FY 2016-FY2017
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT APPLICATION

ILLINOIS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH

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State Information

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

___X_ FY 2016-FY2017

STATE NAME: __ILLINOIS_____
DUNS #: ____067919071_____

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III. State Expenditure Period (Most recent State expenditure period that is closed out)

FROM: July 1, 2014 TO: June 30, 2015

FY 2016-17 MENTAL HEALTH BLOCK GRANT APPLICATION EXECUTIVE SUMMARY

The Illinois Department of Human Services-Division of Mental Health (DMH) is responsible for facilitating, coordinating, and purchasing a comprehensive array of services that provide effective treatments to people most in need of publicly funded mental health care. The policies and practices of the DMH focus on fostering coordination and integration of services provided by DMH funded community agencies, private hospitals, and state hospitals across Illinois. A variety of collaborative initiatives serve to increase coordination with other state agencies whose services are accessed by individuals receiving mental health services. The FY2016-FY2017 Mental Health Block Grant Plan reflects these coordination efforts as well as an emphasis on developing and directing care which is consumer and family driven. DMH continues to transform the mental health service delivery system in Illinois to one that is recovery-oriented. These efforts include increasing consumer and family involvement in planning and implementation activities and expanding the focus on planning and implementation of evidenced-based practices. A wide array of stakeholders representing consumers, family members of individuals with mental illnesses, advocates and public service agencies purchasing or providing treatment to individuals with mental illnesses participate in these efforts. The anticipated outcome is the continued enhancement of activities that support the recovery-orientation of the mental health system and address the needs of consumers and their families.

During FY2016, the priorities of the DMH include: (1) Facilitation and coordination of an effective array of clinical and support services. (2) The provision of services in the least restrictive manner including screening and crisis services for individuals at risk of hospitalization that contribute to reducing the use of hospitalization and identification of individuals who are experiencing psychosis for the first time as a priority population for community-based services.(3) Advancement of the recovery vision including Wellness Recovery Action Planning, expansion of the scope and quality of consumer and family participation, and promotion of the utilization of the Certified Recovery Support Specialist (CRSS) credential. (4) Continuing development of System of Care concept and infrastructure for children, adolescents and their families in Illinois. (5) Enhancement of capacity for community living consistent with the Olmstead Decision, as stipulated in Implementation Plan of the Williams vs. Quinn Consent Decree. (6) Partnership with state agencies and statewide organizations in initiatives which respond to ongoing consumer needs such as the criminal justice system, alcoholism and substance abuse services, vocational and employment services, housing opportunity, and services for military personnel. (7) Bi-directional Integration of Primary Health Care and Behavioral Health Care and the maximization of benefits to adults with SMI and children with SED through Affordable Care. (8) Continuing consultation and partnering with the state Medicaid agency, DHFS, the IDHS Community Health and Prevention Division (CHP) and the Illinois Children's Mental Health Partnership to address the behavioral health

needs of women in pregnancy, single mothers with young children, and early childhood interventions. (9) Enhancement of collaborative efforts with state and local partners to address the mental health needs of adults involved with the criminal justice system and youth in the juvenile justice system. (10) Advancements in the use of data to inform and guide decision-making in C&A Services. The FY2016-17 Plan has been reorganized to comply with the priorities and format established by the SAMHSA.

As of this writing, the Illinois' FY2016 Budget has not been finalized by the Legislature and the Governor. As a result, funding for a number of mental health initiatives reported in previous plans still remains undecided and, in some instances, under dispute. This plan encompasses only those priorities, goals and strategies which have been clearly referenced as certain of continuing in the next two fiscal years. However, it should be noted that several of them are dependent on funding from resources other than state general revenue (GRF) and are thus contingent upon the continued availability of those resources.

PLANNING STEP I

Framework for Planning-Assessment of the Mental Health Service System

Description/Overview of the State's Mental Health System

The Illinois Department of Human Services Division of Mental Health (DMH) has a statutory mandate to plan, fund, and monitor community-based mental health services. Through collaborative and interdependent relationships with service system partners, the DMH is responsible for maintaining and improving an evidence-based, community-focused, and outcome-validated mental health service system that builds resilience and facilitates the recovery of individuals with mental illnesses. The DMH accomplishes this responsibility through the coordination of a comprehensive array of public/private mental health services for adults with serious mental illnesses and children/adolescents with serious emotional disturbances.

IDHS manages human service systems in the state, including management of the public mental health system through DMH. DMH has the statutory mandate to plan, fund, and monitor community-based mental health services and inpatient psychiatric services provided in state hospitals. As such, DMH is the federally recognized State Mental Health Authority for Illinois.

DMH contracts with approximately 180 community mental health agencies to provide community-based services. These contracted organizations provide mental health services funded principally under the Medicaid Rehabilitation Option, including psychiatry, psychotherapy, medications, psychosocial rehabilitation, and case management to individuals eligible for Medicaid. Some services are also funded through a capacity grant mechanism. DMH also operates seven state mental health hospitals and one treatment detention facility. In addition, DMH supports services provided through long term care facilities and in residential settings.

The state's geographic diversity, ranging from inner-city urban areas to sparsely populated rural areas, along with other factors such as stigma, result in mental health service delivery in non-traditional settings. These include physician offices, primary care clinics, general hospitals, emergency rooms, child welfare centers, schools, juvenile detention centers, jails, and prisons. While DMH provides some of the funding, the services provided in these diverse treatment settings are also supported by a variety of other sources.

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

• **Supportive housing.** Access to supportive housing has been a focus for several years and includes a service model, identified funding sources, and a referral network for those

leaving long-term care settings. This investment in supportive housing demonstrates a commitment to helping individuals achieve their independent living goals, with community settings becoming the expected living situation for most adults who are diagnosed with serious mental illnesses.

• **Employment services.** To help individuals access and maintain employment, Illinois has adopted the Individual Placement and Support (IPS) model, an evidence-based practice for which there is robust data indicating success. With the support of both DMH and the IDHS Division of Rehabilitation Services, the IPS model has demonstrated a 63 percent successful Federal Vocational Rehabilitation Rate (the percentage of people stably employed in a job of their choosing after 90 days), which is above the national average.

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

It is the vision of the Division of Mental Health that all persons with mental illnesses can recover and participate fully in life in the community. Within available fiscal resources, the priority for DMH is to provide access to clinically appropriate, effective and efficient mental health care and treatment for individuals who have serious mental illnesses and who have limited social and economic resources. Planning and budgeting decisions are guided by the basic principle that individuals will receive services in the least restrictive, most clinically appropriate environment, with the best possible quality of evidence-based treatment and recovery oriented care.

Statewide efforts to maintain and improve the system of care are coordinated through the Division of Mental Health Central Office based in both Springfield and Chicago. Planning and program implementation are accomplished in conjunction with seven regional administrators. The Central Office is responsible for oversight of the system, policy formulation and review, the operation of seven state hospitals, planning, service evaluation, and allocation of funds. Interagency collaborative efforts and leadership in initiatives such as activities related to transformation, consumer participation and involvement, the promotion of evidence–based practices, planning for clinical services, forensic services, and child and adolescent services are carried out by statewide administrative staff.

The Community-Based Mental Health Service System

Community services are considered the cornerstone of the mental health delivery system. Services provided and purchased by the DMH are geographically based. The DMH is geographically organized into seven service regions. Through these regions, the DMH operates seven state hospitals and contracts with 180 community-based outpatient/rehabilitation provider agencies across the state. These Service Regions are charged with the responsibility for managing care, developing the capacity and expertise of providers, monitoring service provision and increasing the quality and the quantity of participation from persons who receive mental health services. Four regions are located in the Chicago Metropolitan area and surrounding suburbs, and three regions cover the

central, southern and metro-east southern (East St. Louis region) areas of the State. Administratively, each Region has an Executive Director, a lead Clinical Director, a lead Recovery Services Development Specialist, and a Coordinator of Forensic Services.

The DMH continually seeks input from consumers, family members, advocates, and representatives of public and private organizations through the framework of the Illinois Mental Health Planning and Advisory Council (IMHPAC) to aid in planning efforts. The DMH uses emerging developments at the local, state and national levels as a basis for strategically setting statewide parameters and goals, with the regions carrying the responsibility for the development of congruent local systems of care. Regional Strategic Plans reflect the overall goal of the development of a recovery-oriented service system. Ongoing strategic thinking and planning efforts with Regional stakeholders are designed to uniquely meet local area needs within each Region. The regions work with local agencies, state agency partners, and stakeholders to integrate a comprehensive care system that includes mental health, rehabilitation, substance abuse, social services, criminal justice, and education. The DMH is able to improve linkage and insure that treatment occurs in the least restrictive and most cost-effective settings by integrating hospital-based services into a network of community outpatient services and supports that are coordinated across service providers and consumers. By building on the strengths of communities in which consumers live, the region administrators are able to manage DMH funds, and coordinate the most effective use of the local tax dollars and private resources budgeted for public mental health services.

Being part of the IDHS umbrella has provided an opportunity for the DMH to address a number of challenges within the shared mission of one Department, including: disability determination for persons with serious mental illnesses (SMI), prevention, early intervention, integration of vocational and educational services for children with serious emotional disturbances (SED), coordination and development of Mental Illness and Substance Abuse (MISA) services, and, through the coordinated intake process, an opportunity to enhance case finding, early identification, and outreach efforts.

DMH's Forensic Services collaborates with a range of agencies in the criminal justice system to oversee and coordinate the inpatient and outpatient placements of adults remanded to DMH by Illinois county courts because they are considered to be unfit to stand trial (UST) or not guilty by reason of insanity (NGRI). Inpatient services are provided at five state hospitals with secure forensic units. DMH also helps lead several programs to address other individuals with behavioral health needs in jails and prisons, including the Jail Data Link Program and other initiatives focused on recovery, diversion, reintegration, best practices, and the appropriate use of inpatient and community resources. Because of budgetary constraints, many community-based mental health services are available only if the individual has health benefits through private insurance, Medicaid, or Supplemental Security Income. These constraints also apply to individuals involved with the criminal justice and juvenile justice systems.

Mental health services are purchased or delivered by many other state agencies and local mental health authorities in some areas of the state (including 708 boards, the City of Chicago and other municipalities, and Cook County). Over the years, DMH has worked

actively to develop and establish relationships across these systems with the goal of integrating mental health services under its purview with the services provided or purchased by other agencies.

Description and Overview of Child and Adolescent Services

DMH's Child and Adolescent Services (C&A) serves children and adolescents with social, emotional, and behavioral disorders who depend on public funding, through a network of community-based mental health providers. The emphasis is on resilience and evidence informed practice as components in the systemic transformation process. C&A collaborates with the Illinois State Board of Education, the Department of Child and Family Services, the Illinois Department of Juvenile Justice, DHS/Division of Alcoholism and Substance Abuse, the Illinois Department of Healthcare and Family Services, the Illinois Children's Mental Health Partnership, to implement Systems of Care statewide. The Illinois Departments of Children and Family Services (IDCFS) and Juvenile Justice (IDJJ) also have statutory responsibility to provide mental health services in some instances. No single agency is responsible for ensuring the integration of behavioral health care services across all child-serving systems.

The Child and Adolescent Services office has been led by a board certified Child and Adolescent Psychiatrist and consists of Statewide C&A Staff, some of whom are geographically located in each of five regions of the state. Specialty program grants specific to children and adolescents are managed by Central Office Child and Adolescent Services staff who have expertise in systems of care, mental health services in schools, transition services for youth, early childhood services, and mental health prevention and early intervention for children and youth.

