted legislation (September 2015) transferred this program to the Illinois Department of Healthcare and Family Services (DHFS).** The 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. When funding has been awarded for a community grant, parents and providers worked together to provide highly individualized services in the community. These individualized services include intensive home-based support and treatment which allow the child to remain at home. For some children, residential treatment is the appropriate option. Families are encouraged to place their children close to home to optimize parental involvement in treatment.

Additionally, 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. 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. Essential **medical and dental services** are available to children and youth with SED regardless of income and are accessed through case management or referral. Children enrolled in Managed Care programs receive these services as part of their service package. Mental health providers actively assist families to process their medical bills through Medicaid and to obtain health insurance coverage for their children through the DHFS **All Kids** program. Mental health providers may facilitate access to subsidized health care clinics that provide medical and dental services at minimal cost. Funded by the Illinois Legislature since 2006, the State of Illinois provides access to comprehensive health care and affordable health insurance for children and adolescents. 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

**Table 1.2- 1 Individual Placement and Support- Evidence Based Supportive Employment**

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|---|---|
| 1. Priority Area #2:<br>**Promote Provision of Evidence Based and Evidence-Informed Practices** | 2. Priority Type:<br>MENTAL HEALTH SERVICES |
| 3. Population(s) SMI, SED | |
| 4. Goal of the priority area: ***Promote Evidence Based Practices for individuals for whom DMH purchases services within the context of service benefit packages established by DMH and advance the implementation of evidence-informed practices in the child and adolescent service system.*** | |
| 5. Strategies to attain the goal: **(1) During FY2014 and FY2015, maintain the implementation of Evidence Based Supportive Employment.** (2) During FY2014 and FY2015, continue provision of Assertive Community Treatment that meets national fidelity model requirements. (3) Implement video-based training methodologies and develop additional evidence-based content in an effort to increase and improve statewide EIP training**.** (4) By the end of FY 2015, through the provision of rental subsidies, implement a statewide permanent supportive housing initiative which focuses on the acquisition of decent, safe, and affordable housing and support services in a manner consistent with the national standards for this evidence based practice. This evidence based strategy will be reported under Priority # 9 –Advancement of Community Integration. | |

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| 6. **Annual Performance Indicators to measure goal success:**<br>**<u>Indicator #1</u>: Number of consumers receiving supported employment in FY2014 and FY2015. (National Outcome Measure)** |
| a) Baseline measurement (Initial data collected prior to and during SFY 2014): **1,489 consumers received IPS services in FY2012; 2,106 consumers received IPS services in FY2013**. |
| b) First-year target/outcome measurement (Progress to end of SFY 2014): **In FY2014, 2,379 consumers received IPS services.** |
| c) Second-year target/outcome measurement (Final to end of SFY 2015): **In SFY2015, 2,718 consumers received IPS: 2,524 at sites known to be at Fidelity and 194 at sites that had not yet met Fidelity standards. This reflects an increase of 82.5% since FY2012.** |
| d) **Data source:** Data for this indicator are generated through a special web-based database created specifically for the DMH SE initiative. Fidelity and outcomes data are submitted to the DMH SE coordinator. |
| e) **Description of data:** As always, DMH has developed specifications for reporting that DMH funded providers must use when submitting data. |
| f) **Data issues/caveats that affect outcome measures:** DMH only reports data for teams that have been found to exhibit fidelity to the evidenced based practice model |
| **7. Report of Progress toward goal attainment**<br>**Second year target: __X__ Achieved _____Not Achieved (If not achieved, explain why)** |

***This strategic objective has been successfully achieved. During this past fiscal year the number IPS sites increased by 46% and the number of persons served increased by 14%. In FY2015, a total of 44 IPS sites with fidelity to the model served 2,524 unduplicated consumers. An additional 12 sites that were working toward fidelity but had not yet met fidelity standards served 194 consumers. In all, 2,718 consumers received supported employment services. In FY2014, a total of 30 IPS sites with fidelity to the model served 2,137 unduplicated consumers. An additional 11 sites that had not yet met fidelity standards served 242 consumers. In all, 2,379 consumers received supported employment services inFY2014.***

**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 several years have included:

- DMH has received a Mental Health Transformation Grant (MHTG) from SAMHSA of $800,000 per year for five years to enhance state and community capacity to provide and expand evidence-based supported employment programs (EB-SE)/Individual Placement and Support (IPS). The Grant is focused on: (1) Development of the state infrastructure required to support implementation and

sustainability of IPS Supported Employment; (2) Implementation of IPS in two underserved communities completed in FY2015 with an expansion of availability to include all persons needing IPS services in those areas; and, (3) Enhancements to the current IPS model including the integration of physical and behavioral health with employment supports, peer support, and financial literacy. DMH is also working with the UIC Center on Mental Health Services and Research Policy to collect and analyze data and to establish an IPS training web-site.

- Technical assistance to increase fidelity to the IPS Supported Employment Model has increased from 1,695 hours provided to the IPS sites in FY2010 to approximately 4,098 hours provided to 1,400 staff and support personnel in IPS sites across the State in FY2015. More people were able to receive TA with fewer resources in FY2015 because more TA was provided by phone, and large group in-person trainings. IPS Technical Assistance Team activities have included:
    - Initial development of a web-based IPS training portal to further extend training resources.
    - Development of a CY2015 curriculum for Monthly State-wide Technical Assistance Calls with topics that focused on improving employment outcomes.
    - Work with the Recovery Services Development Group (RSDG) to improve integrated Recovery support, IPS/WRAP, and the quality of peer support at IPS Agencies, and,
    - Work with the NAMI Illinois IPS Family Project Team who presented to IPS providers on "Building Family Support for IPS.

Accomplishments <u>in FY2015</u> included:

- IPS technical assistance to ten new IPS teams funded through DRS start-up grants to help spread IPS in underserved IPS areas in Illinois. These new IPS teams are located in Centralia, Mattoon, Sullivan, Quincy, DeKalb, Rockford, Elk Grove Village, Matteson, and the West and South sides of Chicago. Most of these teams are now at fidelity.
- The use of Balancing Incentive Program funds to launch several IPS programs to serve transition-aged youth and young adults. DMH IPS Trainers have provided IPS technical assistance to all these new IPS teams.
- Establishment of the CRSS-E (Certified Recovery Support Specialist – Employment Endorsement). The Illinois Certification Board (ICB) now issues this competency-based credential to Certified Recovery Support Specialists (peer providers) who have demonstrated competency in supporting people in meeting their employment goals.
- Initiation of the development of a web-based training platform, which will provide education and training materials for consumers, providers, family members, state agencies and employers.
- Establishment of the Supported Employment Coordinating Committee, which includes membership from a number of state agencies, including Health Care and Family Services, Commerce and Economic Opportunity, Correction, Children and Family Services, Alcohol and Substance Abuse, and Rehabilitation Services. As

these agencies are becoming educated about IPS, the potential for partnerships designed to serve shared populations are being explored.

- Expansion of the IPS model to transition-aged youth with SMI, transition-aged youth with SMI/DD, and adults with DD. DRS funded 17 agencies for 15 months starting FY2015 to serve these populations of consumers. DMH trainers provide IPS technical assistance to those new IPS Providers who serve the SMI population and have contracts with DMH. Dartmouth Psychiatric Research Center has a contract with DRS to evaluate the effectiveness of these programs. The report will be available in FY2016.
- Education and training on the role of employment in recovery continued 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.
- Illinois became a core state in the Department of Labor Office of Disability Employment Policy's Employment First State Leadership Mentoring Program during FY2015. As part of this program, DMH is currently reviewing all the ways that Medicaid can be used to support IPS.

EBSE is also confronting several challenges:

- State infrastructure issues that make it difficult to expand access to IPS, including its funding model, data systems, quality monitoring (fidelity reviews), training, and reaching at risk populations. The SAMHSA Transformation grant is being used to address these state infrastructure issues and to facilitate sustainability and scalability.
- The IPS braided funding model in which the DRS portion of the model is outcome driven is often insufficient to meet the cost of services. A major portion of the funding for IPS is contingent on producing good employment outcomes-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 could be paid to providers at 120 days and 150 days. This additional funding is still not enough to cover the cost of services that are provided to consumers which cannot be billed to Medicaid [e.g. vocational engagement, job development, job placement, some types of follow-along supports, etc.] Although IPS Providers have been using more DRS funding in FY2014 and FY2015, there has so far been no significant increase of non-Medicaid-enrolled consumers in IPS. Most IPS programs currently mainly serve persons who are Medicaid-enrolled.
- Inconsistency in the completion of comprehensive and in-depth initial vocational profiles of clients seeking work due to providers being unable to bill for that time under the Illinois Medicaid Rule and the lack of general revenue funds to support these services. A vocational profile includes information about work preferences, experiences, skills, current adjustments, strengths, and personal contacts and is designed to serve as the basis for job-finding and job development. A weak vocational profile leads to a weak job search.

- Frequent turnover of employment specialists and IPS Supervisors who have had the extensive training and experience required to implement IPS successfully as well as community support workers and case managers who are instrumental in integrating rehabilitation with mental health treatment thru regular team member contact have been challenges to program sustainability. The web-based IPS training portal noted above will assist with training new staff and an incentive program to reduce staff turnovers is being piloted.
- Current resources to provide IPS technical assistance are insufficient to meet the needs of the rapidly growing number of IPS teams in the State. It is becoming more challenging to provide IPS trainings, conduct IPS fidelity reviews, and provide one-to-one field mentoring of IPS.