The seven geographic Service Regions are responsible for contracting activities with 124 child serving agencies which either provide specialized services or are community mental health centers with children's programming. They also collaborate with and monitor local hospitals that provide psychiatric programs for youth. The localized integration of a comprehensive care system including mental health, substance abuse, child welfare, juvenile justice, and education is within their purview. Each region has access to C&A staff specially designated to address child and adolescent and juvenile forensic service issues. Consumer parents (Family Consumer Specialists) are regionally based and function in the critical system role of connecting DMH services to their communities while providing DMH with the consumer family voice and input from their communities.

The Growth of Community-Based Services

Within Illinois there are numerous private practitioners, community mental health agencies, community hospitals providing inpatient psychiatric care, and community long-term care facilities providing services to individuals with serious mental illnesses. Over the past 40 years, the locus of treatment for persons with mental illness has shifted from institutions to community-based settings. In FY1973, 8% of the DMH's budget was allocated for community services. Until recently, approximately 70% of DMH

expenditures have been allocated for community-based services. However, due to continuing budget reductions, the balance between community based and state hospital expenditures has begun to shift. In FY2014, the DMH purchased community based services for 98,090 adults and 37,107 children and provided state hospital services for 7,187 individuals.

The Illinois Mental Health Collaborative for Access and Choice

DMH began contracting with an Administrative Services Organization (ASO) in FY2008 to assist with implementing DMH established policies and procedures in a variety of areas. The ASO known as the Illinois Mental Health Collaborative for Access and Choice, or The Collaborative serves as an administrative arm to the Division. Tasks performed by the Collaborative include:

- Post-payment review of services
- Authorization of intensive services such as Assertive Community Treatment (ACT), Community Support Teams (CST), and Individual Care Grants (ICG) for children with serious emotional disturbance
- Assisting DMH staff in convening regional consumer conferences
- Operating and Maintaining a Consumer Warm Line and a Consumer Family Care Line.
- Collaborating with DMH on the development and maintenance of an integrated Management Information System (MIS).
- Completion, dissemination, and posting of a variety of mental health reports, manuals, and handbooks, a consumer and family handbook, and a study guide for the CRSS credential.

The work of the Collaborative has been very valuable to DMH in terms of performing administrative and supportive tasks that support the vision for a recovery oriented service system.

Impact of the Economic Recession in Illinois

Illinois is on an annual budget cycle. The vast majority of individuals served in the Illinois public mental health system are unable to pay for their behavioral health care. They are either Medicaid–eligible or their services have been supported through DMH capacity grants. Prior to FY2009, funding for community mental health services in Illinois had shown consistent increases. In SFY 2006 state funding increased by 3.07 percent; in SFY 2007 by 5.54-percent and in SFY 2008 by 2%. However, starting in FY2009, economic conditions in Illinois significantly deteriorated. The Illinois Department of Revenue (IDOR) reported that the Total Revenue Collected (not including taxes collected for local governments) dropped from $29.2 billion in SFY2008 to $27 billion in SFY2009 resulting in a deficit to the state of 7.5% of revenue. In SFY2010 this serious decline continued as revenues dropped another $2.4 billion to $24.5 billion--an 8.9% decrease. Overall, Illinois experienced a loss of over $4.6 billion in revenues in two years, a steep decline of nearly 16%. In FY2011, with some relief in the economic recession, legislative intervention, and temporarily increased taxation, revenues increased by 21% over the FY2010 level to $29.7 billion but barely surpassed the revenues collected in FY2008. The Illinois Department of Employment Security (IDES) reported

that the state's Unemployment Rate (Seasonally Adjusted) peaked in January 2010 at 11.4 (12.1 not seasonally adjusted). Comparatively, by calendar year, the Annual Average percentage of Unemployment rose significantly in CY2009 and CY2010 reflecting an increase in the average number of unemployed persons from 424,600 in CY2008 to 691,900 in CY2010. Since then the average number of unemployed persons has gradually decreased from 637,000 in CY2011, to 594,100 in CY2013 and a significant drop to 460,400 in CY2014.

Although budget reductions occurred in FY2013, funding levels have been maintained in FY2014 and FY2015. As of this writing, the Governor's proposed budget for FY2016, which has not yet been passed, is expected to result in further decreases. The proposed budget eliminates the service benefit packages for the non-Medicaid eligible population; however it continues to contain dollars for some grant funded services such as residential housing, juvenile justice services and limited crisis capacity services. DMH has made every effort to maintain essential mental health services for persons with the most serious mental illnesses through reallocation of existing funds. DMH has strongly encouraged providers to fully support and facilitate applications for individuals who qualify for Medicaid eligibility.

The State Mental Health Strategic Plan (2012)

The Strategic Plan, formulated by a legislatively established Task Force, addressed the wider scope of mental health services in the State and built upon the current structure of statewide service delivery. Seven strategic priorities were 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 Task Force and its subcommittees met through the fall of 2012. The Plan was completed and submitted in February 2013.

Interagency Partnering and Collaboration

DMH works regularly with the following state agencies:

- The Illinois Department of Healthcare and Family Services (IDHFS), the state's Medicaid authority, is the **largest purchaser of mental health services in the state.** It purchases services provided by individual practitioners, hospitals, and nursing facilities, including medication, psychiatry, inpatient services, and long-

term care. Illinois Public Act 096-1501 (Medicaid Reform) required that a minimum of 50 percent of Medicaid clients be enrolled in coordinated care by 2015. IDHFS has implemented a Care Coordination Project known as Innovations which was the vehicle by which this goal was achieved through contracts with Coordinated Care Entities, Managed Care Community Networks, and Managed Care Organizations. IDHFS has also released its Solicitation for Care Coordination Entities for Children with Complex Medical Needs, which is a component of the Innovations project.

- IDHS Division of Alcoholism and Substance Abuse (DASA) to address services for individuals with co-occurring mental and substance use disorders. DMH, DASA, and IDHFS recently collaborated on the completion of an Application for a Planning Grant for Certified Community Behavioral Health Clinics (CCBHC Planning Grant) which was submitted to SAMHSA on August 5, 2015.
- IDHS Division of Developmental Disabilities to address the needs of persons with autism spectrum disorders and individuals with co-occurring developmental disabilities.
- IDHS Division of Rehabilitative Services to increase the access of individuals with serious mental illnesses to vocational rehabilitation services and to improve the coordination of psychiatric and vocational services through initiatives such as the IPS model of supported employment.
- Illinois Housing Development Authority and IDHFS to implement the Williams v. Quinn Consent Decree and provide permanent supportive housing.
- Illinois Department on Aging to increase training opportunities in the geriatric field and to improve the quality and accessibility of services for elderly persons with mental illnesses.
- IDHFS and the Department of Public Health (IDPH) to support people with serious mental illnesses who require long-term care services.
- 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.
- Illinois Department of Corrections (IDOC) and IDJJ to address the needs of adults and juveniles involved with the justice system. It has been estimated by IDOC healthcare staff that 16% of 48,000 in the total DOC population have a mental health disorder. Fourteen percent of the detainees in reporting Illinois county jails have mental illnesses. IDJJ reported that 17 percent of the youth under their purview were identified as having moderate mental health needs during FY 2013 and 50 percent were identified as having mild mental health needs. All of them, representing 67 percent of the population, received some form of mental health treatment (group or individual).
- Illinois Department of Children and Family Services (IDCFS) on a number of initiatives, including Screening, Assessment, and Support Services (SASS). Collaborative efforts include training for child welfare staff and service providers to examine and respond to the trauma children and families experience as a result of physical abuse, neglect, sexual abuse, and domestic violence. IDCFS has noted that 50 percent of children in the child welfare system have mental health problems, often related to early trauma.

- Illinois State Board of Education on the Interconnected Systems Model of School Based Mental Health and collaboration on the Illinois Positive Behavioral Interventions and Supports to facilitate the integration of community mental health providers in schools to address prevention and early intervention and provide for the social, emotional, and behavior supports for students, teachers and families.

Community Integration in Long Term Care

There are a substantial number of individuals with serious mental illnesses who require long-term care services. Some require this level of care because of functional limitations associated with their mental illnesses, and others require it for functional limitations associated with both mental illness and medical needs. In either case, the lack of viable community alternatives and supportive services for persons in this situation may necessitate their admission to and continued care in longer term care facilities. The Illinois Department of Public Health (DPH) is responsible for monitoring the licensing requirements of nursing facilities and the Department of Healthcare and Family Services (DHFS) oversees Medicaid funding. The DMH has made a concerted effort to assist community providers and these two state agencies to understand the service needs of persons with serious and disabling mental illnesses. DMH is currently working to develop community-based alternatives to accommodate the needs of this population in transitioning to the community through the Money Follows the Person (MFP) initiative and the Williams Consent Decree (See Section C-18 for further information.)

Collaborative Planning in Mental Health and Substance Abuse Prevention and Treatment

DMH and the DHS Division of Alcohol and Substance Abuse (DASA) have worked together over the years to collaborate, develop and implement initiatives focusing on consumers with co-occurring disorders. These collaborations have included co-location projects at four state hospitals and sharing service delivery site resources, which allowed DASA funded providers to perform screening and assessment for consumers on-site, and to provide consultation to DMH staff regarding the substance abuse treatment needs of consumers when these services were warranted. This approach resulted in the development of more hospital staff training and expansion of the role of the DASA providers to perform linkage and engagement activities. However, funding for these efforts has not been available in recent years.

Although budgetary constraints in Illinois have impeded funding for any special initiatives to address the needs of consumers with co-occurring disorders, both divisions continue to highlight the clinical importance of integrated treatment for individuals who are dually diagnosed. DMH and DASA have jointly participated in the SAMHSA National Policy Academy on co-occurring disorders. Treatment funded by DHS/DASA in Illinois emphasizes services that are consumer-oriented, geographically accessible, comprehensive, bridging continuing care responsibilities between all levels of an integrated system of care. DASA contracts with Heartland Alliance to fund the Illinois

Co-Occurring Center for Excellence (ICOCE) to provide training, technical assistance, and consultation to agencies that provide dual diagnosis treatment to assist providers in acquiring skills that assure the highest quality of integrated care is provided. ICOCE defines its central role as fostering the use of evidence-based practice models for the treatment of co-occurring substance use and mental health disorders. Consultation is also provided in related areas such as recovery-oriented systems of care, supported employment, illness management, motivation to change and organizational change issues, cultural competence, HIV-AIDS, and trauma. Consultation and training are offered to DASA providers as requested and needed due to limited resources. The concepts, practices, and skills developed from IDDT and ICOCE, continue to be useful in addressing the treatment needs of individuals with co-occurring disorders.

DMH continues to implement Wellness Recovery Action Planning (WRAP) which is seen as bridging the gap between traditional mental health treatment and traditional substance abuse treatment for individuals with co-occurring disorders. The use of WRAP principles of self-determination, personal responsibility, and empowering support are a means of addressing an individual's divergent needs. In reference to children and youth, DASA has been a leading participant in the DMH Family Driven Care initiative and has collaborated with DMH in providing training on trauma informed prevention, treatment and recovery as well as adolescent and family co-occurring disorders and their treatment.