**FY2015 IPS Activity Report**

| | **7/1 –9/30, 2014** | **10/1 –12/31, 2014** | **01/1–3/31, 2015** | **4/1-6/30, 2015** |
|---|---|---|---|---|
| Number of locations at fidelity | 30 | 31 | 32 | 44 |
| Number of consumers receiving supported employment | 1,589 | 1,652 | 1,718 | 1,725 |
| Number employed in competitive jobs | 609 | 625 | 637 | 708 |
| Number of working people transitioned off the IPS Caseload successfully employed | 99 | 81 | 71 | 90 |

**Table 1.2- 2 Assertive Community Treatment**

| 1. Priority Area #2:<br>**Promote Provision of Evidence Based and Evidence-Informed Practices** | 2. Priority Type:<br>MENTAL HEALTH SERVICES |
|---|---|
| **3. Population(s)** SMI, SED | |
| **4. Goal of the priority area:** ***Promote Evidence Based Practices for individuals for whom DMH purchases services within the context of service benefit packages established by DMH and advance the implementation of evidence-informed practices in the child and adolescent service system.*** | |
| **5. Strategies to attain the goal:** (1) During FY2014 and FY2015, maintain the implementation of Evidence Based Supportive Employment. (2) **During FY2014 and FY2015, continue provision of Assertive Community Treatment that meets national fidelity model requirements**. (3) Implement video-based training methodologies and develop additional evidence-based content in an effort to increase and improve statewide EIP training**.** (4) By the end of FY 2015, through the provision of rental subsidies, implement a statewide permanent supportive housing initiative which focuses on the acquisition of decent, safe, and affordable housing and support services in a manner consistent with the national standards for this evidence based practice. This evidence based strategy will be reported under Priority # 9 –Advancement of Community Integration. | |
| **6. Annual Performance Indicators to measure goal success:**<br>**<u>Indicator #2:</u>**<br>**Number of persons with SMI receiving Assertive Community Treatment in FY2015 and** | |

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|---|
| **FY2016 (National Outcome Measure).** |
| a) Baseline measurement (Initial data collected prior to and during SFY 2014): |
| b) First-year target/outcome measurement (Progress to end of SFY 2015): |
| c) Second-year target/outcome measurement (Final to end of SFY 2016): |
| **Data Source:** DMH funded providers by contract must submit demographic, clinical information and claims data for all individuals receiving services funded using DMH dollars. The DMH provides data specifications to assure consistency of reporting. |
| e) **Description of data:**. 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. |
| f) **Data issues/caveats that affect outcome measures:** DMH does not receive claims data for individuals whose ACT services are purchased through an MCO. DMH does require these individuals to be registered in the same MIS as individuals for whom DMH purchases the ACT services. |
| **7. Report of Progress toward goal attainment**<br>**Second year target: __X__ Achieved _____Not Achieved (If not achieved, explain why)** |

***DMH was successful in maintaining all 21 ACT teams that were created with fidelity to the model throughout FY2015, and has added another 10 teams, for a total of 31 teams, all of whom met fidelity during the most recent review. This evidence-based practice was provided to 1,020 individuals in FY2015.***

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. By the end of FY2013 there were 21 ACT Teams in the State that continued to provide services throughout FY2014. An additional 10 teams were initiated in FY2015, bringing the number of teams in the state to 31. All teams were reviewed for fidelity during FY2015 and were found to be at fidelity with the ACT model.

**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. In order to ensure fidelity, DMH negotiates contracts with providers that are consistent with the model, provides opportunities for training, and conducts fidelity reviews. DMH has conducted day long retreats for ACT teams, monthly learning collaborative calls with ACT teams led by a nationally known consultant, and coordinated an expanded training program for contracted vendors that provide ACT services under the Williams-Colbert Consent Decrees.

**Table 1.2- 3 Evidence Informed Practices**

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|---|---|
| 1. Priority Area #2:<br>**Promote Provision of Evidence Based and Evidence-Informed Practices** | 2. Priority Type:<br>MENTAL HEALTH SERVICES |
| 3. Population(s) SMI, SED | |
| 4. Goal of the priority area: ***Promote Evidence Based Practices for individuals for whom DMH purchases services within the context of service benefit packages established by DMH and advance the implementation of evidence-informed practices in the child and adolescent service system.*** | |
| 5. Strategies to attain the goal: (1) During FY2014 and FY2015, maintain the implementation of Evidence Based Supportive Employment. (2) During FY2014 and FY2015, continue provision of Assertive Community Treatment that meets national fidelity model requirements. **(3) Implement video-based training methodologies and develop additional evidence-based content in an effort to increase and improve statewide EIP training.** | |
| **6. Annual Performance Indicators to measure goal success:**<br>**<u>Indicator #3:</u> The number of training events (including video-based) held to advance evidence-informed practices each fiscal year** | |
| a) Baseline measurement (Initial data collected prior to and during SFY 2014): | |
| b) First-year target/outcome measurement (Progress to end of SFY 2014): | |
| c) Second-year target/outcome measurement (Final to end of SFY 2015): | |
| d) **Data source:** Each training event will be documented and the data aggregated across the year for comparison with subsequent years. | |
| e) Description of data:. | |
| f) Data issues/caveats that affect outcome measures: | |
| **7. Report of Progress toward goal attainment**<br>**Second year target: __X_ Achieved _____Not Achieved (If not achieved, explain why)** | |

***This strategy was successfully accomplished in FY2015. Statewide, eight training events were held in FY2015 as in-person didactic sessions. Additionally, telephone consultations with Ph.D. level consultants occurred twice a month. The training focused on Cognitive Behavioral Therapy and Parent Management. These events were part of the Evidence Based/Informed Training initiative which is now in its eighth year. This group of participating agencies was identified as Cohort VIII in FY2015.***

Cohort VIII consisted of seven agencies: Ben Gordon Center (DeKalb, IL), Bobby Wright Comprehensive Behavioral Health Center, Inc. (Chicago, IL), Bridgeway (Galesburg, IL Ecker Center for Mental Health (Elgin, IL), Hoyleton Ministries (Hoyleton, IL), Iroquois Mental Health Center (Wateska, IL), and Transactions of

Western Illinois (Quincy, IL). These agencies trained twenty-seven clinicians in Evidence Informed Practices and treated five hundred forty two children and adolescents in clinical settings. The training consisted of eight in-person didactic sessions focused on Parent Management, Cognitive Behavioral Therapy, Trauma, Anxiety, and Depression, twice monthly telephone consultations by PhD level consultants, and the addition of Professional Learning Communities.

The Project Educare and PracticeWise "state of the art" web based learning systems were identified as valuable tools by cohort members. Project Educare's web site alone welcomed four hundred plus providers and families dealing with children and adolescents presenting with emotional/behavioral problems. The site continued to provide CEU's for professionals, Evidence –informed webinars and direct links to resources on diagnosis and treatment. The Columbia, Ohio and DECA trainings available on the web site proved to be a great resource for the cohort members in preparation for a session on Data Informed Practice.

The development of the Professional Learning Community within the cohort provides for continuing peer support within the agencies and their surrounding communities. Towards the end of the initiative the seven agencies all provided a detailed narrative of their plans to disseminate the information acquired from the training. The majority elected to provide internal training within the agency to ensure that new clinicians were trained in the use of PracticeWise. Participants also have access to the summaries of training sessions via manuals, or on electronic learning platforms which would be accessible to staff on an ongoing basis. Some agencies have decided to include follow up and monitoring to ensure sustainability. The concentrated effort made by this cohort continues to support the fidelity of the implementation of evidence based practices in child and adolescent mental health programs in Illinois.

**Background**

DMH established the Evidence Informed Practice Initiative (EIP) nearly ten years ago. The goal was to bring well researched, effective based interventions into children's mental health services in Illinois. The Department of Mental Health has continued to commit state funding to support programs and initiatives that train and disseminate information regarding evidence based practices.

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.** A statewide collaborative workgroup that includes families, community level practitioners and secondary education professionals 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. Community mental health agencies participating and

receiving training in the initiative continue to work on integrating the Common Elements utilized through the PracticeWise online resource, Cognitive Behavioral Therapy, and Parent Behavioral Therapy into ongoing practice.

In FY2015, the **Project Educare** website was accessed 426 times. The website 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 CEU's for licensed clinicians and evidence-informed practices (EIP) resources for providers. The DECA and Ohio Trainings are also available on this website.

In FY2015, the **Practice Wise** website was accessed 2,383 times. This website offers innovative tools and services to help clinicians and organizations improve the quality of health care for children and adolescents. The Datstat Practicewise link provides access to the following three elements of Practice Wise:

- Practitioner Guides: Practice Wise 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.

- 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.

- 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.

**(2) Assessing the quality of services provided in community mental health agencies:** Over the years research has consistently shown that youth treated by Evidence Informed Clinicians have more significant positive outcomes on the Ohio and Columbia Scales vs. those being treated by Non-Evidence Informed clinicians. (Please refer to scale below).
In FY2015, DMH continued to utilize the Outcomes Analysis online data based system to monitor treatment progress and individual child and adolescent outcomes. During FY 2015, 174 community mental health agencies consisting of 2,945 clinicians utilized the system to monitor the clinical outcomes of 43,166 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). The web-based database system (DAT-STAT) has not only allowed for the tracking of treatment responses by individual client as well as for provider agencies to track clinical outcomes per clinical provider, per clinical service, and to track clinical outcomes per region, gender, ethnicity, and EBP (Evidenced-based Provider Certified).

As can be seen in the scale below, the data from DAT-STAT shows that there continued to be a significant improvement in clients who received treatment from Evidence Informed Clinicians using Evidence Based methods taught during FY2015.

**Evidence Based Training Initiative Cohort 8 and Statewide**

**FY2015 Score Averages for:**
**Ohio Problem/Functioning Scales**
**Columbia Impairment Scale – Parent &Youth**

| | **Cohort 8** | **Statewide** |
|---|---|---|
| **Columbia-Parent** | **11.66% Improvement** | **9.35% Improvement** |
| Intake | 21.71 | 21.82 |
| 90 Day | 19.18 | 19.78 |
| **Columbia-Youth** | **11.50% Improvement** | **11.02% Improvement** |
| Intake | 16.97 | 18.16 |
| 90 Day | 15.02 | 16.16 |
| **Ohio-Problem Scale** | **21.31% Improvement** | **14.37% Improvement** |
| Intake | 26.33 | 26.46 |
| 90 Day | 20.72 | 22.66 |

**Table 1.3 Five Year Strategic Plan**

| 1. Priority Area:<br>**Implementation of the State Five Year Strategic Plan for Mental Health Services** | 2. Priority Type:<br>MENTAL HEALTH SERVICES |
|---|---|
| 3. Population(s) SMI, SED, OTHER: | |
| 4. Goal of the priority area: ***The development of an integrated, effective, and high quality statewide system of mental health services.*** | |
| 5. Strategies to attain the goal:<br>Work jointly with system partners to meet the goals and carry out the activities of the Five Year Strategic Plan for the delivery of mental health services in Illinois. | |
| **6. Annual Performance Indicators to measure goal success:**<br>**There are no indicators for this strategy. Progress in establishing and implementing the statewide plan will be reported yearly.** | |
| a) Baseline measurement (Initial data collected prior to and during SFY 2014): N/A | |
| b) First-year target/outcome measurement (Progress to end of SFY 2014): N/A | |
| c) Second-year target/outcome measurement (Final to end of SFY 2015): N/A | |
| d) Data source: N/A | |
| e) Description of data: N/A | |
| f) Data issues/caveats that affect outcome measures: N/A | |
| **7. Report of Progress toward goal attainment**<br>**Second year target: _X__ Achieved _____Not Achieved (If not achieved, explain why)** | |

***This Priority and its strategy have been actively pursued during FY2014and FY2015. Work has continued with stakeholders and system partners. The work that has so far been accomplished is reflected by the achievements cited in this Implementation Report. The following are highlights of some of the progress and specific accomplishments in FY2015 as DMH continues working on meeting the goals and objectives of the Five Year Strategic Plan:***

**In FY2015 DMH continued to ensure that the service needs of individuals not eligible for Medicaid are considered (Goal 2)-**

- **Nearly 1 of every 6 consumers received services paid solely from Non-Medicaid sources, largely out of the DMH service benefit packages. (Table 1.1 above)**
- **Implementation of the new initiatives such as the re-direction of funding from closed state hospitals to community–based crisis services are targeting individuals who are non-Medicaid eligible and providing access to an array of services not ordinarily available.**