PLANNING STEPS

1. Assessment of Strengths and Needs in the Service System

The consistent vision for mental health services in Illinois is a well-resourced and transformed mental health system that is person centered and community driven; that provides a continuum of culturally inclusive programs which are integrated and effective; a range of direct and support services (including prevention, early intervention, treatment and supports) that support healthy lifelong development through equal access and promote recovery and resilience**.** The fundamental belief (credo) is that:

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

-The expectation is recovery

-The individual is central

Accordingly, all children with a diagnosis of, or at risk for developing, an emotional disorder will have access to a family-driven, youth-guided, trauma-informed, culturally and linguistically competent, strengths-based system of care that supports optimal physical and mental health and social and emotional wellbeing. All adults with a diagnosis of, or at risk for developing, a mental illness will have access to a coordinated, integrated, well-funded mental health system that promotes recovery and social inclusion through timely access to prevention, treatment, and recovery support services. In Child and Adolescent services, the emphasis is on resilience and evidence informed practice as components in the systemic transformation process. Many of the activities in which the DMH is engaged are providing the foundation to make this vision a reality even in an era of great fiscal challenge.

VALUES AND PRINCIPLES

Principles operationalize our values and help us realize our goal of providing quality, accessible, community-based care that provides a full range of options to individuals who seek our services.

In Illinois, the following principles guide the design, delivery, and evaluation of all mental illness prevention, treatment, and recovery support services:

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

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

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

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

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

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

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

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

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

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

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

SYSTEM STRENGTHS

A person-centered, recovery focus

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

A Commitment to Evidence-Based and Evidence-Informed Practices in Illinois

Evidence-based practices are interventions for which there is consistent scientific evidence showing that, when implemented with fidelity to the model, they improve individual outcomes. Evidence-informed practices refer to those practices determined by children, their families, and practitioners to be appropriate to the needs of the child and family, reflective of available research, and measurable with respect to meaningful outcomes.

Illinois has devoted resources to support the implementation and use of evidence-based practices for adults with mental illnesses in such areas as outreach, engagement and treatment (Assertive Community Treatment), housing (Permanent Supportive Housing), employment (Individual Placement Services), and recovery (Wellness Recovery Action Planning). Dollars also have been allocated to support the implementation and measurement of evidence-informed practices with child-serving agencies. Illinois has received several federal System of Care grants. Based on recent collaborative efforts on behalf of children and adolescents, Illinois is poised to create state-of-the-art services for children and families based on System of Care values, principles, and practices.

A pledge to work together

Collaborative efforts that support adults and children with mental health conditions abound. Examples include SASS (Screening, Assessment and Support Services), which is a collaborative effort between IDCFS, DMH, and IDHFS to provide crisis services to youth with serious emotional disturbances; the DMH Jail Data Link program, which was

developed by DMH to identify and coordinate services between county jails and mental health agencies for individuals with mental health needs; and the Integrated Care Pilot and Care Coordination Effort projects that span multiple state agencies. The behavioral health and law enforcement systems work together in problem-solving courts and on law enforcement Crisis Intervention Teams. Support for Illinois service members, veterans, and their families comes from a broad range of community, faith-based, and fraternal organizations, as well as elected officials and the general public.

Coordination of Care
Illinois Public Act 096-1501 (Medicaid Reform) requires the provision of coordinated care for adults and children who receive Medicaid-funded services. This may spur the development of innovative service models to improve health care outcomes, use of evidence-based practices, and encourage meaningful use of electronic health records (EHRs).

A focus on technology
Technology is increasingly being used to help drive both service provision and data collection and analysis. Telepsychiatry, e-prescribing, and other mobile and video tools are currently being used in limited capacities to make services accessible to Illinois residents with mental health needs who otherwise might not be served. With establishment of the statewide Office of Health Information Technology (HIT), housed in the Governor's office, the state understands the need to embrace the potential for HIT to improve health care quality and reduce costs. Although Illinois behavioral health providers have exceeded the national average of 10 percent for implementation of EHRs, there is still much work to be done. (See the discussion of "gaps" below.) However, under a grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA), the state has begun developing needed infrastructure to promote the exchange of health information among behavioral health and medical care providers.

2. Unmet Service Needs

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

The SAMHSA Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2009 to 2013 found that:

- In Illinois, about 322,000 adults (3.4% of all adults) per year in 2009–2013[*]* had SMI within the year prior to being surveyed. In 2012-2013, Illinois' percentage of SMI among adults was lower than the national percentage of 4.1%.

[*] Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: Illinois, 2014*. HHS Publication No. SMA–15–4895IL. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

- In the same period, 2009-2013, about 88,000 adolescents per year (8.5% of all adolescents in the State) had at least one Major Depressive Episode (MDE) within the year prior to being surveyed. (The percentage increased over this period.) About 33,000 adolescents with MDE (37.6% of all adolescents with MDE) per year in 2009–2013 received treatment for their depression within the year prior to being surveyed.
- The survey also found that 42.6% of all adults with Any Mental Illness (AMI) between 2009–2013 received mental health treatment or counseling within the year prior to being surveyed. Illinois' percentage of mental health treatment among adults with AMI was similar to the national percentage in 2009–2013.
- Additionally, among adults served in Illinois' public mental health system in 2013, 53.5% of those aged 18–20, 40.7% of those aged 21–64, and 72.4% of those aged 65 or older were not in the labor force. Only 16.3% of all adults served were employed.

According to a June 2015 PEW Foundation publication, titled Mental Health and the Role of the States, "In 2013, an estimated 44 million American adults (18.5 Percent of the population 18 and older) had a mental illness in the past year. Of these, patients with a serious mental illness defined as any mental, behavioral or emotional disorder that substantially interfered with or limited one or more life activities—numbered 10 million". It is further stated that…"The financial implication of mental health issues are significant for states. Because the presence of mental illness is associated with less, and less effective preventive care and disease management, those with chronic physical health conditions incur higher health care costs than individuals with similar ailments who are not mentally ill". When individuals have co-occurring mental illnesses and substance use disorders, the picture becomes further complicated. Per the PEW Foundation report, "1 in 5 adults with mental illness also had a substance abuse disorder. The increased disease burden created by these coexisting conditions complicates patient care and adds to its cost. Additionally, people with serious mental illnesses die 25 years earliest, on average, than the rest of the population". As stated above, in Illinois, DMH is purchasing services for 20% of the adult population in need and services for 32% of the child/adolescent population in need. Although data are not available for individuals receiving mental health treatment from private sector providers, it is clear that public mental health services are addressing less than a third of the needs of individuals who have a need for mental health services.

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

policies, funding and other factors, Illinois overall mental health utilization rates are substantially lower than the National average. The multi-year report also included utilization/penetration rates per 1,000 population partitioned by race/ethnicity for Illinois versus all states/territories reporting in FY2014. A similar pattern is shown:

Fragmentation of Services

One of the significant strengths of the Illinois mental health system— the diversity of agencies and providers serving adults with mental illnesses and children with emotional disorders—is also a key weakness. Individuals and families must interact with a range of agencies to access services. This fragmentation results in some frustration for consumers, potential duplication of services, increased costs, and interruptions in care. The situation is especially acute for certain groups, including youth transitioning to the adult system of care and individuals with mental health conditions who come into contact with the criminal justice system for lack of more appropriate alternatives.

	Caucasian	Black/African American	Asian	American Ind Alas. Native	Hispanic/Latino Descent
Illinois	9	14.8	2.5	6.6	8.8
U.S.	18.8	34.5	5.3	22.6	17.8

Insufficient resources

Reduced funding for behavioral health services also creates significant gaps in service. Between 2009 and 2012, Illinois experienced a large reduction in mental health funding. The reduction in funding was particularly pronounced for Illinois residents not eligible for Medicaid; in fact, the proposed FY2016 budget eliminates much of this funding. Illinois' decision to participate in the expansion of Medicaid under the Affordable Care Act may provide a safety net. However, overall lack of funding for mental health results in gaps of specific services, such as permanent supportive housing, and for particular groups, such as transition-age youth and individuals currently ineligible for Medicaid. Moreover, the evidence-based practices the state promotes require a significant amount of training, supervision, and monitoring to ensure fidelity to the model, costs which are not reimbursed by Medicaid.

Lack of Consistent Data and Support for its Use

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

development efforts. Across agencies, redundancy and some duplication in data collection and lack of uniformity in data definitions inhibit collaboration.

Workforce Challenges

Ultimately, behavioral health care is only as good as the workforce that provides it. Overall, the health care workforce in America is aging and insufficiently sized and trained to meet the growing demand for integrated physical and behavioral health care. Illinois has made strides in addressing the education of future behavioral health care workers through collaboration with some key universities on graduate and training programs in psychology and social work. The state also has advocated and developed employment for peers, family members, and veterans as service providers. However, there is an overall lack in Illinois, as elsewhere, of such specialists as child and adolescent psychiatrists, advanced practice nurses, physician assistants, and other behavioral health care workers. Workforce members need to be trained to provide trauma-informed, culturally competent services, especially to youth involved in the justice system and returning veterans. Recruitment and retention of a sufficient number of culturally competent/sensitive staff and those with the language proficiencies to meet the needs of the ethnic populations served is also an issue.

The "Prevalence and Access" Gap

Prevalence estimates and access data are gathered and reported yearly and reflect the gap that exists between the probable number of adults in the state with SMI and children/youth with SED and the actual numbers of those receiving services in the public mental health system.

Adults

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

Children and Adolescents

For an estimate of Children and Adolescents with Serious Emotional Disturbance, Illinois has used the 7% estimate provided in the CMHS notice in the Federal Register, Volume 63, Number 137, July 17, 1998 based on the midpoint of the number estimated at the

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

In the next two years Illinois proposes to build on its strengths and address gaps in services to continue the creation of an evidence-based, recovery-focused, consumer- and family-driven system of mental health for the 21st century. Consistent with these expectations, DMH has identified the critical priorities in planning for the next two fiscal years.

B. Planning: Priorities, Goals, Strategies and Performance Indicators

1. Quality and Data Collection Readiness

The DMH utilizes data to support decision making in a wide variety of areas including utilization management, quality improvement activities, resource allocation and planning efforts. As such, data is frequently analyzed and interpreted and utilized for these purposes throughout the year. Information is disseminated to a wide variety of entities in different formats that have been designed to be user-friendly. Through the use of quantitative measures of organizational functioning, comparisons can be made against a standard over extended time or between organizational units. Target levels for the performance indicators provide focus for evaluation and planning.

States must answer the questions below to help assess readiness for CLD collection:

1. **Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).**

The Illinois Division of Mental Health Management Information System was designed to collect information at the consumer level by provider. The data collected has its foundation in data standards developed jointly with SAMHSA's Center for Mental Health Services in collaboration with SMHA data managers, NASMHPD and the NASMHPD Research Institute as well as other mental health system stakeholders.

DMH/ASO Community Reporting System

DMH worked with its Administrative Services Organization (ASO) the Illinois Mental Health Collaborative for Access and Choice to design and develop a comprehensive information system that "went live" in September of 2008. All community mental health

agencies with whom DMH contracts are required to use data standards and specifications developed by DMH and the Collaborative as the basis for submitting data. DMH funded community providers are contractually required to register all individuals funded with any DMH dollars in the DMH/ASO Community Reporting Information System. DMH reporting standards require full reporting of consumer and service data by community providers.

Two primary data systems are used to collect administrative data for individuals receiving DMH funded services. Each system and the type of information recorded and reported are displayed in the table below.

Type of Information	**Information System Used to Collect Data**
Provider Characteristics	DMH ASO Information System; DHS Contracting System
Consumer Enrollment, Demographics and Characteristics	DMH ASO Information System
Admission, Assessment and Discharge	DHS/DMH MIS – Clinical Inpatient System
Services Provided	DMH ASO Information System
Prescription Drug Utilization	DHS/DMH MIS – Clinical Inpatient System – State Operated Hospital Services Only
Service Authorization and Utilization Management	DHS/DMH ASO Information System

2. **Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).**

The Illinois DMH Management Information system was designed to collect information for adults with mental illnesses, children/adolescents with emotional disturbances and individuals with a co-occurring mental illness and substance abuse problem. The latter population must have a mental health diagnosis as their primary diagnosis.

3. **Is the state currently able to collect and report on the draft measures at the individual client level (that is, by client served, but not with client-identifying information)?**

Many of the newly proposed client level measures are (1) outside of the scope of data collected by the state mental health authority and thus are not collected; (2) different than the measures that have been developed and tested in collaboration with SAMHSA, other SMHAs, NRI and other stakeholders over many years or (3) new measures that would require the modification of data collected at the local level and the state level as well as the information systems that capture the data. The newly proposed measures that require the adoption and utilization of tools such as the PHQ-9, or the collection of health related information such as Hemoglobin A1c testing (while important) are not feasible in that they would be costly to implement at the individual consumer and agency/provider level,

and it would be costly for these entities to make information system modifications to collect this data. The reduced morbidity measures focusing on suicidality, cardiovascular disease and ED follow-up would also require the introduction of new data elements. Additionally, the operational definitions for the cardiovascular and the ED follow-up measures are not defined. With regard to measures different than those that are currently collected by SMHAs, it is unclear why SAMHSA wishes to utilize different measures when other more relevant measures exist that are the product of many long hours of work and collaboration. For example, it is widely recognized in the mental health field that the CAPHS survey (1) was not designed for the mental health population, thus many items are too general, and (2) the survey items do not focus on mental health recovery oriented concepts that are important to mental health consumers, their families and the SMHAs who are the purchasers of care. SMHAs and other mental health stakeholders worked for many years to develop the MHSIP Adult Consumer Survey as well as the Youth Services Survey (Family and Youth version) and most SMHAs utilize these surveys. The school attendance measure has long been discussed as an indicator, however accessing valid and reliable data with regard to a child's average daily attendance is not feasible as there is no accessible source for this data, other than a youth or parent's recall. Measures that reflect the work of the mental health field over many years such as education, criminal behavior (number of adults 18 and older who incur new criminal charges while in treatment collected via the MHSIP survey, homelessness and stable housing are generally reportable.

4. **If not, what changes will the state need to make to be able to collect and report on these measures?**

Actual barriers include the following: (1) some measures are out of scope of the SMHA; it is unlikely that the state will collect this data, or instruct providers to implement these measures locally as there are costs associated with new data collection, both operational and political. (2) New measures require costly changes to information systems at the state and local level at a time when the Illinois mental health budget is being reduced and some programs/services are being eliminated; At this point, it is unlikely that dollars will be allocated to modify these systems. (3) Some measures, such as the CAPHS survey, are not appropriate for the targeted population.

Uniform Reporting System

The DMH is prepared to continue submitting data through the mental health Uniform Reporting System (URS) as has been the case for a number of years.

FY 2016-FY2017 PLANNING TABLES

Please note that information about targets for FY2016 and FY2017 is missing from many of the following tables. As we have not as yet obtained substantive data for FY2015 which is identified by SAMHSA as the year for establishing baseline measures, we are unable to project FY2016 and FY2017 data targets at this time.

Plan Table 1.1

1. Priority Area: **Facilitation of an effective array of clinical and support services for adults and children.**	2. Priority Type MENTAL HEALTH SERVICES
3. Population(s) SMI, SED:	
4. Goal of the priority area: *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 available through Medicaid: o Mental health assessment o Psychological evaluation, if recommended, o Treatment plan development, review and modification: o Crisis intervention, o Psychotropic medication administration, monitoring, and training; o Therapy/counseling services o Community support (includes Community Support services for individuals, groups, and families; Community Support residential services and services of Community support teams,) o Assertive community treatment, o Psychosocial rehabilitation o Mental health intensive outpatient, o Case management (includes Mental health case management, Client-centered consultation, and Transition linkage and aftercare) Work with system partners to provide supportive services including: o Educational services, o Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA), o Substance abuse services (through DASA), o Services for co-occurring mental health and substance abuse disorders, o Medical and dental (through DHFS for Medicaid eligible individuals), and o Community Integrated Living Arrangements (CILA) for Adults, and, o Wraparound services (for Children and Adolescents)	
6. Annual Performance Indicators to measure goal success: **Indicator: Number of individuals who receive mental health services.**	
a) Baseline measurement (Initial data collected prior to and during SFY 2015):	
b) First-year target/outcome measurement (Progress to end of SFY 2016):	
c) Second-year target/outcome measurement (Final to end of SFY 2017):	
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:** 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**: None

Plan Table 1.2

1. Priority Area #2: **Promote Provision of Evidence Based and Evidence-Informed Practices**	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s) SMI, SED	
4. Goal of the priority area: *Promote Evidence Based Practices for individuals served in DMH funded agencies and advance the implementation of evidence-informed practices in the child and adolescent service system.*	
5. Strategies to attain the goal: (1) During FY2016 and FY2017, maintain the implementation of Evidence Based Supportive Employment. (2) During FY2016 and FY2017, continue provision of Assertive Community Treatment that meets national fidelity model requirements. (3) By the end of FY 2017, through the provision of rental subsidies, implement a statewide permanent supportive housing initiative which targets an additional 400 consumers acquiring 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 discussed under Priority # 7 – Advancement of Community Integration. (See Plan Table 1.7 below)	
6. Annual Performance Indicators to measure goal success: **Indicator #1: Number of consumers receiving supported employment in FY2016 and FY2017. (National Outcome Measure)**	
a) Baseline measurement (Initial data collected prior to and during SFY 2015):	
b) First-year target/outcome measurement (Progress to end of SFY 2016):	
c) Second-year target/outcome measurement (Final to end of SFY 2017):	
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. DMH is working to promote fidelity in all IPS agencies and thereby expand the database.	
6. Annual Performance Indicators to measure goal success: **Indicator #2**: **Number of persons with SMI receiving Assertive Community Treatment in FY2016 and FY2017 (National Outcome Measure).**	
a) Baseline measurement (Initial data collected prior to and during SFY2015):	
b) First-year target/outcome measurement (Progress to end of SFY 2016):	
c) Second-year target/outcome measurement (Final to end of SFY 2017):	
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:** ACT Teams must meet fidelity standards to be defined as an ACT Team and be reimbursed. ACT data is reported only for those teams. DMH continues work diligently to promote fidelity to the ACT standards and thereby increase the ACT database.

Plan Table 1.3

1. Priority Area: **Use of Data for Planning**	2. Priority Type: 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: Assess access to care by tracking the number of individuals who received treatment partitioned by race, gender and age.	
6. Annual Performance Indicators to measure goal success: **Indicator:** **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 2015):	
b) First-year target/outcome measurement (Progress to end of SFY 2016):	
c) Second-year target/outcome measurement (Final to end of SFY 2017):	
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: 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: None	

Plan Table 1.4

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

(a) Utilize the training and technical assistance provided by the Illinois Center of Excellence for Behavioral Health and Justice to facilitate appropriate responses to the needs of persons with behavioral health disorders who are involved with the criminal justice system. (b) Maintain the Mental Health Juvenile Justice Initiative.
6. Annual Performance Indicators to measure goal success: Indicator #1: **a. Number of technical assistance and training events provided with number of participants.** **b. Number of Illinois counties involved and represented by attendees of the events.**
a) Baseline measurement (Initial data collected prior to and during SFY 2015): N/A
b) First-year target/outcome measurement (Progress to end of SFY 2016):
c) Second-year target/outcome measurement (Final to end of SFY 2017): Target is contingent upon extension of current Bureau of Justice Assistance grant beyond October1, 2016.
d) Data source: Quarterly data reports and descriptions of events gathered and reported to BJA and DMH by the Center of Excellence.
e) Description of data: Agendas for training events. Documentation of technical assistance events (e.g. dates, consultant and individuals receiving TA).
f) Data issues/caveats that affect outcome measures:

6. Annual Performance Indicators to measure goal success: Indicator #2: **Number of youth served by the MHJJ Program statewide.**
a) Baseline measurement (Initial data collected prior to and during SFY 2015):
b) First-year target/outcome measurement (Progress to end of SFY 2016):
c) Second-year target/outcome measurement (Final to end of SFY 2017):
d) Data source: MHJJ Program Data Base maintained by contracted evaluator (Northwestern University)
e) Description of data: Aggregate the number of youth receiving services from the Mental Health Juvenile Justice program across the year that will be compared to data from subsequent years.
f) Data issues/caveats that affect outcome measures: None

Plan Table 1.5

1. Priority Area: **Expansion of the scope of consumer and family participation through advancement of the recovery vision and family driven care.**	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s) SMI, SED OTHER:	
4. Goal of the priority area: *Establish and enhance the public mental health system of care based upon principles of Recovery and Resilience in which consumers and families are knowledgeable and empowered to participate and provide direction at all levels of the system.*	
5. Strategies to attain the goal: **Strategy #1:** Conduct a series of statewide teleconferences designed to disseminate important information to adult consumers and parent/caregivers across the State. **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. **Strategy #3:** Enhance competency and encourage WRAP trained and certified facilitators to provide an increasing number of WRAP® classes in the State. **Strategy #4:** In FY2016 and FY2017, continue to advance Family Driven Care in Illinois by certification of parent providers as Family Partner Professionals.
6. Annual Performance Indicators to measure goal success: Indicator #1: **Number of statewide teleconferences held each year.**
a) Baseline measurement (Initial data collected prior to and during SFY 2015):
b) First-year target/outcome measurement (Progress to end of SFY 2016):
c) Second-year target/outcome measurement (Final to end of SFY 2017):
d) Data source: Document each teleconference event and aggregate by year for comparison across years.
e) Description of data: Teleconference agendas
f) Data issues/caveats that affect outcome measures: None

6. Annual Performance Indicators to measure goal success: Indicator #2: **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 2015:
b) First-year target/outcome measurement (Progress to end of SFY 2016):
c) Second-year target/outcome measurement (Final to end of SFY 2017):
d) Data source: Document each training event and aggregate by year for comparison across years.
e) Description of data: Agenda for each training event held
f) Data issues/caveats that affect outcome measures:

6. Annual Performance Indicators to measure goal success: Indicator #3: **(a) Number of WRAP Refresher trainings offered statewide each year** **(b) Number of WRAP participants each year**
a) Baseline measurement (Initial data collected prior to and during SFY 2015: N/A
b) First-year target/outcome measurement (Progress to end of SFY 2016):
c) Second-year target/outcome measurement (Final to end of SFY 2017):
d) Data source: Training Agendas and attendance sheets documenting participation.
e) Description of data: WRAP Refresher training agendas for each event; Attendance Sheet
f) Data issues/caveats that affect outcome measures: None

6. Annual Performance Indicators to measure goal success: Indicator #4: **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 2015):
b) First-year target/outcome measurement (Progress to end of SFY 2016):
c) Second-year target/outcome measurement (Final to end of SFY 2017):
d) Data source: 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: Reports showing the number of parents certified as FPPs
f) Data issues/caveats that affect outcome measures: None

Table 1.6 Statewide System of Care

1. Priority Area: **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: MENTAL HEALTH SERVICES
3. Population(s) SED, Other:	
4. Goal of the priority area: ***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: (1) Establish and maintain a System of Care Technical Assistance Center for Illinois (STACI). (2) Focus on developing and providing training relative to SOC principles, High Fidelity Wraparound, care coordination, evidence based practices, promising approaches and frameworks, family and youth leadership as well as other topics that support the expansion of the SOC framework statewide. (3) Focus on the development of the SOC Social Marketing Campaign designed to develop educational materials and the forums necessary to inform the statewide service infrastructure and the public about SOC such as an annual SOC conference, SOC education and awareness plans, and ensuring that cross-agency committees and initiatives have the necessary supports to incorporate SOC values and principles into their planning processes.	
6. Annual Performance Indicators to measure goal success: **Indicator #1: 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 and operational as evidenced by the number of FTE staff actively employed and the number of technical assistance events during the fiscal year.**	
a) Baseline measurement (Initial data collected prior to and during SFY 2015): N/A	
b) First-year target/outcome measurement (Progress to end of SFY 2016): TBD	
c) Second-year target/outcome measurement (Final to end of SFY 2017): TBD	
d) Data source: Organization and budget documents; calendar of events-dates, times, and attendance.	
e) Description of data: Number of staff hired and training/TA agendas for events held.	
f) Data issues/caveats that affect outcome measures: Ability to hire staff in a timely way.	