**Fidelity to evidence-based practices (EBPs) and evidence-informed service models has been established as a contractual requirement for all vendors/providers and is included in all contracts in Attachment B.**

**Fidelity to treatment models is to be assessed whenever/wherever service is provided on an ongoing basis -Fidelity reviews of Individual Placement & Support (Supported Employment) and Assertive Community Treatment (ACT) are**

**conducted on an on-going basis. Both these programs are experiencing significant growth. (Table 1.2 and Table 1.3 above)**

**The direct and active involvement of individuals with lived experience in agency decision making and service delivery in mental health provider agencies has continued to be ensured in FY2015:**
**(1) As of July 2015, 173 individuals with CRSS certification were active in the State, and all were in good standing with the Illinois Certification Board (ICB). This reflects a 66% increase in the number of CRSS certified individuals since October 2013 when 107 were reported active in the state. (Table 1.7-2 below)**
**(2) A requirement that individuals with the CRSS credential be employed has been recently included in contracts for new initiatives such as Region 1 South Community Crisis Services and Northwest Community Crisis Services.**

**DMH was awarded the System of Care Expansion Implementation Cooperative Agreement effective October 1st 2014 which is providing federal funding for four years totaling $3,915,844 to implement a comprehensive strategic plan to improve and expand the service delivery system for Illinois youth. In FY2015, a System of Care Project Director was appointed and a Systems of Care Technical Assistance Center for Illinois (STACI) was established. (Table 1.8 below)**

**To close the service gap between community behavioral health providers and the Veterans Health Administration (VHA) System of Care and organize all strategic behavioral health priorities across state agencies for service members, veterans and their families, DMH has participated in the formation and implementation of the Illinois Joining Forces Initiative and the legislative creation of the Illinois Joining Forces Foundation which was effective in early FY2015 (on 8/18/14).**

**DMH is chairing the Behavioral Health Workgroup, one of the nine working groups in the IJF initiative. The Behavioral Health Workgroup has:**

- **Facilitated a coordinated crisis service intervention system between the VA facilities and community providers through the use of emergency response teams across the State.**
- **Worked to enhance community provider capacity to serve SMVF through Military and Veteran 101 cultural competency training.**
- **The workgroup was responsible for education sessions that trained well over 1200 provider staff through one-day workshops across the State. The training has primarily been in Behavioral Health, but has included events about serving service members, veterans and families with behavioral health issues in the Justice system, events for general health providers, and events for providers from other related areas including education and social services.**

**In FY2015, Illinois Joining Forces evolved from an organizational model of state agency sponsorship (state convening power) to a stand-alone foundation. The Articles of Incorporation, Not for Profit status have been accomplished. The**

**Board of Directors was appointed and an Executive Director was hired. Bylaws, Board Committees, and fund development activities have been accomplished or are well underway.**

**Also in FY2015, participation in a SAMHSA Academy resulted in additional collaboration with the Division of Alcohol and Substance Abuse, the development of a Illinois Joining Forces Behavioral Health Working Group Subcommittee for Substance Use Disorders, and the development of a Military and Veteran Cultural Competency Workshop specifically targeted towards the state's community of substance use prevention providers. (Table 1.10 below)**

**To improve continuity of care among local and state level mental health, detention and correctional agencies, linkages to community services for individuals with serious mental illness released from Illinois jails are monitored and maintained. The Jail Data Link program is being expanded to cover additional counties. In FY2015, 84% of individuals eligible for the Jail Data Link program were indeed linked and 50% were still linked 30 days later. (Table 1.5-1 below)**

**Background**:
The Mental Health 2013-2018 Strategic Plan for mental health services in Illinois was completed and submitted to the Governor and the Legislature during FY2013. The plan was developed by the Mental Health Services Strategic Planning Task Force established by the Illinois State Legislature in August 2011 (Pub. Act 097-0438.) As directed by the legislature, the Task Force included a broad range of stakeholders, with the shared mission of producing a five-year comprehensive strategic plan. Task Force members included mental health consumers and family members, mental health providers/vendors, academia, representatives from trade associations and labor unions, state agencies, members of the judiciary, law enforcement, courts, the legislature, and representatives from the Governor's office. Over 180 individuals from all across the state representing a broad range of experience with mental health issues participated.

To complete the strategic plan, the Task Force established five standing committees. Four of these committees were charged with focusing on one of the following specific population groups: adults, children and adolescents, veterans, and individuals with forensic involvement. The fifth committee studied and developed a plan regarding administrative issues facing DMH. Each committee met multiple times to review data, study information provided by DMH and other stakeholders, and develop a series of goals and objectives based on seven strategic priorities identified by the Legislature:

- Provide sufficient home- and community-based services to give consumers real options in care settings.
- Ensure that hospitalizations and institutional care, when necessary, are available to meet demand now and in the future.
- Improve access to care.
- Ensure quality of care in all care settings via the use of appropriate clinical outcomes.

- Reduce regulatory redundancy.
- Maintain financial viability for providers in a cost-effective manner to the state.
- Ensure that care is effective, efficient, and appropriate regardless of the setting in which it is provided.

The finalized Mental Health 2013-2018 Strategic Plan consisted of 67 goals subsumed by short range and long-range objectives addressing the wider scope of mental health services in the State and building upon the current structure of statewide service delivery.

**Table 1.4-1 Use of Data-Access**

| 1. Priority Area:<br>**Advancement in the Use of Data** | 2. Priority Type:<br>MENTAL HEALTH SERVICES |
|---|---|
| 3. Population(s)-SMI, SED, | |
| **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. **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. | |
| 6. **Annual Performance Indicators to measure goal success:**<br>**Indicator #1:**<br>**Number of adults and number of children/adolescents receiving services from DMH-funded community-based providers.** | |
| a) Baseline measurement (Initial data collected prior to and during SFY 2014): | |
| b) First-year target/outcome measurement (Progress to end of SFY 2014): **135,197 individuals served including 36,507 under the age of 18 and 98,690 adults ages 18-75.** | |
| c) Second-year target/outcome measurement (Final to end of SFY 2015): **125,971 individuals served including 34,888 under the age of 18 and 91,083 adults 18-75.** | |
| d) Data source:<br>DMH funded providers by contract must submit demographic, clinical information and claims data for all individuals receiving services funded using DMH dollars. The DMH provides data specifications to assure consistency of reporting. | |
| e) Description of data:<br>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. | |
| f) Data issues/caveats that affect outcome measures: | |
| **7. Report of Progress toward goal attainment**<br>**Second year target: __X_ Achieved _____Not Achieved (If not achieved, explain why)** | |

***This strategy was again effectively accomplished in FY2015. 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. Managed Care has been implemented in Illinois in the past two years and a substantial number of***

***individuals are being served by MCOs outside of the SMHA system. It is anticipated that as the number served by MCOs grows, there will be a concomitant decrease in the numbers served in the SMHA public mental health system as was the case in SFY2015. Additionally, the community mental health services budget has remained limited since FY2011. Although DMH has 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.***

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

| (1) | (2) | (3) | (4) |
|---|---|---|---|
| **Fiscal Year** | **FY 2013 Actual** | **FY 2014 Actual** | **FY 2015 Actual** |
| **Performance Indicator** | **96,259** | **98,690** | **91,083** |
| **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 2013 Actual** | **FY 2014 Actual** | **FY 2015 Actual** |
| **Performance Indicator** | **39,499** | **36,507** | **34,888** |
| **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 Department of Healthcare and Family Services Medicaid Management Information Service (DHFS/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.

**Table 1.4-2 Use of Data-MHSIP Surveys**

| 1. Priority Area:<br>**Advancement in the Use of Data** | 2. Priority Type:<br>MENTAL HEALTH SERVICES |
|---|---|
| 3. Population(s)-SMI, SED, | |
| **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. **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.** | |
| **6. Annual Performance Indicators to measure goal success:**<br>**Indicator #2:**<br>**Percentage of: (a) adult consumers and (b) caregivers of youth reporting positively about outcomes** | |
| a) Baseline measurement (Initial data collected prior to and during SFY 2014): | |
| b) First-year target/outcome measurement (Progress to end of SFY 2014): **N/A** | |
| c) Second-year target/outcome measurement (Final to end of SFY 2015): **N/A** | |
| d) Data source:<br>DMH utilizes the MHSIP Adult Consumer Perception of Care Survey and the Youth Services Survey for Families to collect this data. | |
| e) Description of Data:<br>A random stratified sample of adults receiving treatment in June of each year is selected for the survey. A survey is disseminated to persons in the sample via mail by October 1st, with a goal of all data collected by early November. Similarly a random stratified sample of caregivers of children and adolescents receiving services in June is also selected to receive the survey. This method will be used for the surveys for FY2015. | |
| f) Data issues/caveats that affect outcome measures:<br>The indicator values will be compared with data collected in preceding and succeeding years. | |
| **7. Report of Progress toward goal attainment**<br>**Second year target: _____Achieved_X__ Not Achieved (If not achieved, explain why)**<br><br>**Although dollars have been allocated for this task, it has been difficult to hire staff to help implement the survey. However, an additional staff person designated for this activity has now been hired. The survey will be implemented shortly to gather data needed for the URS tables and for state planning efforts.** | |

**Table 1.5-1 Jail Data Link –Program Progress**

| Priority Area:<br>**Maintain effective systems to serve the forensic needs of justice–involved consumers.** | 2. Priority Type:<br>MENTAL HEALTH SERVICES |
|---|---|
| 3. Population(s) SMI, SED, OTHER: | |
| 4. Goal of the priority area:<br>***Maintain a system of care to address the mental health needs of consumers with criminal justice involvement.*** | |

| |
|---|
| **5. Strategies to attain the goal**:<br>(a) **Monitor and maintain linkages to community services for individuals with serious mental illness released from Illinois jails**. Contingent on funding availability, expand the Jail Data Link to cover additional counties in Illinois. (b) Maintain the Mental Health Juvenile Justice Initiative. |
| **6. Annual Performance Indicators to measure goal success:**<br>**Indicator #1:**<br>**Percentage of eligible individuals released from jail who are linked to community-based services.** |
| a) Baseline measurement (Initial data collected prior to and during SFY 2014): |
| b) First-year target/outcome measurement (Progress to end of SFY 2014): |
| c) Second-year target/outcome measurement (Final to end of SFY 2015): |
| d) Data source:<br>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. |
| e) Description of data:<br>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. |
| f) Data issues/caveats that affect outcome measures:<br>The number of individuals reported as "eligible" for linkage was significantly reduced in FY2013 by redefining the data "eligibility" criterion. Detainees that are "sanctioned" through Specialty Court and those considered for crisis only case openings are no longer included in the eligibility criterion. Comparison to previous years is no longer valid as this new baseline has been established. |
| **7. Report of Progress toward goal attainment**<br>**Second year target: X Achieved_____Not Achieved (If not achieved, explain why)** |

***This strategic objective has been accomplished in FY2015. Linkages to community services for individuals with serious mental illness released from Illinois jails were monitored and maintained. The FY2015 data reflects that 84% of those eligible were indeed linked. Of those linked, 50% were still linked at the 30 day interval. The number of persons linked in FY2015 increased slightly from FY2014 but the percentage of all those eligible for linkage who were actually linked decreased. The percentage of persons still linked at 30 days increased.***

**Jail Data Link in FY2013, FY2014, and FY2015**

| Fiscal Year | Eligible for Jail Linkage | Actual Linkage | 30 day longevity | 60 day longevity |
|---|---|---|---|---|
| **FY2013** | **875** | **832 (95.1%)** | **430 (51.2%)** | **N/A** |
| **FY2014** | **1,210** | **1,086 (89.8%)** | **495 (45.6%)** | **N/A** |
| **FY2015** | **1331** | **1113 (83.6%)** | **554 (49.7%)** | **N/A** |

**This data does not include Cook County, but does include Will, Mclean, Peoria, St Clair, Winnebago and Rock Island counties. In FY2014, Champaign and Macon Counties were included.**

The system continues to lack sufficient and dedicated case management involvement in linkage of individuals identified by JDL. This will become a greater issue in FY2016 with the loss of DMH funding for liaisons in Peoria, St. Clair, and Will counties. In Cook County, for example, there were 5,033 individuals reported as cross matched and eligible for linkage in FY2015. However, without participating agencies to follow-up, linkages could not be verified through data link and are therefore not included in the statistics cited above.