Indicator #2 (FY2016): a. A Director of Training is hired

b. The number of training events held in FY2016 and FY2017 relative to SOC principles, High Fidelity Wraparound, care coordination, evidence based practices, promising approaches and frameworks, family and youth leadership as well as other topics that support the expansion of the SOC framework statewide
a) Baseline measurement (Initial data collected prior to and during SFY 2015): N/A
b) First-year target/outcome measurement (Progress to end of SFY 2016): TBD
c) Second-year target/outcome measurement (Final to end of SFY 2017): TBD
d) Data source: Director of Personnel; Documentation to support training, e.g. agendas
e) Description of data: Number of events on Training Calendar and attendance
f) Data issues/caveats that affect outcome measures: Ability to hire staff in a timely way.

Indicator #3 (FY2016) a. A Director of Communication is hired. **b. The number of meetings convened by this office in FY2016 and FY2017 dedicated to the development of a SOC Social Marketing Campaign designed to develop educational materials and forums necessary to inform the statewide service infrastructure and the public about SOC, an annual SOC conference, SOC education and awareness plans, and ensuring that cross-agency committees and initiatives have the necessary supports to incorporate SOC values and principles into their planning processes.**
a) Baseline measurement (Initial data collected prior to and during SFY 2015): N/A
b) First-year target/outcome measurement (Progress to end of SFY 2016): N/A
c) Second-year target/outcome measurement (Final to end of SFY 2015): TBD
d) Data source: Director of Personnel; Educational material developed
e) Description of data: Staff hired and working; Material developed
f) Data issues/caveats that affect outcome measures: Ability to hire staff in a timely way.

Plan Table 1.7

1. Priority Area: **Advancement of Community Integration**	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s) SMI, SED, OTHER: SMI	
4. Goal of the priority area: ***Complete the successful transition of individuals with diagnosed SMI who are residents of long term nursing homes, from this level of care to the less restrictive settings, ideally, independent living in the communities with appropriate and necessary support services.***	
5. Strategies to attain the goal: By the end of FY 2017, through the provision of rental subsidies, implement the transition of residents from 24 designated nursing homes (statewide) categorized as IMDs to permanent supportive housing - , safe and affordable housing and support services in communities of preference in a manner consistent with the national standards for this evidence based supportive housing practice.	
6. Annual Performance Indicators to measure goal success: **Indicator: 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 2015): 1,306 consumers (cumulative) will be transitioned by the end of SFY2015. Note: Accomplished	
b) First-year target/outcome measurement (Progress to end of SFY 2016): 1,706 consumers (cumulative) will be transitioned by the end of SFY2016. Note: Budget projection	
c) Second-year target/outcome measurement (Final to end of SFY 2017): The number of consumers to be transitioned by the end of SFY2017 is currently unknown as this will depend on the court ruling.	
d) Data source: 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: 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: The Consent Decree should sunset in 2016. This action may continue depending on the negotiations between parties and the court decision.	

Plan Table 1.8

1. Priority Area: **Coordination and facilitation of mental health services for Illinois servicemen, veterans, and their Families (SMVF).**	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s) OTHER Service Members , Veterans, and their Families (SMVF) requiring mental health services:	
4. Goal of the priority area: ***Collaborate with military and state agency partners to improve access to home and community-based mental health services for active service members, veterans, and their families.***	
5. Strategies to attain the goal: a). Develop and maintain partnerships with the Federal Veterans Administration, the Illinois Departments of Veterans' Affairs (IDVA), and Military Affairs (IDMA), and other agencies and organizations meeting regularly to develop, establish and maintain a coordinated system of care.	

b). Develop an inventory of existing behavioral health system providers and services to provide a referral system. c). Build a coordinated crisis service intervention system between the VA and community providers, with special emphasis on suicide prevention. d). Educate and train community providers in military and veteran clinical cultural competence.
6. Annual Performance Indicators to measure goal success: **Indicator #1: The number of collaborative meetings attended by DMH staff representatives that have agendas aimed at completing the strategies and coordination of services.**
a) Baseline measurement (Initial data collected prior to and during SFY 2015): 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.
b) First-year target/outcome measurement (Progress to end of SFY 2016): By the end of FY2016, the number of formal partnerships, IJF BHWG members, and collaborative meetings attended by DMH representatives that have agendas aimed at completing the behavioral health inventory and coordination of services.
c) Second-year target/outcome measurement (Final to end of SFY 2017): 1. By the end of FY2017, the number of formal partnerships, IJF BHWG members, and collaborative meetings attended by DMH representatives that have agendas aimed at completing the behavioral health inventory and coordination of existing services.
d) Data source: 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.

Indicator #2. **The number of Military and Veteran 101 Clinical Cultural Competency Workshops completed during the fiscal year and the number of participants each year.**
a) Baseline measurement (Initial data collected prior to and during SFY 2015): **N/A**
b) First-year target/outcome measurement (Progress to end of SFY 2016):
c) Second-year target/outcome measurement (Final to end of SFY 2017):
d) Data source: Calendar dates of these events and attendance records of each.
e) Description of data: See Above.
f) Data issues/caveats that affect outcome measures: None.
Indicator #3: An Annual Report describing progress of: (1) Partnering with the Federal Veterans Administration, the Illinois Departments of Veterans' Affairs (IDVA), and Military Affairs (IDMA), and increasing the number of other agencies and organizations statewide to address a coordinated system of care. (2) Increasing and expanding the membership of the Illinois Joining Forces (IJF) Behavioral Health Working Group (BHWG). (3) Creating and maintaining a coordinated Crisis Service Intervention System that addresses SMVF needs.
a) Baseline measurement (Initial data collected prior to and during SFY 2015):
b) First-year target/outcome measurement (Progress to end of SFY 2016): By the end of FY2016, a report on the number of formal partnerships, IJF BHWG members, and describes collaborative meetings attended by DMH representatives that have agendas aimed at completing the behavioral health inventory and coordination of services and on the status of the system of care for SMVF individuals citing collaborative accomplishments during the fiscal year.
c) Second-year target/outcome measurement (Final to end of SFY 2017): 0

By the end of FY2017, a report on continued progress which documents increases in the number of formal partnerships, IJF BHWG membership, describes collaborative meetings attended by DMH representatives that have agendas aimed at completing the behavioral health inventory and coordination of existing services, and reports on improvements in the status of the system of care for SMVF individuals citing collaborative accomplishments during the fiscal year. period.
d) Data source: 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.

Plan Table 1.9:

1. Priority Area: **Advancement of the use of interactive communication technology.**	2. Priority Type: MENTAL HEALTH SERVICES
3. Population(s) SMI, SED, OTHER:	
4. Goal of the priority area: ***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: Through FY2017, 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: **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 2015):	
b) First-year target/outcome measurement (Progress to end of SFY 2016):	
c) Second-year target/outcome measurement (Final to end of SFY 2017):	
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: 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: Continued funding	

C. ENVIRONMENTAL FACTORS AND PLAN

1. The Health Care System and Integration

The expansion of Medicaid in Illinois to persons meeting the requirements of the ACA has been accomplished. The Illinois Department of HealthCare and Family Services (IDHFS), as the State's Medicaid Authority, has the continuing mandated responsibility to monitor access to Medicaid services, and the Illinois Department of Insurance is monitoring coverage for mental health services under healthcare reform. Continuing inter agency discussions regarding strategies and mechanisms to monitor the implementation of ACA, evaluate if QHPs and Medicaid are offering sufficient services, and evaluate the consistency of services with the provisions of MHPAEA are taking place, however this responsibility does not fall under the purview of DMH. The DMH does however continue to collect enrollment/registration data for individuals enrolled in various Medicaid managed care initiatives. This data may permit DMH, at some point, to compare the services received by individuals under Medicaid Managed Care and other Medicaid programs to those individuals for whom DMH purchases services. However, DMH has not as of yet been able to retrieve this information.

Most services provided by DMH-funded providers are Medicaid reimbursable, although some services are still purchased through a capacity grant mechanism. Table 1.1 provides a list of Rule 132 Medicaid Mental Health Services purchased by DMH. MHBG Funds are being used only to purchase services not covered elsewhere. These services are not Medicaid reimbursable.

Behavioral Health/Primary Health Integration. The importance of the integration of mental health and substance abuse services with primary health care has continued to be supported and advocated by DMH, DASA (the Division of Alcoholism and Substance Abuse) and HFS. All three entities have collaborated on various initiatives aimed at increasing integration across the state. These include the current Balancing Incentive Program, Screening, Brief Intervention and Referral to Treatment (SBIRT) as well as prior collaboration on an Emergency Room Diversion program and other initiatives. Medicaid managed care programs implemented over the past few years by HFS have also emphasized behavioral health and primary health care integration. Some mental health agencies have demonstrated significant progress toward Primary Care Behavioral Health Integration and have plans that demonstrate expanding their integration across the child and adolescent and adult populations they serve. Screening and referral for prevention and wellness education, health risks, and recovery supports are largely dependent on the policies and practices of individual provider agencies. This information is not collected at the state level. However, the DMH Office of Recovery Support Services reviews and monitors the level of support for recovery across agencies statewide, and advocates for employment of

CRSS credentialed staff and the use of non-credentialed individuals with lived experience to provide peer support.

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

Primary and Behavioral Health Integration Summit: DMH, in collaboration with the DHS Division of Alcohol and Substance Abuse (DASA), the Illinois Department of Healthcare and Family Services (IDHFS), and the Illinois Department of Public Health (IDPH planned and convened a successful summit a few years ago. This one day event "**"Beginning the Conversation: A Statewide Policy Summit on Advancing Bidirectional Behavioral Health and Primary Care Integration"** served to jump-start interest, discussions, and strategic planning among primary care and behavioral health providers and policymakers.

Additional activities in this arena are:

- The Williams vs. Quinn Settlement is resulting in an effort to provide optimum services to members of the class who are transitioning to the community from long term care and require primary health care and medical treatment.
- DMH continues to explore and emphasize options for more extensive collaboration with Health Resources and Services Administration (HRSA) funded Federally Qualified Health Centers (FQHCs) particularly in rural areas where the integration of services offers greater access for rural residents.
- DMH continues to emphasize the importance of assisting adult consumers in the completion of applications for Medicaid benefits as individuals with serious mental illnesses who are Medicaid recipients are entitled to the range of health services covered in the Illinois Medicaid plan.
- DMH, DASA and HFS recently collaborated on the submission of a SAMHSA planning grant for Certified Community Behavioral Health Clinics that includes a focus on behavioral/health primary health integration.
- DMH is working with HFS on a State Innovation Model Planning Grant focusing on behavioral health/primary health integration.