JDL case managers need to be funded to support current and expanded county jail participation. Lack or loss of Medicaid benefits is another key factor in successful linkage which is being addressed (see below).

**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 and this has become even more critical with the loss of funding in FY2016 for the current liaisons.

Despite its high volume of individuals eligible for linkage, Cook County Jail Linkage has very limited case management resources, mainly through one provider. A major linkage obstacle for many of the consumers identified by Jail Data Link has been the loss of Medicaid funding or the closure of their cases by the community agency providing services. Public Act 96-0872, (2012) 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 the expansion of Medicaid under ACA will allow agencies to 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.

**Table 1.5-2 Jail Data Link Expansion**

| | |
|---|---|
| Priority Area:<br>**Maintain effective systems to serve the forensic needs of justice–involved consumers.** | 2. Priority Type:<br>MENTAL HEALTH SERVICES |
| 3. Population(s) SMI, SED, OTHER: | |
| 4. Goal of the priority area:<br>***Maintain a system of care to address the mental health needs of consumers with criminal justice involvement.*** | |
| 5. Strategies to attain the goal:<br>Monitor and maintain linkages to community services for individuals with serious mental illness released from Illinois jails. **Contingent on funding availability, expand the Jail Data Link to cover additional counties in Illinois.** Maintain the Mental Health Juvenile Justice Initiative. | |
| **6. Annual Performance Indicators to measure goal success:**<br>**Indicator #2:**<br>**Expansion of the Jail Data Link Project to four new counties by the end of FY2015.** | |
| a) Baseline measurement (Initial data collected prior to and during SFY 2014): **7 COUNTIES** | |
| b) First-year target/outcome measurement (Progress to end of SFY 2014): **9 COUNTIES** | |
| c) Second-year target/outcome measurement (Final to end of SFY 2015): 11 COUNTIES | |
| d) Data source: A daily cross match of individuals receiving mental health services who are detained in an Illinois County jail. | |
| e) Description of data:<br>Number of Illinois counties participating in Jail Data Link.<br>(Data is collected to track the number of individuals who are linked with community based mental health service providers and aggregated across the year for comparison with data from succeeding years.) | |
| f) Data issues/caveats that affect outcome measures: | |
| **7. Report of Progress toward goal attainment**<br>**Second year target: ____ Achieved ___X___Not Achieved (If not achieved, explain why) SEE BELOW** | |

***The FY2014 target of 9 counties with active Jail Data Link programs was successfully achieved. At the end of FY2013, seven counties - Cook, Will, Mclean, Peoria, St Clair, Winnebago and Rock Island counties were continuing to link individuals to community services. In FY2014, Champaign and Macon Counties were included, bringing the number of counties to nine.***

***Sangamon and DuPage Counties were projected to join by FY2015. However, in spite of DMH offers of technical support and encouragement, the mental health agencies and jails in these counties were not able to design and carry out the effective collaborative effort required to implement JDL in the past fiscal year. Loss of state funding for JDL in FY2016 will make continuation of JDL projects in Will, Winnebago, and St. Clair more difficult. Further expansion of JDL will also be a challenge given funding issues.***

**Table 1.5-3 Mental Health Juvenile Justice Program**

| | |
|---|---|
| Priority Area:<br>**Maintain effective systems to serve the forensic needs of justice–involved consumers.** | 2. Priority Type:<br>MENTAL HEALTH SERVICES |
| 3. Population(s) SMI, SED, OTHER: | |
| 4. Goal of the priority area:<br>***Maintain a system of care to address the mental health needs of consumers with criminal justice involvement.*** | |
| 5. Strategies to attain the goal:<br>Monitor and maintain linkages to community services for individuals with serious mental illness released from Illinois jails. Contingent on funding availability, expand the Jail Data Link to cover additional counties in Illinois. ***Maintain the Mental Health Juvenile Justice Program*** | |
| **6. Annual Performance Indicators to measure goal success:**<br>**Indicator #3:**<br>**Number of youth served by the MHJJ Program statewide.** | |
| a) Baseline measurement (Initial data collected prior to and during SFY 2013): **541** | |
| b) First-year target/outcome measurement (Progress to end of SFY 2014): **327** | |
| c) Second-year target/outcome measurement (Final to end of SFY 2015): **368** | |
| d) Data source:<br>**MHJJ Program Data Base maintained by contracted evaluator Northwestern University** | |
| e) Description of data:<br>**Aggregate the number of youth receiving services from the Mental Health Juvenile Justice program across the year that will be compared to data from subsequent years.** | |
| f) Data issues/caveats that affect outcome measures: **None** | |
| **7. Report of Progress toward goal attainment**<br>**Second year target: __X___ Achieved ____Not Achieved (If not achieved, explain why)** | |

***This strategic objective was substantively addressed in FY2015. The program has been maintained! 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 continues to demonstrate that completion of the MHJJ project is associated with overall clinical improvement, decreased functional impairment, and reduced rates of recidivism for youth.***

***The Table below offers a comparative view of activity in the program since FY2013 with recent projections for FY2016. Compared to FY2014, the number of youth actually enrolled in the program and receiving treatment services designed to avert re-arrest, reduce the intensity of their emotional disturbance, and improve their functioning and quality of life increased by 35% in FY2015 and the re-arrest rate dropped by 7%.***

| | | | | |
|---|---|---|---|---|
| **FY 2013** | Referred | Screened | Eligible | Enrolled |
| | 541 | 262 | 261 | 251 |
| **FY 2014** | Referred | Screened | Eligible | Enrolled |
| | 327 | 272 | 252 | 230 |

| | | | | |
|---|---|---|---|---|
| **FY 2015** | Referred | Screened | Eligible | Enrolled |
| | 368 | 346 | 311 | 311 |
| **FY 2016 Full Year Projected** | Referred | Screened | Eligible | Enrolled |
| | 375 | 360 | 350 | 350 |

| | **FY'13** | **FY'14** | **FY'15** | **FY'16** | |
|---|---|---|---|---|---|
| Linked to services | **96.17%** | 91.27% | 97.11% | 95% | |
| Re-arrest rate[1] | N/A | 22% | 15% | N/A | |

**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 MHJJ program currently covers 29 Illinois counties, involving 20 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.

The MHJJ program is overseen through the DHS/DMH Forensic Services 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. Whenever any court personnel (Judge, attorney, probation officer, detention center staff) refers a minor who is in detention, a liaison (a masters level clinician from a community agency), with parental consent, will assess that child. These specially-trained MHJJ liaisons 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. Should that child have a major mental illness (with psychotic or affective disorders), the liaison will work with the family to identify appropriate community services (using a wraparound model that includes mental health, medication, substance abuse, special education and public health services). Based on this action plan, youth are linkedwith appropriate community-based services. MHJJ liaisons continue to monitor the progress of each youth for a period of six months. DHS provides funding for MHJJ to the

[1] To examine rates of re-arrest, we examined the number of cases that were closed because of youth re-arrest and also examined whether Monthly Service Reports indicated re-arrest while participating in the program. Among youth with closing reports in FY 2014 and FY 2015, there were no youth with re-arrest as the reason for case closure. According to data from the Monthly Service Reports a relatively small proportion of youth were re-arrested while participating in MHJJ. Approximately 22% of youth who entered the MHJJ program in FY 2014 were re-arrested during their stay in the program. Re-arrest in FY 2015 was lower at 15%. In sum, the majority of youth who participate in MHJJ appear to be successfully diverted from re-arrest, at least while in the program. These findings speak positively of the program and may be related to the positive outcomes showing that youth's mental health and overall functioning significantly improve while in MHJJ. These findings also provide support for the cost-effectiveness of the program, in that the State of Illinois is spending less money on arrests and legal processing of youth who complete the MHJJ program.

community agencies from state general revenue funds (GRF). Most agencies receive funding for one liaison. 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. MHJJ is a simple model that can be expanded to these and other juvenile justice populations and is applicable in multiple settings (urban, suburban and rural) as it makes use of existing community services at no cost to the courts.

In FY2016, the MHJJ Program expanded its eligibility criteria to include youth who are "at risk" of coming into contact with the criminal justice system. "At risk" youth have a mental illness or symptoms, and may have had ancillary contact with police (e.g., school resource officers, station adjustments. They are not receiving necessary services and/or any type of intervention that could divert them from becoming more involved in the criminal justice system. This expansion includes: (1) Wards of the Illinois Department of Children and Family Services (DCFS) who have become justice involved, otherwise meet MHJJ eligibility criteria, and need the kind of services and monitoring for the courts that MHJJ provides. (2) Youth with mental illnesses who may have had ancillary contact with police (e.g., school resource officers, station adjustments) and would benefit from MHJJ services. (3) In keeping with the growing concern over how trauma has impacted many youth (with and without mental illness) in the juvenile justice system, youth with significant trauma histories/symptoms who have come into contact with the justice system. Many of the agencies have programs that could cross refer into MHJJ to capture those youth. The program anticipates a slight increase, perhaps 15-20% in the number of youth referred.

The overall mission of MHJJ has largely remained unchanged. 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 program priority. MHJJ continues to emphasize targeted outreach to, and education of, referral sources of minority youth with serious mental illnesses. As research has shown that an estimated 75% of children in the juvenile justice system have experienced traumatic victimization, the MHJJ program has moved into the delivery of Trauma Informed Care as a priority for the youth it serves.