Medicaid Expansion: Legislation enacted by the Illinois General Assembly and signed by the Governor in July 2013 expanded Medicaid coverage to persons below 138% of the Federal Poverty Level. Coverage became available to adults with annual income below 138 percent of the federal poverty line, which is $15,860 for individuals and $21,408 for couples. The measure was expected to enroll 342,000 people by 2017. Prior to this, Medicaid was only available to children, their parents or guardians, adults with disabilities or seniors. Enrollment for the newly eligible population began on October 1, 2013 with coverage starting on January 1, 2014

Integrated Care Program: DMH worked with DHFS to pilot an integrated managed care system which has been implemented in Suburban Cook County and adjacent counties in the Chicago Metropolitan Area (not including the City of Chicago) that

includes behavioral health with primary health care. Medicaid AABD (aged, blind and disabled) recipients are being placed into a managed care arrangement with vendors who will be implementing a fully integrated service delivery system.

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

2. Health Disparities

Enrollment/registration data collected by DMH includes race, ethnicity, gender, age, the primary language spoken by individuals accessing services and whether the individual requires an interpreter to receive services. LGBTQ status is not currently collected, but we will determine if/when this data can be incorporated into the state information system. DMH providers submit information as part of their agency profile with regard to the languages spoken by agency staff. DMH providers are required to submit claims for all DMH purchased services provided to enrolled/registered individuals. A special code has been developed to track individuals and services provided to individuals for which oral interpretation (translation) and sign language is required to provide appropriate services to individuals accessing treatment. A report is produced annually showing the language of individuals accessing services and the languages spoken by agency staff. This information provides DMH staff with a means of monitoring the extent to which there is a match between the specific primary languages spoken by clientele served by the agency and agency staff and where disparities may exist.

DMH continues to actively monitor access to services partitioned by race, ethnicity, gender, age, and the match between primary language spoken by individuals accessing services and agency service staff. When disparities are identified, DMH can initiate planning to address these issues. One of the primary goals of DMH strategic planning is assuring that vendors providing mental health services are culturally and linguistically competent or at least minimally culturally and linguistically capable. A two-pronged strategy thus addresses disparity issues---one centered within the SMHA and one at a broader mental health services system level. DMH will need to have further discussion with regard to how mental health block grant dollars will be used to address these issues.

The state also requires all vendors to develop cultural competency plans to "comply with Title VI of the Civil Rights Act of 1964, Americans with Disabilities Act of 1990, Americans with Disabilities Act Amendments Act of 2008, Illinois Human Rights Act,

the 1970 Constitution of the State of Illinois and any laws, regulations or orders, federal or state, which prohibit discrimination on the grounds of race, sex, color, religion, national origin, age, ancestry, marital status, disability, or the inability to speak or comprehend the English language".

3. Use of Evidence in Purchasing Decisions

Evidence Based Practices are emphasized in purchasing and policy decisions. DMH regional staff work closely with provider agencies and are responsible for tracking and disseminating information about Evidence Based Practices (EBPs). As noted elsewhere in this plan, there are three EBPs being implemented on a statewide basis in Illinois. The provision of evidence-based supportive employment through the Individual Placement Services (IPS) model, Assertive Community Treatment (ACT), and Permanent Supportive Housing (PSH) are being consistently tracked. DMH policy requires adherence to national fidelity standards for EBPs and purchasing decisions are largely made in reference to local needs and the capacity of provider agencies to provide services at the level of fidelity required. DMH has used information about EBPs and fidelity standards educationally in working with partner agencies, such as IDHFS, the State Medicaid agency, in revising the Illinois Medicaid Rule accordingly. Services are purchased either directly or indirectly to maintain the EBP or to build provider capacity to meet fidelity standards and increase service delivery.

Purchasing decisions made in the past few years regarding the provision of ACT demonstrate this process. DMH closely monitors agencies that have ACT teams to ensure fidelity to the ACT model. As a result, some agencies that determined that they did not have the capacity to deliver the evidence-based ACT model, chose to adopt the step-down model of the Community Support Team (CST) instead. If teams do not meet fidelity standards, they are not reimbursed for delivering the Evidence Based Practice. Agencies not meeting fidelity for ACT must provide alternative modalities for less reimbursement. The number of persons served by ACT teams has substantially increased (by 30%) in the past few years. At the end of FY2014 there were 21 ACT teams in Illinois which were reviewed in FY2015 using a tool with standards based on the Dartmouth tool and the state Medicaid rule.

The following value based purchasing strategies are used in Illinois:

- Leadership support, including investment of human and financial resources.
- Use of available and credible data to identify better quality and monitor the impact of quality improvement interventions.
- Provider involvement in planning value-based purchasing.
- Gaining consensus on the use of accurate and reliable measures of quality.
- Quality measures focused on consumer outcomes and also on process issues and care

- Statewide teleconferences to educate consumers and empower them to select quality services
- Emphasis on quality as a priority across the entire state infrastructure.
- Ongoing assessment of the impact of purchasing decisions.

4. Prevention For Serious Mental Illness

Although there has been increasing interest in early identification of schizophrenia and other psychotic disorders in Illinois, special funding allocated for this purpose has only become available in SFY 2015 to provide limited services to persons presenting with psychosis for the first time. Interventions for individuals identified at clinical high risk (CHR) or at risk mental state (ARMS) have largely been limited to persons so identified who are insured sufficiently or are able to afford receiving treatment that would benefit them. There are no specific programs in Illinois to address this need. However, the current national interest in treating persons with First Episode Psychosis initially utilizing the 5% Set Aside in block grant funding may serve to improve the recognition of prodromal symptoms and support the design of programmatic intervention based on recent research.

5. Evidence–Based Practices for Early Intervention (5 Percent Set-Aside)

DMH has planned to engage consultants with expertise in the treatment of First Episode Psychosis and coordinated specialty care team model to obtain consultation on program design considerations and the feasibility of implementing the model in a manner that meets the needs of individuals with FEP and results in successful outcomes. Key issues to be addressed in consultation are the diagnostic categories associated with FEP, planning for the integrated use of IPS and ACT with a team approach for persons with FEP versus embedding individuals with expertise working with the FEP population on existing teams, sustainability, outreach and education, and site selection. Data collection for planning has focused on tracking those persons with FEP who enter the public service system and have been funded through GRF capacity grants. Consultants will also be used to assist DMH in identifying training needs of providers with whom the DMH contracts and to plan for implementation of the model based on the results of the feasibility assessment. Limited on-going consultation may continue to be necessary. Initial consultation at the state and provider levels is currently being planned with the BeST Center at NEOMED in Ohio and the Portland State University EASA Center for Excellence in Oregon. However, the current budget impasse (e.g. no state FY 2016 budget) has resulted in postponement of the consultation planned in August due to all expenditures being at a standstill without a budget appropriation and the mechanisms to pay.

Illinois has had an interest in individuals who experience a first psychotic break for a number of years as evidenced by the creation of a service benefit package in 2011 to address these individuals' needs. Due to budget reductions and limited funding for individuals who were not Medicaid eligible, the benefit package for those individuals was limited to primarily case management, medication and some assessment services.(Benefit packages are not included in the proposed budget for FY2016.) Individuals who are enrolled in Medicaid meeting the criteria for first psychosis have had access to the full range of services in the DMH state Medicaid plan which includes team services such as Assertive Community Treatment, Community Support and Individual Placement Services when they meet medical necessity criteria for these services. However, the focus outside of individual treatment plans has not been on the development of team services to provide early intervention services to this population. The availability of dollars to address this population's needs is both exciting and timely.

Weekly planning meetings have been convened with key DMH management staff to discuss the possibilities and options for implementing an evidenced based approach to early intervention for persons who present with First Episode Psychosis using information provided by SAMHSA. Although Illinois has not been involved in NIMH RAISE research projects nor in substantive discussions regarding team–based approaches to serve this population, consensual validation of the CSC approach as an impressive and exciting new development has led to focused discussion of whether and how it might best be implemented in Illinois.

The following points reflect the direction of our current planning:

- Focusing on older adolescents, college age youth, and younger adults aged between16 and 35 who experience FEP.

- As a prerequisite for effective planning and implementation, state level consultation and training will be required as well as statewide education for mental health providers and stakeholders and more targeted intervention for agencies that will work with DMH to implement this model.

- DMH is considering the use of set aside dollars to establish two teams in areas of the state with greater incidence of FEP and with the population bases sufficient to provide a reasonable number of clients with FEP. Of additional concern is addressing areas and populations with limited access to treatment.

- Preferable locations will be those communities with larger universities that have concentrations of College Age Youth who are most likely to have experienced first episodes and would require immediate early intervention. Areas in which services are generally limited for transition age youth and young adults will be appropriate as a nucleus for building better systems of care to address this population.

- Providers who have ongoing IPS programs and established experience with ACT and Community Support Team services are considered preferable sites.

DMH will build in an evaluation component when planning the implementation of services for individuals with FEP. Data collection thus far, has focused on identification of these individuals.

6. Participant Directed Care

DMH has not been able to introduce voucher and self-directed programs largely due to non-availability of funding and the lack of the infrastructure required for effective implementation. To demonstrate some efficacy in this venue, pilot projects and studies are required for Illinois stakeholders to buy into this approach. Funds for this have simply not been available.

7. Program Integrity

The Division of Mental Health has a long history of targeting the use of mental health block grant dollars to purchase services for individuals who are uninsured and toward the purchase of services that are non-Medicaid reimbursable. Continuing capacity for purchasing mental health services covered under the state benchmark for the uninsured population will need to be evaluated as state projections regarding the uninsured population are finalized and as the budgets for FY2016 and FY2017 are established for the use of general revenue funds to purchase services for these individuals. Although Mental Health Block Grant funds have historically been utilized to serve this population, it is estimated that the $17 million dollars allocated to Illinois alone will not be sufficient to cover full service provision.

All DMH vendors are required to register/enroll all individuals for whom services are purchased using DMH dollars. DMH contracts require vendors to utilize dollars associated with specified funding streams for specific services. Information regarding family and individual income and household size are required data elements. The use of block grant dollars is governed by contracts, called Community Service Agreements, that are executed with each provider with whom the Division contracts. The contracts clearly state the service for which block dollars are allocated and the rules for reporting expenses associated with the services purchased.

The state has a number of individuals that are responsible for program integrity activities:

- DMH Fiscal Services is responsible for receiving expenditure reports with regard to how contracted vendors expense block grant dollars. All DMH vendors are required to submit audited financial reports to the DMH on an annual basis.
- DMH clinical and community services staff are responsible for developing policy with regard to the services purchased from DMH vendors.

- Decision support staff develop policy with regard to the reporting of services purchased from DMH vendors.

DMH program integrity activities are largely conducted at the regional level and include:

- budget reviews,
- claims/payment adjudication
- analysis of expenditure reports and reconciliation of expenses,
- compliance reviews,
- review and evaluation of narratives on the use of funds and process issues encountered at the client level, and,
- providers are required to complete an annual audit.

The fundamental payment method employed for persons who are not enrolled in Medicaid and are uninsured have been fee-for-service to purchase a limited package of services and capacity grants to providers based upon client service data reports and projections. (These grants from state funds have been largely eliminated in the currently proposed budget.) DMH also develops logic models and projected outcomes to determine payment methodologies and needed funding to tailor service programming. This method was employed in redistributing funding to the community from the recent closure of a state hospital. The service needs of consumers who ordinarily presented for hospitalization were identified, programming and costs were assessed, and funding was allocated to meet a range of needs. This approach proved to be very successful and is anticipated in relation to future payment methodology.