**Table 1.6 Uninsured and Underinsured Clients**

| 1. Priority Area:<br>**Planning and preparation to address the needs of uninsured and underinsured consumers within fiscal limitations.** | 2. Priority Type:<br>MENTAL HEALTH SERVICES |
|---|---|
| 3. Population(s) (SMI, SED, OTHER): | |
| 4. Goal of the priority area:<br>***Within budgetary constraints, utilize resources to purchase mental health services for uninsured and under-insured consumers.*** | |
| 5. Strategies to attain the goal: Use financial resources from the state general revenue fund, the Mental Health Block Grant, and other available federal grants as a basis to fund the purchase of mental health services for adult and child/adolescent consumers who may remain unable to access services through the venue of ACA Health Care Reform. | |
| **6. Annual Performance Indicators to measure goal success:**<br>**The total amount of dollars expended to fund the purchase of mental health services for uninsured and underinsured consumers.** | |
| a) Baseline measurement (Initial data collected prior to and during SFY 2014): The total amount of dollars expended to fund the purchase of mental health services for uninsured and underinsured consumers in FY2013. **$11,998,106** | |
| b) First-year target/outcome measurement (Progress to end of SFY 2014):<br>The total amount of dollars expended to fund the purchase of mental health services for uninsured and underinsured consumers in FY2014. **$10,526,625** | |
| c) Second-year target/outcome measurement (Final to end of SFY 2015):<br>The total amount of dollars expended to fund the purchase of mental health services for uninsured and underinsured consumers in FY2015. **$6,596,700** | |
| d) Data source:<br>DMH ASO Community Reporting System and structured program reports collected by DMH staff from community agencies. | |
| e) Description of data: Paid claim amounts for uninsured and underinsured consumers served by DMH | |
| f) Data issues/caveats that affect outcome measures: | |
| **7. Report of Progress toward goal attainment**<br>**Second year target: ___X__ Achieved _____Not Achieved (If not achieved, explain why)** | |

***This strategy is continuing to be accomplished. In FY2015, $6,596,700 was spent to provide mental health services to persons who were not enrolled in Medicaid. This 37% decrease from the amount spent in FY2014 ($10,526,625) reflects both an overall increase (3.25%) in the number of individuals actually funded by Medicaid in FY2015 as well as a decline in the number of actual persons served that were funded by non-Medicaid resources (-29.8%) and a decline in the number served by both (-25.7%). The increase in Medicaid enrollment may have been due, in part, to aggressive ACA enrollment and the expansion of Medicaid in Illinois. See Table1.1 for greater detail.***

***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. In***

***addition to General Revenue funds, a variety of limited federal grants such as the PATH Grant for Homeless, grants for crisis and residential services, and grants for services in Criminal and Juvenile Justice have enhanced the financial resources for serving persons who are otherwise uninsured.***

***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-Get Covered 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 continued absence of an enacted budget going into SFY2017 has prompted DMH to look for dollars other than General Revenue Funding to sustain this need. MHBG funds are being considered as a possible source for this purpose, provided that these funds can be re-directed without damaging consequences.***

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. DMH is making every effort to maintain essential mental health services for persons with the most serious mental illnesses through reallocation of existing funds. As additional support 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. Consumers who qualify to apply for expanded Medicaid eligibility and to participate advantageously in the insurance programs through Affordable Care are being supported in applying for coverage.

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.

**Table 1.7-1 Consumer Teleconferences**

| 1. Priority Area:<br>**Expansion of the scope of consumer and family participation through advancement of the recovery vision and family driven care.** | 2. Priority Type:<br>MENTAL HEALTH SERVICES |
|---|---|
| 3. Population(s) SMI, SED OTHER: | |
| 4. Goal of the priority area:<br>***Establish and enhance the public mental health system of care based upon principles of*** | |

| |
|---|
| ***Recovery and Resilience in which consumers and families are knowledgeable and empowered to participate and provide direction at all levels of the system.*** |
| 5. Strategies to attain the goal:<br>***Strategy #1: Conduct a series of statewide teleconferences designed to disseminate important information to adult consumers and parent/caregivers across the State.***<br>**Strategy #2:** Support the role of Certified Recovery Support Specialists (CRSS) 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.<br>**Strategy #3:** In FY2014 and FY2015, advance Family Driven Care in Illinois by certification of parent providers as Family Partner Professionals. |
| **6. Annual Performance Indicators to measure goal success:**<br>**Indicator #1:**<br>**Number of statewide teleconferences held each year.** |
| a) Baseline measurement (Initial data collected prior to and during SFY 2014): |
| b) First-year target/outcome measurement (Progress to end of SFY 2014): **21 Conference Calls-10 for adult consumers and 11 for parent/caregivers. Aggregate participation = 4,897** |
| c) Second-year target/outcome measurement (Final to end of SFY 2015): **21 Conference Calls-10 for adult consumers and 11 for parent/caregivers. Aggregate participation=5,236** |
| d) Data source:<br>Document each teleconference event and aggregate by year for comparison across years. |
| e) Description of data: |
| f) Data issues/caveats that affect outcome measures: |
| **7. Report of Progress toward goal attainment**<br>**Second year target: __X__ Achieved_____Not Achieved (If not achieved, explain why)** |

***This strategy was successfully achieved in FY2015 and is continuing in FY2016. Twenty one (21) statewide teleconference calls were conducted with an aggregate participation count of more than 5,200 consumers and parents. Ten teleconferences were conducted for an audience of adult consumers in FY2015 with an aggregate attendance of 4,889 (duplicated). Eleven teleconference calls were conducted for a participating audience of parents/caregivers in FY2015 with an estimated aggregate attendance of 347 parent/caregivers. The dates, topics, and number of participants of each teleconference are detailed in the tables below.***

## Adult Consumer Education Teleconferences in FY2015

| Date of Call | Topic | Number of Participants |
|---|---|---|
| July 24, 2014 | Stepping Up to the Plate | 440 |
| August 28, 2014 | Sculpting Our Relationships | 427 |
| September 25, 2014 | Exploring Our Future | 460 |
| October, 2014 | Forgiving Ourselves and Others | 464 |
| January 22, 2015 | The Power of Setting Goals | 464 |
| February 26, 2015 | The Power of a Recovery Path | 489 |
| March 26, 2015 | The Power of Justice | 462 |

| | | |
|---|---|---|
| April 23, 2015 | The Power of Relating to Others | 602 |
| May 28, 2015 | The Power of the Words We Use | 558 |
| June 25, 2015 | The Power of "Me Well" | 523 |

**Parent/Caregiver Teleconference Calls**

Eleven calls were conducted in FY2015 with an estimated aggregate attendance of 347 parent/caregivers. Parent Empowerment Calls are educational calls being offered to all parents in Illinois who have a child with an emotional and /or behavioral concern that focus on giving parents information they need to advocate for and support their children. Family Consumer Specialists host these monthly statewide teleconferences to provide parents with kind of information that allows them to more effectively evaluate and drive their children's care and provide the feedback that incents and improves the service system. The dates, topics, and number of participants of each teleconference are detailed in the table below.

**Parent Empowerment Calls in FY2015**

| Date of Call | Topic | Number of Participants |
|---|---|---|
| July 3, 2014 | IEP or 504 Plan? | 33 |
| August 7, 2014 | The Protective Factors | 32 |
| September 4, 2014 | Behavior Intervention Plans | 44 |
| October 2, 2014 | Advocating For A Lifetime | 23 |
| November 6, 2014 | What Parents Should Know about Juvenile Justice | 44 |
| December 4, 2014 | System Update | 19 |
| January 1, 2015 | No Call – New Year's Day | - |
| February 5, 2015 | I Care Very Much, But I'm Tired (Compassion Fatigue) | 44 |
| March 5, 2015 | Social and Emotional Learning Standards For Home, Too! | 25 |
| April 2, 2015 | Meeting the Needs of Your Student | 35 |
| May 7, 2015 | The Protective Factors | 25 |
| June 4, 2015 | Crisis Happens -- Be Prepared | 23 |

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. These calls provide 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.

**Table 1.7-2 Certified Recovery Support Specialists**

| 1. Priority Area:<br>**Expansion of the scope of consumer and family participation through advancement of the recovery vision and family driven care.** | 2. Priority Type:<br>MENTAL HEALTH SERVICES |
|---|---|
| 3. Population(s) SMI, SED OTHER: | |
| 4. Goal of the priority area:<br>***Establish and enhance the public mental health system of care based upon principles of Recovery and Resilience in which consumers and families are knowledgeable and empowered to participate and provide direction at all levels of the system.*** | |
| 5. Strategies to attain the goal:<br>**Strategy #1:** Conduct a series of statewide teleconferences designed to disseminate important information to adult consumers and parent/caregivers across the State.<br>***Strategy #2: 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.***<br>**Strategy #3:** In FY2014 and FY2015, advance Family Driven Care in Illinois by certification of parent providers as Family Partner Professionals. | |
| **6. Annual Performance Indicators to measure goal success:**<br>**Indicator #2:**<br>**Number of training events held each year to increase stakeholder understanding of the CRSS credential and to increase competency in CRSS domains.** | |
| a) Baseline measurement (Initial data collected prior to and during SFY 2014): | |
| b) First-year target/outcome measurement (Progress to end of SFY 2014): | |
| c) Second-year target/outcome measurement (Final to end of SFY 2015): | |
| d) Data source:<br>Document each training event and aggregate by year for comparison across years. | |
| e) Description of data: | |
| f) Data issues/caveats that affect outcome measures: | |
| **7. Report of Progress toward goal attainment**<br>**Second year target: __X___ Achieved _____Not Achieved (If not achieved, explain why)** | |

***This objective was substantively accomplished in FY2015. Six competency training events based on a two day curriculum were held at three locations in the State with a total of 688 participants. During FY2015, a second series was actively planned that was held in the first quarter of FY2016 attended by 724 individuals. In all, 1,412 individuals attended these twelve competency events. Additionally, three CRSS Ethics Workshops were held at the same locations with a registration of 355 individuals. (See Table Below for detailed information)***

***As of July 2015, 173 individuals with CRSS certification were active in the State, and all were in good standing with the Illinois Certification Board (ICB*). *This reflects a 66% increase in the number of CRSS certified individuals since October 2013 when 107 were reported active in the state. A year earlier, in July 2014, 152 individuals with CRSS certification were active in the State, and all were in good standing with the Illinois Certification Board (ICB*). *This reflects a 12% increase in the number of CRSS certified individuals in one year.***

## CRSS Training Events in FY2015-2016

| Date | Location | Number of Attendees | Competency Event |
|---|---|---|---|
| May 15, 2014 | Springfield | 100 | Day One |
| July 15, 2014 | Mt. Vernon | 60 | Day One |
| July 17, 2014 | Springfield | 78 | Day Two |
| August 20, 2014 | Chicago | 230 | Day One |
| September 10, 2014 | Chicago | 178 | Day Two |
| October 28, 2014 | Mt. Vernon | 42 | Day Two |
| **Total FY2015** | | **688** | |
| July 7, 2015 | Mt. Vernon | 32 | Day One |
| July 14, 2015 | Springfield | 92 | Day One |
| July 28, 2015 | Chicago | 280 | Day One |
| August 18, 2015 | Mt. Vernon | 25 | Day Two |
| August 25, 2015 | Springfield | 70 | Day Two |
| September 1, 2015 | Chicago | 225 | Day Two |
| **Total FY2016** | | **724** | |
| October 20, 2015 | Mt. Vernon | 34 | CRSS Ethics |
| October 26, 2015 | Springfield | 96 | CRSS Ethics |
| November 3, 2015 | Chicago | 225 | CRSS Ethics |
| **Total CRSS Ethics** | | **355** | |

**Background:**

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 their 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 DHS 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.