DMH assists providers in meeting compliance standards through the use of a comprehensive Provider Manual that is posted on the DHS/DMH Website and is periodically reviewed and updated. Agencies are visited and monitored for compliance on a regular basis. Consultation is provided as part of post-payment review processes with providers, focused technical assistance may be offered, and findings may result in requests for recoupment of funds as appropriate and necessary. Additionally, DMH requires all providers to be certified and accredited through a nationally recognized accreditation organization.

DMH requires that coordination of benefits be applied to all individuals accessing DMH purchased services. Under this requirement, vendors must obtain and report third party liability benefits that apply to an individual. DMH dollars are thus to be used as "last resort dollars" which essentially means that individuals who are insured are expected to use their insurance benefits to cover the provision of services. Although DMH utilizes a sliding fee scale to determine the amount that providers may be reimbursed for all non-Medicaid eligible individuals, the reimbursement is dependent upon household income and size. DMH works collaboratively with the Department of Healthcare and Family Services (HFS), the Illinois Medicaid Agency, to determine Medicaid eligibility at the level of the individual consumer. Medicaid billable services are thus reimbursed using federal dollars and state match dollars to purchase services for these individuals.

A Utilization Management (UM) Program ensures that individuals being served receive the services best suited to support their recovery needs, satisfy their preferences, are cost effective, consistent with medical necessity criteria and evidence-based practices, and provided in the most appropriate treatment setting. A "Thresholds Model" is employed for the following services: therapy/counseling, psychosocial rehabilitation and community support group. DHS/DMH requires clinical review and authorization when the number of services received by an individual exceeds the 75th percentile as compared to all users of that service statewide. This means that at least 75% of existing consumers are not expected to require authorization for their services because their utilization, based on historical patterns, will not exceed the clinical review threshold. Thresholds are the same for adults and children/adolescents and are calculated by provider and consumer per fiscal year. An example of a current threshold is that authorization is required to continue to provide Therapy Counseling to a specific individual beyond 10 hours in a specific fiscal year. Providers are required to obtain authorization prior to receiving reimbursement for services delivered to consumers beyond the specified thresholds. Authorization for reimbursement is made based upon medical necessity. The DMH has required pre-authorization of Assertive Community Treatment and Community Support Team services for a number of years.

Utilization Management for Services Purchased Using Block Funds

MHBG dollars are largely directed to support residential services which are not reimbursable Medicaid services. Currently, a mechanism is in place to track the allocation of funds for this service and providers are required to submit reporting for some activities associated with it. While DMH has worked toward improving and enhancing the mechanisms that are in place to better track this data, the continuously changing fiscal and service environment may require some necessary and appropriate shifting and reallocation of block grant funds within guidelines established by SAMHSA. The primary expenditure of MHBG dollars is to reimburse non-covered services. The collection of performance and outcome data in this regard is supported through state funding.

8. Consultation with Tribes

This section is not applicable. Illinois has no Tribal reservations within its boundaries. Primary health care, community health and mental health services are provided to medically underserved members of federally recognized American Indian Tribes and family members residing in the City of Chicago area by the American Indian Health Service of Chicago, Inc. This agency, incorporated in 1975, operates as a non-profit charitable organization and is not funded through DMH. Further information may be obtained from the agency's Website at www.aihschicago.org .

9. Primary Prevention for Substance Abuse

This section is not applicable to the MHBG. This section will be addressed in the SABG submission by the DHS Division of Alcohol and Substance Abuse (DASA).

10. Quality Improvement Plan

The DMH Quality Improvement Mission and Vision has been described in previous applications. A description of the Division's Quality Improvement Mission and Vision as well as the mechanisms employed to assure quality is again described below.

Quality Improvement Mission and Vision
The Division of Mental Health Quality Management Committee serves as the primary point of contact for communication and planning in respect to Quality Assurance and Continuous Quality Improvement. The Quality Management Committee works with Division staff to assess the degree to which the Division meets requirements; recommends actions to bring the Division into compliance with requirements, and recommends actions that will improve the Division's ability to meet its requirement.

The core values and concepts of continuous quality improvement include continuous assessment of key activities with an eye toward improving processes and outcomes, consumer service and focus, decisions based on facts, data and analysis, employee involvement/empowerment and teamwork. The Quality Management Committee partners with the various units within the Division to ensure that stated needs, issues and concerns are addressed. The Quality Management Committee reviews and provides advice related to various quality improvement work products and engages in problem-solving to resolve issues and risk where needed. The Committee lends support to units within the Division to ensure successful implementation of continuous quality improvement efforts and ensure quality of service delivery.

Quality Reviews, Standards and Provider Audit Requirements
Quality standards and provider audit requirements are defined by Illinois Administrative Code (Title 19, Part 507). Quality improvement and program and financial decision-making rely on relevant, accurate data and insightful planning based on reliable data sources. A necessary and important ingredient of any system established to support management and program improvement activities is a system of monitoring and accreditation. The system for monitoring community providers includes the following activities:

- Certification Reviews: Performed by the DHS Bureau of Accreditation, Licensure, and Certification (BALC). These reviews verify that the sites and services of providers are meeting standards for Medicaid certification. These reviews are performed at least every 3 years, more often if significant findings are discovered in an earlier review.

- Clinical Practice and Guidance Reviews: Provided annually as a DHS/DMH collaborative effort to guide providers in meeting best-practice standards, including recovery principles.

- Fidelity Reviews: A review by DHS/DMH providing feedback to providers on fidelity to specific service definitions, with the goal of ensuring that providers are maintaining fidelity and identifying areas that need improvement.

- Post-payment Reviews: A review of Medicaid and Non-MCO services following payment of services billed examining documentation, including medical necessity for such services. This review is provided by the Collaborative. Findings resulting in a request for recoupment are subject to an appeals process.

Monitoring reviews are followed by an exit conference in which results are shared with managers of the programs reviewed. The DMH regional staff respective to the provider reviewed and other DMH staff also receive monitoring review results. Tools and protocols regarding reviews are available on the DMH Web site. Agencies with identified deficits are expected to develop corrective action plans which are then monitored by DMH regional staff.

Performance Measurement
Data is used for monitoring and the results are shared with a range of stakeholders. National Outcome Measures (NOMs) and other performance data are incorporated into the DMH quality improvement plan as reports reflecting the performance of the total system are produced. When there are challenges meeting performance targets, a more specific and detailed analysis of data elements and processes is performed to determine the causes of the problem. Determining the problem then leads to finding a solution. A similar process is used to address situations wherein performance targets are routinely exceeded.

The DMH regularly produces reports reflecting service trends, system performance, and financial status. The use of surveys reflecting views of consumers and caregivers is an important element in improving services and service delivery. The DMH website and The Collaborative website includes links regarding conferences, presentations, training, registration/enrollment requirements and issues, financial issues, monitoring tools, and clinical issues, among them utilization management.

The Division has developed a number of state specific indicators and measures that are regularly monitored and reviewed. The National Outcome Measures have been incorporated into this process. Many of these indicators and measures are described in the priorities, goals and indicators section of this application.

11. Trauma

Currently DMH encourages providers to seek out education and training in the

treatment of post-traumatic stress disorders, to provide trauma–informed care, and to develop appropriate screening tools and referral mechanisms. However, DMH does not have any written policies in reference to these issues. Statewide implementation would require substantive funding which is not currently available.

Trauma Initiatives

Consistent with Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Core Measures, beginning in 2009, a trauma screening is administered upon admission to any DMH hospital. Results of this screening are incorporated into an individualized Personal Safety Plan that identifies potential triggers for the re-experience of trauma as well as types of interventions likely to be most helpful and effective. DMH hospitals have also adopted the trauma sanctuary model, which establishes a therapeutic milieu for information sharing, communication and problem solving.

Juvenile Justice

The DHS/DMH Juvenile Forensic Trauma Program, initiated in 2008, offers therapists who provide evidence-based, trauma-specific services to youth involved in the juvenile justice system consultation and provides the needed training and consultation to system partners to create an environment that is more trauma-sensitive and trauma-informed. Juvenile Forensic Trauma therapists are providing these evidence-based trauma services at two Illinois Youth Centers (Warrenville and Chicago) through Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), a cognitive behavioral-based treatment with demonstrated efficacy in helping adolescents recover from a variety of traumatic experiences. Juvenile Forensic Trauma therapists also provide training to the facility staff in the areas of adolescent development, trauma and adolescent brain development. This training is being provided to all staff at each of the sites.

Service Members, Veterans, and their Families

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, both DMH and DASA are working to improve partnerships 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 proposed grants, DASA is seeking to provide substance abuse treatment and/or recovery support services to at least 200 returning Illinois National Guard members and to increase treatment outreach efforts to engage teens with substance abuse problems and who either currently have or have had a deployed parent. 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.

During FY2013 and FY2014, 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 FY2015, DMH has participated in the formation and implementation of the Illinois Joining Forces Initiative and the legislative process that created the Illinois Joining Forces Foundation, Public Act 098-0986, which became effective on 8/18/14. DMH has chaired 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 the training has been primarily in Behavioral Health, specialized events in 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 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)

In 2008, the Illinois Legislature enacted Public Act 095-0576 directing the Department of Veterans Affairs, in consultation with the Department of Human Services, to contract with professional counseling specialists to provide a range of confidential and direct treatment services to veterans. 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.

Public Act 095-0576 also directed the Department of Veterans Affairs, in consultation with the Department of Human Services, to:

- Develop 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.
- Provide 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.
- Provide veterans' families with a referral network of providers skilled in treating deployment stress, combat stress, and post-deployment stress.

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

12. Criminal and Juvenile Justice

DMH Forensic Services oversees and coordinates the inpatient and outpatient placement of adults remanded by Illinois County Courts to the Department of Human Services under the 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). Inpatient services are provided at 5 state hospitals with secure forensic Units. The average forensic census in FY14 was 663, with an average of 270 individuals in unfit to stand trial (UST) legal status and 393 individuals in Not Guilty by Reason of Insanity (NGRI) or extended UST (USTG2) legal status. In regards to non-mandated justice involved individuals with behavioral health needs, DMH has also been centrally involved in several key programs and initiatives that have impacted large numbers of justice involved individuals including the Jail Data Link Program, the Cook County Community Reintegration Initiative (CRC), the Veterans Reintegration Initiative (VRI), the Transformation Transfer Initiative, the Illinois Mental Health Court Association, and the Illinois Center of Excellence for Behavioral Health and Justice. All these efforts of DMH in working with both the forensic and justice involved population involvement have laid the groundwork for a more comprehensive and effective system of care and treatment that stresses best practices, recovery, diversion, and appropriate use of inpatient and community resources.

Individuals involved in the criminal and juvenile justice systems who qualify are currently being enrolled in Medicaid by both the Illinois Department of Corrections and the Illinois Department of Juvenile Justice. Coordination with the criminal and juvenile justice system is ongoing and includes planning around diversion issues, support for mental health services in correctional facilities, and addressing the needs of individuals re-entering their communities. Some of the services provided to this population include: Assertive Community Treatment, MISA services (treatment for co-occurring mental illness and substance abuse disorders), and IPS (supported employment). Permanent

supportive housing, and residential placement may be considered for some individuals who need access to these services. Current projects that DMH Forensics is working on include: (1) Forensic System Building regional workshops to improve the quality of collaboration; (2) Creating a state–of-art data base for mental health courts.