In FY2013 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. Workgroups were subsequently formed and have continued the effort to assist agencies to effectively utilize CRSS professionals, implement peer programs, and advance agency culture toward a recovery oriented system. These efforts proved to be fruitful. As of October 4, 2013 there were 107 individuals with CRSS certification active in the State, and all were in good standing with the Illinois Certification Board (ICB). As of July 2014, 152 individuals with CRSS certification were active, an increase of 45 new individuals in a period of nine months.

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.

**Table 1.7-3 Certified Family Partnership Professionals**

| | |
|---|---|
| 1. Priority Area:<br>**Expansion of the scope of consumer and family participation through advancement of the recovery vision and family driven care.** | 2. Priority Type:<br>MENTAL HEALTH SERVICES |
| 3. Population(s) SMI, SED OTHER: | |
| 4. Goal of the priority area:<br>***Establish and enhance the public mental health system of care based upon principles of Recovery and Resilience in which consumers and families are knowledgeable and empowered to participate and provide direction at all levels of the system.*** | |
| 5. Strategies to attain the goal:<br>**Strategy #1:** Conduct a series of statewide teleconferences designed to disseminate important information to adult consumers and parent/caregivers across the State.<br>**Strategy #2:** 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.<br>**Strategy #3: In FY2014 and FY2015, advance Family Driven Care in Illinois by certification of parent providers as Family Partner Professionals.** | |
| **6. Annual Performance Indicators to measure goal success:**<br>**Indicator #3:**<br>**The number of individuals who are credentialed as CFPPs by the end of each fiscal year.** | |
| a) Baseline measurement (Initial data collected prior to and during SFY 2014): | 15 |
| b) First-year target/outcome measurement (Progress to end of SFY 2014): | 20 |
| c) Second-year target/outcome measurement (Final to end of SFY 2015): | 18 |

| |
|---|
| d) Data source:<br>The number of parents certified as Family Partner Professionals will be aggregated across the year for comparison with data collected for subsequent years. |
| e) Description of data: |
| f) Data issues/caveats that affect outcome measures: |
| **7. Report of Progress toward goal attainment**<br>**Second year target: __X__ Achieved _____Not Achieved (If not achieved, explain why)** |

***This strategy was substantively addressed in FY2015. The Illinois Certification Board (ICB) reported 18 CFPPs in good standing in the State. The certification process continues but it is speculated that dwindling provider budgets have resulted in lay-offs and changes in role (ie: to Case Manager) that decrease the pool of Family Resource Developers (FRDs) from which applicants for this certification are mostly drawn.***

**Background**:

Family peer-to-peer support is the most fundamental element of the children's mental health family movement. Sharing information, support and advocacy with one another is vital for families overcoming the challenges of raising and supporting a child with emotional, mental or behavioral disorders. CFPPs perform a unique function in the specialty of healthcare and human services, and can work in a variety of settings, using various approaches to provide supportive services with a wide range of consumer populations. In recognition of the need to assure quality care for children and families, the Illinois Certification Board (ICB), the Department of Human Services (DHS)/Division of Mental Health (DMH), DHS/Division of Alcoholism and Substance Abuse (DASA), Department of Children and Family Services (DCFS), Children's Mental Health Partnership (ICMHP), State Board of Education (ISBE), NAMI, and Illinois Federation of Families (IFF), collaboratively developed the CFPP Model.

The Certified Family Partnership Professional (CFPP) credential certifies a minimum-level of competency for parents providing peer support to other families of a child with an emotional/behavioral disorder. CFPPs are trained to incorporate their unique life experiences gained through parenting a child with emotional and/or behavioral challenges that required them to personally access resources, services, and supports from multiple child-serving systems to achieve their family goals. Certification is granted to persons who meet specified professional standards and 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. DMH Family Consumer Specialists in each Region provide assistance in the application process to those who wish to pursue the credential.

DMH is working to expand the CFPP role. The goal for this credential has been recognition under the Illinois Medicaid Rule (Rule 132) and authorization to provide services at the Mental Health Practitioner (MHP) level. In FY2014, contract language was revised to mandate that agencies with SASS contracts have an action plan for

certification of any Family Resource Developers who are not currently billing at the Mental Health Professional (MHP) level according to Rule 132 definitions.

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

**Table 1.8 Statewide System of Care**

| 1. Priority Area:<br>**Lead in the development and implementation of a statewide, unified, state –of –the-art System of Care to promote optimal social and emotional development for all children, adolescents, and young adults with behavioral health needs.** | 2. Priority Type:<br>MENTAL HEALTH SERVICES |
|---|---|
| 3. Population(s) SED, Other: | |
| 4. Goal of the priority area:<br>***Create a State of the Art Behavioral Health System in Illinois that ensures the highest level of fidelity and service delivery based on Systems of Care Values and Principles, family driven, and emphasizes services that are evidence-based.*** | |
| 5. Strategies to attain the goal:<br>**(1) Apply for a SOC Expansion Cooperative Agreement Grant to obtain funding from SAMHSA.** (2) Formalize the state's capacity to identify, engage, and oversee SOC development and implementation opportunities around the state,<br>(3) Develop a System of Care Technical Assistance Center for Illinois (STACI). | |
| **6. Annual Performance Indicators to measure goal success:**<br>**Indicator #1: (FY2014) An Application for a System of Care (SOC) Expansion Implementation Cooperative Agreement Grant is submitted by IUY to SAMHSA.** | |
| a) Baseline measurement (Initial data collected prior to and during SFY 2014): N/A | |
| b) First-year target/outcome measurement (Progress to end of SFY 2014):<br>**Application was completed, submitted, and grant has been awarded.** | |
| c) Second-year target/outcome measurement (Final to end of SFY 2015): | |
| d) Data source: | |
| e) Description of data: N/A | |
| f) Data issues/caveats that affect outcome measures: | |
| **7. Report of Progress toward goal attainment**<br>**First year target: ___X_ Achieved _____Not Achieved (If not achieved, explain why)** | |

| 5. Strategies to attain the goal:<br>**(**1) Apply for a SOC Expansion Cooperative Agreement Grant to obtain funding from SAMHSA. **(2) Formalize the state's capacity to identify, engage, and oversee SOC development and implementation opportunities around the state.**<br>(3) Develop a System of Care Technical Assistance Center for Illinois (STACI). |
|---|
| **6. Indicator #2 (FY2015) A statewide SOC Project Director is hired to help coordinate and facilitate exchange of information and best practices among all statewide SOC activities** |

| |
|---|
| a) Baseline measurement (Initial data collected prior to and during SFY 2014): N/A |
| b) First-year target/outcome measurement (Progress to end of SFY 2014): N/A |
| c) Second-year target/outcome measurement (Final to end of SFY 2015): **See below** |
| d) Data source: N/A |
| e) Description of data: N/A |
| f) Data issues/caveats that affect outcome measures: N/A |
| **7. Report of Progress toward goal attainment**<br>**Second year target: ___X_ Achieved _____Not Achieved (If not achieved, explain why)** |

| |
|---|
| 5. Strategies to attain the goal:<br>**(**1) Apply for a SOC Expansion Cooperative Agreement Grant to obtain funding from SAMHSA. (2) Formalize the state's capacity to identify, engage, and oversee SOC development and implementation opportunities around the state.<br>**(3) Develop a System of Care Technical Assistance Center for Illinois (STACI).** |
| **6. Indicator #3 (FY2015) A Systems of Care Technical Assistance Center for Illinois (STACI), dedicated to ongoing development and implementation of Systems of Care values and coordination of statewide planning, preparation, and education surrounding Systems of Care, is established.** |
| a) Baseline measurement (Initial data collected prior to and during SFY 2014): N/A |
| b) First-year target/outcome measurement (Progress to end of SFY 2014): N/A |
| c) Second-year target/outcome measurement (Final to end of SFY 2015): **See below** |
| d) Data source: N/A |
| e) Description of data: N/A |
| f) Data issues/caveats that affect outcome measures: N/A |
| **7. Report of Progress toward goal attainment**<br>**Second year target: ___X_ Achieved _____Not Achieved (If not achieved, explain why)** |

***Initial steps in the implementation of a statewide System of Care (SOC) were successfully achieved in FY2015.***

***The target strategy for FY2014 was achieved in FY2015 when DMH was awarded the System of Care Expansion Implementation Cooperative Agreement that became effective as of October 1st 2014 and provides a total of $3,915,844 in federal funding over the next four years to implement a strategic plan that develops and establishes a statewide system of care approach.***

***As of May 1st an interim System of Care Project Director was appointed. Funding is allocated for hiring into the position.***

***A System of Care Technical Assistance Center for Illinois (STACI) was established in FY2015 and is now dedicated to supporting ongoing development and implementation of Systems of Care values across the state of Illinois. STACI will coordinate statewide planning, preparation, and education surrounding Systems of Care, as new and existing entities attempt to integrate Systems of Care into their delivery model.***

Illinois United for Youth (IUY) is the System of Care (SOC) collaborative planning initiative supported by an awarded Substance Abuse Mental Health Services Administration (SAMHSA) Statewide SOC Expansion Planning Grant. In February and March of 2014, IUY successfully completed an application for SAMHSA funding titled, "Implementation of Cooperative Agreements for Expansion of the Comprehensive Community Mental Health Services for Children and their Families Program (System of Care (SOC) Expansion Implementation Cooperative Agreements) grant." The application process was based upon the Illinois United for Youth (IUY) System of Care plan: Pathways-Illinois' Strategic Plan for Children's Mental Health.

The IUY Stakeholders identified the following goals for moving forward with the implementation of the strategic plan during FY2015 which have now been accomplished:

**1. Develop and establish a Systems of Care Technical Assistance Center for Illinois (STACI)**.

The STACI is dedicated to supporting ongoing development and implementation of Systems of Care values across the state of Illinois and coordinating statewide planning, preparation, and education surrounding Systems of Care, as new and existing entities attempt to integrate Systems of Care into their delivery model.

**2. Formalize capacity to identify, engage, and oversee SOC development and implementation opportunities around the state.**

The position of a statewide SOC Project Director is being established to help coordinate and facilitate exchange of information and best practices. Additionally, work to expand opportunities for youth and families to participate in the planning and delivery of services is being done through support to Youth MOVE-Illinois and the Illinois Family Organization. The aim is to strengthen family-driven and youth-guided services, and support the youth and family voice at all levels of policy and program development.

**Background:**

The DMH Child and Adolescent Office monitors and facilitates the array of services for youth with SED and their families. It has especially been active in the advancement of family driven care, the promotion of evidence informed practices, and the establishment of an online data system to monitor treatment progress and individual child and adolescent outcomes. The office manages specialty programs and projects such as mental health services in schools, transition services for youth, early childhood services, and mental health prevention and early intervention for children and youth. In the past few years the Office has been active in overseeing the implementation of several local SAMHSA System of Care grants including: (1) The ACCESS Initiative in Champaign County, an integrated network of community-based services and supports aimed at increasing service capacity for youth with serious emotional disturbances and their families; and, (2) Project Connect, a collaborative initiative in three underserved rural southeastern Illinois counties (White, Saline, and Gallatin), aimed at establishing a System of Care for youth and families.

The DMH C&A Office was awarded a Substance Abuse Mental Health Services Administration (SAMHSA) Statewide SOC Expansion Planning Grant to bring agencies

together to plan a statewide system of care approach. Illinois United for Youth (IUY) is the System of Care (SOC) planning initiative that resulted from the Grant. IUY formulated a comprehensive strategic plan to improve and expand the service delivery system for Illinois youth with a focus on community-based interventions that are fully rooted in the Systems of Care Philosophy. IUY is leveraging the commitment of youth, their families, the child-serving state Departments, a myriad of stakeholders, and the collective experience gained from SAMHSA-funded local Systems of Care to work towards the adoption and integration of Systems of Care Principles across the service delivery systems for youth. A set of multiple strategies was identified and submitted to SAMHSA as "Pathways: Illinois Strategic Plan for Children's Mental Health" Pathways established a framework grounded in System of Care principles and practices while assuring the flexibility that allows funders and operating agencies to implement change in manageable increments. Successful implementation relies on applying strategic planning efforts to multiple locations within the State, each with varying degrees of need, resources, infrastructure, funding and other supports. A central feature of the IUY Pathways approach is the establishment and availability of training, technical support, and an infrastructure designed to inform stakeholders, persons in leadership positions, and the public about the benefits of the System of Care framework.

**Table 1.9: Permanent Supportive Housing – Williams Initiative**

| 1. Priority Area:<br>**Advancement of Community Integration** | 2. Priority Type:<br>MENTAL HEALTH SERVICES |
|---|---|
| 3. Population(s) SMI, SED, OTHER: | |
| 4. Goal of the priority area:<br>***Complete the successful transition of individuals with SMI from longer term institutional care into their communities with appropriate and necessary support services.*** | |
| 5. Strategies to attain the goal:<br>By the end of FY 2015, through the provision of rental subsidies, implement a statewide permanent supportive housing initiative which targets consumers in long term care to transition into decent, safe and affordable housing and support services in their communities in a manner consistent with the national standards for this evidence based supportive housing practice. | |
| **6. Annual Performance Indicators to measure goal success:**<br>**Indicator:**<br>**Number of consumers transitioning from long term institutional settings who access appropriate permanent supportive housing. (National Outcome Measure)** | |
| a) Baseline measurement (Initial data collected prior to and during SFY 2014): **The Court approved target was: 640 consumers (cumulative) to be transitioned by the end of SFY2013. Note: 643 achieved** | |
| b) First-year target/outcome measurement (Progress to end of SFY 2014): **The Court approved target for SFY2014 was exceeded by more than 15%. 832 consumers (cumulative) were to be transitioned and 960 were actually transitioned by the end of SFY2014.** | |
| c) Second-year target/outcome measurement (Final to end of SFY 2015): **The Court approved target of 1,306 consumers for SFY2015 was exceeded by six. 1312 class members were actually transitioned by the end of SFY2015.** | |
| d) Data source:<br>Individuals receiving permanent supported housing have not been 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. | |

| |
|---|
| e) Description of data:<br>The data for this indicator will be generated from permanent supportive housing applications of individuals in longer term institutional settings which are stored in the special database, as well as a special PSH outcomes database. |
| f) Data issues/caveats that affect outcome measures: **(Original target for FY2014 was projected to be 1,280 based on non-agreed methodology which included 40% of all members of the Williams class assessed and not objecting to placement (2 of every 3,or 3,200). The agreed methodology recalculated this number to be 832.The recalculated FY2015 target was 1,306 based on 70%. The methodology was subsequently revised in Court and the above targets were approved.)** |
| **7. Report of Progress toward goal attainment**<br>**Second year target: ___X__ Achieved_____Not Achieved (If not achieved, explain why)** |

***This strategy was successfully accomplished in FY2015 and expectations were exceeded! At the end of FY2015, the State achieved its projection of 1,306 and exceeded this number by 6.***

***As of June 30, 2015, the cumulative number of consumers diagnosed with serious mental illnesses who have transitioned into PSH, including Williams and Colbert Class Members were 4,140. The state continues to pursue all available opportunities and partnerships to increase subsidized housing options, including being a recipient for two HUD released 811 voucher awards. Additionally, Chicago Housing Authority has made available a total of 400 tenant-based vouchers, 60 accessible public housing units and 200 project-based vouchers specifically for Class Members under the Williams and Colbert Consent Decrees. These vouchers are currently being processed for receipt.***

***With the transition activities of Williams, Colbert and MFP, the number of consumers benefitting from Permanent Supportive Housing has steadily grown. DMH's defined target population is listed in the Table below ranging from young adults aging out of the ICG/MI program or out of DCFS guardianship, residents of DMH funded supported or supervised residential settings, to persons in long term care facilities and long-term patients in state hospitals. DMH has utilized approximately $16 million of dedicated funding to Permanent Supportive Housing expansion. DMH continues to contract with six (6) entities to carry out Subsidy Administration duties for the entire state. Expansion of PSH Bridge Subsidies for non-Class Members or MFP participants is currently suspended due to funding contingencies. At the end of FY2015, 112 agencies had applied for access to this Initiative on behalf of the eligible consumers. During FY2015 DMH partnered with the Department of Healthcare and Family Services (DHFS) for PSH subsidies and services to meet the needs of an additional 415 consumers under the Money Follows the Person federal demonstration.***

**Individuals Approved and Eligible for PSH Housing by Priority Population Group in FY2015**

| **All Approved Applications by DMH Priority Population Grouping (As of June 30, 2015)** | |
|---|---|
| **Priority Population** | **Total** |
| Resident of long term care | 3034 |

| | |
|---|---|
| Resident of DMH funded residential | 608 |
| Experiencing homelessness | 362 |
| At risk of placement in long term care | 46 |
| Extended long term patient at state hospital | 38 |
| Aging out DCFS ward | 44 |
| Aging out ICG recipient | 8 |
| **Grand Total** | **4,140** |

**Background:**
Since FY2009 Illinois has implemented DMH Permanent Supportive Housing (PSH), a specific Evidence-Based model in which a consumer lives in a house, apartment (2 people shared upon mutual agreement) or similar setting. 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 criterion for supportive housing includes: 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 is integrated housing with persons who do not have mental illness. 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.

**Williams Consent Decree**

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

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

assuring linkages are completed for requisite services, including all needed mental health services as well as medical and other necessary services and supports.

The state is now entering its fifth year of the five year settlement. Since implementation, 1,312 former residents of IMDs have been afforded an opportunity to move into affordable apartments (signed leases) made possible by the PSH model with a bridge subsidy into Supervised Residential settings. In FY2015, the state invested $24 Million to build the infrastructure for transitioning Williams Class Members and to support the development of permanent supportive housing units with service supports necessary for successful transitions. There are eleven community mental health centers that provide a full array of services and supports, including Assertive Community Treatment (ACT) and/or Community Support Teams (CST), plus an additional nine agencies that provide transition coordination services and case management.

Additionally, in FY2015, the state expanded the Cluster Housing model. Partnering with two Williams community mental health centers, the state invested resources to house up to 32 Class Members into clustered PSH units, two on the north side of Chicago and one on the south side. This model comes with 24 hour peer support staff on the premises with the addition of psychiatric nurse time to address complex medical conditions.

**Table 1.10 Service Members. Veterans and their Families (SMVF)**

<table>
<tr><td>1. Priority Area:<br>Coordination and facilitation of mental health services for Illinois Service Members Veterans and their Families.</td><td>2. Priority Type:<br>MENTAL HEALTH SERVICES</td></tr>
<tr><td colspan="2">3. Population(s) OTHER<br>Service Members, Veterans, and their Families (SMVF) needing mental health services:</td></tr>
<tr><td colspan="2">4. Goal of the priority area:<br>Collaborate with Department of Defense, Department of Veterans Affairs, Illinois Departments of Military Affairs and Veterans' Affairs, and other state agency and partners to improve access to home and community-based mental health services for SMVF.</td></tr>
<tr><td colspan="2">5. Strategies to attain the goal:<br>• In coordination with collaboration partners develop and maintain an inventory of existing behavioral health system providers and services.<br>• Evaluate the adequacy of the existing network to ensure SMVF have access to needed services.<br>• Facilitate a coordinated crisis service intervention system between the VA and community providers, with special emphasis on suicide prevention.<br>• Enhance community provider capacity to serve SMVF through Military and Veteran 101 cultural competency training.<br>• Establish veteran contacts within each DMH regional office to facilitate coordination of SMVF services.<br>• Continue relationships with SAMHSA Service Members, Veterans, and their Families Technical Assistance Center and SAMHSA SMVF Policy Academy and Implementation Academy alumnae.<br>• Build capacity within Illinois Joining Forces Foundation (IJFF) particularly the Illinois Joining Forces (IJF) Behavioral Health Working Group (BHWG).</td></tr>
</table>

| |
|---|
| **6. Annual Performance Indicators to measure goal success:**<br>**Indicator:**<br>**Number of collaborative meetings attended by DMH staff representatives that have agendas aimed at completing the behavioral health inventory and coordination of existing services.** |
| a) Baseline measurement (Initial data collected prior to and during FY 2014):<br>By the end of FY2013, the number of collaborative meetings attended by DMH representatives that have agendas aimed at completing the behavioral health inventory and coordination of existing services. Minimum of Six (6). |
| b) First-year target/outcome measurement (Progress to end of FY 2014):<br>By the end of FY2014, the number of collaborative meetings attended by DMH representatives that have agendas aimed at completing the behavioral health inventory and coordination of existing services. Minimum of Nine (9). |
| c) Second-year target/outcome measurement (Final to end of FY 2015):<br>1. By the end of FY2015, the number of collaborative meetings attended by DMH representatives that have agendas aimed at completing the behavioral health inventory and coordination of existing services. Minimum of Twelve (12).<br>2. A report on the status of the system of care for SMVF individuals with documentation of collaborative accomplishments over the two year period. |
| d) Data source:<br>Meeting Minutes and records of DMH staff members assigned to this collaborative task. |
| e) Description of data: See Above. |
| f) Data issues/caveats that affect outcome measures: None. |
| **7. Report of Progress toward goal attainment**<br>**Second year target: ___X__Achieved_____Not Achieved (If not achieved, explain why)** |

***These strategies have been achieved in SFY2014-2015 and expectations were exceeded. During FY2014, and FY2015, DMH participated in more than 21 major collaborative meetings that had agendas aimed at completing the behavioral health inventory and coordination of existing services.***

***During FY2013, FY2014, and FY2015, DMH participated in planning and built relationships through the SAMHSA SMVF Technical Assistance Center and the SAMHSA SMVF Policy Academy. DMH participated with other Illinois SMVF service agencies in four policy academies, of which two were Implementation Academies, Workforce and Suicide Prevention, designed to evaluate and strengthen the state plan. Relationships continue with these national resources and with the Policy and Implementation Academy alumnae.***

***Beginning in FY2013 through all of FY2014, DMH participated in the formation and implementation of the Illinois Joining Forces Initiative and was active in the legislative process that created the Illinois Joining Forces Foundation, Public Act 098-0986, which became effective early in this fiscal year. During FY2015 Illinois Joining Forces evolved from an organizational model of state agency sponsorship (state convening power) to a stand-alone foundation. The Articles of Incorporation, Not for Profit status were accomplished. A Board of Directors was appointed and an Executive Director has been hired. Bylaws, Board Committees, and fund development activities have been accomplished or are well underway.***

***DMH continues to chair the Behavioral Health Workgroup, one of the nine working groups in the IJF initiative. The Behavioral Health Workgroup has:***

- ***Facilitated a coordinated crisis service intervention system between the VA facilities and community providers through the use of emergency response teams across the State.***
- ***Worked to enhance community provider capacity to serve SMVF through Military and Veteran 101 cultural competency training.***
- ***The workgroup was responsible for education sessions that trained well over 1200 providers in one day workshops across the State.***

***While this training was primarily in Behavioral Health, during FY2015 specialized events such as serving service members, veterans and families with behavioral health issues in the Justice System; events for general health providers; and events for providers from areas such as education and social services have also been conducted. Training content has included issues in military culture, the social/emotional issues faced by service members and their families facing deployment; the problems confronting returning service members seeking reintegration and return to normal civilian life; special interventions for families; the assessment and treatment of Post-Traumatic Stress Disorder (PTSD); and, Traumatic Brain Injury (TBI)***

***Illinois also participated in a SAMHSA Service Members, Veterans, and their Families Technical Assistance Center Substance Use Disorders (SUD), Prevention, Treatment, and Recovery (PTR) Virtual Implementation Academy. Recommendations from this academy have resulted in additional collaboration with the Division of Alcohol and Substance Abuse, the development of a Illinois Joining Forces Behavioral Health Working Group Subcommittee for Substance Use Disorders, and the development of a Military and Veteran Cultural Competency Workshop specifically targeted towards the state's community of substance use prevention providers. These workshops will be conducted in collaboration with the state SUD partners to form a solid infrastructure for SUD PTR. SUD PTR activities are also being incorporated across all Illinois Joining Forces Working Groups.***

**Background**:
DMH collaborates with the Illinois Departments of Veterans Affairs and Military Affairs (National Guard and Air Guard), to coordinate and improve services for service members, veterans, and their families throughout the state. Military personnel returning from the wars in Iraq and Afghanistan are at increased risk of traumatic brain injury, post-traumatic stress disorder, depression, anxiety and other mental health symptoms as well as new-onset heavy drinking, binge drinking and other alcohol-related problems. Anxiety, depression and engagement in high risk behaviors, such as substance abuse, are more likely among adolescents in families with a deployed parent than among similar adolescents in non-deployed families (Chandra et al., 2009) Given the increasing recovery needs among returning military personnel and their families, DMH and DASA have partnered with the Illinois National Guard and Illinois Department of Veterans Affairs in order to improve access to mental health services, alcohol and other drug

treatment, and recovery support services among military personnel returning from deployment and their families.

- Through a SAMHSA grant of approximately $2 million over 5 years, DMH has established the Illinois *Veterans Reintegration Initiative (VRI)* to increase diversion for criminal justice-involved veterans with trauma histories in Cook and Rock Island counties. The VRI was aimed at the delivery of trauma-informed, evidence-based treatment to 120 consumers per year over a 5-year program period, as well as specialized training for 1,000 police officers in street-level responses to veterans demonstrating mental illness.

- The Department of Veterans Affairs, in consultation with the Division of Mental Health, established the Illinois Warrior Assistance Program (IWAP), staffed by mental health professionals through Magellan Health Services. IWAP provides a 24-hour, toll free number for confidential assistance with emotional challenges veterans may face reintegrating into civilian life. Screenings for traumatic brain injury and post-combat trauma reactions are also available through IWAP.

Since 2008, the Department of Veterans Affairs, in consultation with the Department of Human Services, has also:

- Developed an educational program designed to train and inform primary health care professionals, including mental health care professionals, on the effects of war-related stress and trauma.
- Provided informational and counseling services for the purpose of establishing and fostering peer support networks through the state for families of deployed members of the reserves and National Guard.
- Provided veterans' families with a referral network of providers skilled in treating deployment stress, combat stress, and post-deployment stress.

Additionally, the Division of Mental Health, as a member of the Illinois Families of Fallen Service Member Task Force, offered the first in a series of outreach events to surviving families of fallen service members.

**Illinois Joining Forces**

In the past two years extensive work has been done in Illinois to implement and sustain this nation-leading model, awarded by the U.S. Department of Veterans Affairs and the National Association of State Directors of Veterans Affairs for its groundbreaking work in creating smarter, collaborative community support for those in uniform past and present. The Illinois Joining Forces (IJF) is a joint Department of Veterans' Affairs (DVA) and Department of Military Affairs (DMA) effort to better serve veterans, service members, and their families throughout the state. IJF brings together, under a common umbrella; public, non-profit, and volunteer organizations to foster increased awareness of available resources and to better partner and collaborate with participating organizations. It has been estimated that Illinois alone has as many as 500 veteran- and military-related organizations but the lack of collaboration and coherence between them has resulted in

veterans and service members being frustrated and unaware of the many resources available to them.

The IJF was launched in SFY2013 and is characterized by:

- A focus on collaboration, as well as streamlining of duplicative services through partnerships to better support veterans, service members, and their families.
- A network of organizations with improved capability awareness and intra-network referrals.
- Increased effectiveness of the many resources provided by veteran- and military-related organizations in Illinois through transparency and navigability.
- Production of practical, impactful policy recommendations to be included in the annual report of the Illinois Discharged Service Member Task Force.

Three key principles underline the IJF initiative: (1) No Wrong Door for access; (2) No Wrong Person for eligibility; (While VA has some delimiting criteria, the IJF initiative declines no one regardless of dishonorable discharge, length of service etc.) and, (3) Universal assessment –Have you or your family member ever served in the Armed Forces?

IJF serves as the focal point for organizations across Illinois and is working toward a more navigable system of support for service members, veterans, and their families by employing an online referral network and collaboration tools. There are nine working groups in IJF including: healthcare, behavioral health, homelessness, disability benefits, legal, deployment support, education, and employment & training. The workgroups meet quarterly to stay aware of the ongoing work of participating organizations and to address targeted military and veterans' issues. The IJF workgroups use the military and veteran expertise of their members to educate organizations that assist service members and veterans but do not have military/veteran-specific programs. The Behavioral Health Working Group offers classes to interested civilian mental health care providers. The deployment support working group can offer a "Military Families 101" course to interested civilian primary school educators as well. This education increases the collective capability of Illinois-based organizations to serve military and veteran communities. As a result of Illinois Joining Forces and the collaboration it enables, the entire "system of support" is becoming more navigable for service providers and for the service members, veterans, and families.

Public Act 098-0986, which became effective on 8/18/2014, created the Illinois Joining Forces Foundation, a not-for-profit foundation. Provisions in the law for incorporation, the appointment of a Board of Directors, and the collection of funds ensures the long-term sustainability of Illinois Joining Forces, now considered to be critically important for the support of the state's military and veteran communities.

**Table 1.11 Child/Adolescent Rural Telepsychiatry**

| 1. Priority Area:<br>**Advancement of the use of interactive communication technology.** | 2. Priority Type:<br>MENTAL HEALTH SERVICES |
|---|---|
| 3. Population(s) SMI, SED, OTHER: | |

| |
|---|
| 4. Goal of the priority area:<br>***Develop the infrastructure to advance the use of interactive communication technology for clinical work in areas of Illinois where critical behavioral health professional shortages exist.*** |
| 5. Strategies to attain the goal:<br>Through FY2015, continue to track Tele-psychiatry services at rural sites in Illinois and, contingent upon funding opportunities, plan for further expansion of the program. |
| **6. Annual Performance Indicators to measure goal success:**<br>**Indicator #1: Number of youth living in rural areas receiving services through Tele-psychiatry.** |
| a) Baseline measurement (Initial data collected prior to and during SFY 2014): |
| b) First-year target/outcome measurement (Progress to end of SFY 2014): |
| c) Second-year target/outcome measurement (Final to end of SFY 2015): |
| d) Data source: The DMH contractor that maintains and services the system also tracks the number of Tele Psychiatry events, hours, and the number of individuals served. |
| e) Description of data:<br>Aggregate data on the number of youth receiving Tele-psychiatry services in rural areas across each year for comparison with subsequent years of data. |
| f) Data issues/caveats that affect outcome measures: |
| **7. Report of Progress toward goal attainment**<br>**Second year target: ___X__ Achieved _____Not Achieved (If not achieved, explain why)** |

***This strategy has been actively pursued in FY2015 and substantively achieved! DMH has continued to successfully implement Tele-psychiatry services at rural sites in Illinois. The Tele-psychiatry Project provided 1,268 sessions of tele-psychiatry services to 194 children in five community mental health agencies in DMH regions 4 and 5 that otherwise could have gone untreated or have needed to travel great distances for treatment.***

**Background:**

There is a well-documented shortage of child and adolescent psychiatrists in the United States. Up to 20% of children suffer a mental health condition. There are less than 300 Child and adolescent psychiatrists in Illinois with at least 90% concentrated in or around the Chicago metropolitan area leaving the rural areas with only 10% of certified child and adolescent psychiatrists to cover the great need of services in these communities. The DMH Tele-psychiatry Project is providing psychiatric services to children and adolescents in the areas of the state where communities don't have access to board certified child psychiatrists. The most common diagnoses of children served have been: Bipolar Disorder, Attention-Deficit/Hyperactivity Disorder (ADHD), and Post-Traumatic Stress Disorder.

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 clinicians remain 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.

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. The establishment of a process for billing telemedicine allowed the program to maintain capacity despite the cut in funds. Currently, services are continuing at six sites which are utilizing the full amount of available psychiatric time. To supplement grant funds, the Tele-psychiatry provider agency has continued to bill Medicaid for all applicable patients. Billing to date has been sufficient to cover the costs of the program not covered by grant funding, and the Department is not being asked for additional funding for current services. 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.

As funding becomes available to support expansion, the contracting agency providing the tele-psychiatry services has agreed to work with DMH to expand services to other areas or needs and is continually searching out and applying for funding that may support the expansion of Tele-psychiatry. As a national subject matter expert, the agency has been sought for guidance by other groups considering tele-psychiatry programs. In the past year, the program was presented to Illinois Health Connect and consultation has been provided to the Illinois Tele-mental Health Task Force with the aim of bringing this service to other rural communities. The provider agency will certainly continue to work with the department (DMH) if there are other areas or needs, and if funding that would support expansion becomes available.