Jail Data Linkage Project An innovative initiative referred to as the Jail Data Linkage Project that 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 was initiated in 1999. This initiative was based on findings published by the Bureau of Justice Assistance and other national experts who found that 6.1% of male and 15% of female detainees in the Cook County Jail, suffered from mental illness. The cross match between DMH records and jail census data is based on an automated match between the two data sources which is performed on a daily basis.

In FY2014 Data-Link identified over 95,000 new jail bookings. Of this number, 16,000 were identified as having a case at one time opened with the Division of Mental Health. Unfortunately, very few of those identified were linked due to the lack of funding for case-management services and reduced community capacity to serve this population which has high numbers of individuals that do not have health benefits in place. The Jail Data Link database also interfaces with the Mental Health Court database and is utilized for identification of eligible Mental Health Court clients by virtue of booking/diagnosis and treatment information provided. FY2014 data reflects that nearly 90% of all those eligible for linkage through JDL were actually linked and 45% of those linked were engaged at the end of 30 days. Public Act 96-0872, introduced in August 2012, has allowed (in certain instances) detainees to maintain their Medicaid Benefits for 30 days and possibly longer depending on benefit packages. This provides significant support for many consumers identified by Jail Data Link who lost their Medicaid funding or were closed by the community agency providing services when they were detained. The current budget for this program is $180,000.

The Illinois Center of Excellence for Behavioral Health and Justice (the Center), referenced above**,** became operational in June of 2012. The mission of the Center is to equip communities to appropriately respond to the needs of persons with behavioral health disorders that are involved in the criminal justice system. A key component of this mission is enhancement and development of Problem Solving Courts through technical assistance, consultation, training, and information dissemination. The Center has determined that there are 84 problem solving courts across Illinois judicial circuits. These courts include 21 mental health courts, 46 drug courts, 14 veteran's courts, 1 youthful offender court, and 2 courts addressing women's issues. The Illinois Center of Excellence for Behavioral Health and Justice also provides training to a variety of entities on a wide range of topics. For example, the Center provides training to problem solving courts, and to IDJJ staff on trauma-informed care. Issues relevant to conditional release and recovery, trauma, and cognitive behavioral approaches (for residential providers), and on mental health treatment models for correctional inmates have also been a focus of training.

Mental Health Courts. Problem-Solving Courts, such as mental health courts and drug courts, are comprised of teams of specially trained judges, attorneys, probation officers, and clinical specialists who provide wrap-around services and intensive monitoring of defendants who are in the criminal justice system as a result of substance abuse, mental health, or co-occurring disorders. Mental health courts move beyond the criminal court's traditional focus on case processing to address the root causes of behaviors that bring people before the court. These courts work to improve outcomes for all parties--the individuals charged with crimes, their victims, and their communities. Mental health courts, for certain defendants with serious mental illnesses, are specialized dockets that employ a problem-solving model for traditional criminal court processing. Participants are identified through mental health screening and assessments and voluntarily participate in a judicially supervised treatment plan developed jointly by a team of court personnel and mental health professionals. Adherence to the treatment plan or other court conditions is rewarded, non-adherence may be sanctioned, and success or graduation is defined according to predetermined criteria. The goals of mental health courts are increased public safety for communities, increased treatment engagement by participants, improved quality of life for participants, and more effective use of resources for communities. A study found that mental health courts meet the public safety objectives of lowering post-treatment arrest rates and shortening periods of incarceration. Both clinical and criminal justice factors were found to be associated with these outcomes.

Cook County has a network of seven courts are post adjudicatory probation mental health court programs which target felony non-violent offenses, many of which are felonies resulting from repetitive criminal activity. These courts facilitate compulsory medical, psychiatric and substance abuse treatment through a sentence of Mental Health Court Probation (usually 2 years) as an alternative to incarceration in the Illinois Department of Corrections. The probationer is required to comply with the recommendations by the Mental Health Treatment Court team which include participation in specified evaluations and treatment programs, compliance with medication prescriptions, reporting to probation (weekly decreasing to monthly as ordered), appearing in Court as ordered, and participating in any vocational, educational or job training program as directed. Since the inception of these courts, a total of 779 defendants have been admitted and provided with comprehensive treatment services. Of the 572 cases finally disposed by June 10, 2015, 264 (46%) defendants were successfully terminated. At that time, there were 207 active participants in Cook County's Mental Health Courts.

These courts and other diversion initiatives are the results of effective partnerships and collaborations that includes consumers, family members of consumers, treatment providers, law enforcement and correction professionals, legal personnel and members of the judiciary. Working together, they help to integrate the effective elements of the mental health, substance use systems and criminal justice systems.

Transformation Transfer Initiative Grants. Illinois applied for and received a third Transformation Transfer Initiative (TTI) grant in FY2013 that provided $220,000 in

funding for forensic community projects including: (1) the development of a Problem Solving Court Integrated Database, (2) forensic process cross training for courts, sheriffs, and DMH hospital forensic staff; and, (3) forensic and recovery based training for staff providing residential care in the community.

Juvenile Forensic Programs

Mental Health Juvenile Justice (MHJJ) is a DHS funded initiative to help identify community services for minors who have severe mentally illnesses being released from juvenile detention centers. This project is overseen through the DHS/DMH Forensic Services Program. 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. 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). Next, the liaison identifies funding sources. MHJJ is funded from the state general revenue funds. DHS provides funding to the community agencies, with most agencies receiving funding for one liaison. MHJJ began at seven pilot sites in 2000 and has expanded to all Juvenile Detention Centers in Illinois. Since FY2007, DHS has been funding liaisons in 21 community agencies servicing 34 counties. In addition MHJJ also funds juvenile justice mental health re-entry liaisons that provide linkage and case management for youths exiting Illinois Youth Centers in the Department of Juvenile Justice. Similar to the MHJJ model, the IYC liaison links youth to appropriate services in their home communities and provides ongoing monitoring for a period of six months. 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 is expanding its eligibility criteria to include youth who are "at risk" of coming into contact with the criminal justice system. This expansion includes: (1) Youth who are wards of the Illinois Department of Children and Family Services (DCFS) that have become justice involved who otherwise meet eligibility criteria and need the kind of services and monitoring, particularly 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) that were not getting services and/or any type of intervention that could divert them from becoming more involved in the criminal justice system. (3) Youth with trauma histories/symptoms that have come into contact with the justice system or are at risk for such in keeping with the growing concern over how trauma has impacted many youth (with and without mental illness) in the juvenile 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. Many of the agencies had 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 **Juvenile Justice Mental Health Re-Entry** program also responds to the dilemma of the increasing number of youth in the juvenile justice systems who suffer from serious mental illnesses. Youth incarcerated at any of the eight Illinois Department of Juvenile Justice (IDJJ) Facilities who display the symptoms of a serious mental illness or who have a severely mentally ill diagnosis may be referred to the program which provides evaluation, referral, linkage, case management and advocacy services to them as they prepare to re-enter their community. The JJMH-R program services all 102 Illinois counties and provides linkage and transition to youth in all the IDJJ facilities. Eligibility requires that youth are ages 13-17, have a serious mental illness and exiting an IYC on probation or parole.

13. State Parity Efforts

Mental Health Parity in Illinois

In August 2011, the Governor signed the Illinois Behavioral Health Parity Law that brought state law into line with the federal MHPAEA requiring mental health coverage to be comparable with other physical health coverage. This law added addiction health care and autism health care to the definition of behavioral health care and is applicable to any plan of a small employer (with 2-50 employees) as well as larger employers required by federal law.

Insurance companies in Illinois must now provide the same coverage for mental health and substance abuse disorders that they provide for all other conditions. Insurers are prevented from including additional barriers within the policy – such as financial requirements, treatment limitations, lifetime limits or annual limits – to treatments for mental, emotional, nervous, and substance abuse disorders if no such stipulations exist for other health conditions. Illinois' new law exceeded the requirements of the federal mental health parity law, and was recommended by the Governor's Health Care Reform Implementation Council.

The Illinois Behavioral Health Parity Law:

- Added substance use disorders to the list of mental illnesses covered by the parity law
- Added that medical necessity criteria with regard to substance use disorders will be determined in accordance with criteria established by the American Society of Addiction Medicine.
- Required insurers to cover treatment for Substance Use Disorders in a residential facility
- Prohibited non-quantitative treatment limitations that are not used on a comparable basis for medical surgical benefits

- Provided that lifetime limits on coverage can only be applied to mental health benefits if lifetime limits are also imposed on medical-surgical coverage and such lifetime limits are imposed in the same manner to mental health benefits as medical-surgical benefits; and that annual limits on coverage can only be applied to mental health benefits if annual limits are also imposed on medical-surgical coverage and such annual limits are imposed in the same manner to mental health benefits as medical-surgical benefits.
- There can be only one deductible.

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

14. Medication Assisted Treatment

This section is not applicable to the MHBG. This section will be addressed in the SABG submission by the DHS Division of Alcohol and Substance Abuse (DASA).

15. Crisis Services

Illinois is well aware of the importance of crisis services for individuals with mental illnesses and their families. The array of services purchased by DMH includes crisis intervention as well as capacity grants for staffing to assure the availability of such services. As reported in other sections of this application, Illinois has been a leader in the implementation and adoption of Wellness Recovery Action Planning. There is also a tacit understanding that individuals have in place Psychiatric Advanced Directives that provide instructions with regard to actions to be taken in the event that an individual needs to rely on a trusted individual to make decisions regarding psychiatric care on their behalf. DMH implemented peer operated warm lines through its contract with Beacon-Value Options approximately seven years ago. The individuals operating these lines speak with literally thousands of individuals in a year. Policies and procedures determine when referrals to treatment are necessary and should be made. As also reported in another section of the application, DMH staff collaborate constructively with DPH on the annual Illinois Suicide Plan.

With regard to crisis stabilization, several DMH funded providers have implemented living room models, and DMH also purchases crisis residential beds for those individuals requiring these services. DMH has also been a leader in terms of working with law enforcement entities around CIT and working with individuals with mental illnesses. NAMI Illinois has put into place family to family programs and has supported these activities over the years.

DMH also understands the importance of working with Emergency Departments with regard to individuals with mental illnesses in crisis situations who present for treatment.

DMH crisis intervention funding may be used by contracted providers to provide crisis intervention services to individuals who present at Hospital Emergency Departments. Targeted funding in two areas in which DMH hospitals were closed over the past few years was allocated to assure continued access to crisis intervention services in Emergency Departments as well as other locations, and to assure availability of crisis residential and substance use residential services as well as community based services (e.g., acute community services) to individuals presenting with a crisis. These dollars were allocated in additional to the traditional crisis care services described previously.

16. *Recovery*

The DMH vision is that the expectation is recovery. This vision and the mission of the Division are derived from recovery-based values. As such, the provision of mental health care that is consumer and family driven is an important priority of the Illinois Division of Mental Health. This priority is consistent with the current emphasis on involving consumers and families in orienting the mental health system towards recovery, and to improve access to, and accountability for mental health services. DMH continues to work within a constricted financial environment in which the resources required to fully actualize new broad initiatives that expand consumer involvement and family driven care are not readily available.

However, a variety of initiatives that are available to all individuals receiving services regardless of funding that support consumer and family participation are continuing. These initiatives are described below:

- Under direction of DMH, the Collaborative, the DMH ASO, has established a statewide "warm line" as a cutting edge source of peer and family support. Staffed by five Peer and Family Support specialists, the toll-free number is operational Monday through Friday, 8am to 5pm except holidays and receives 60 to 120 calls per week. These professionals are persons in recovery, or family members of persons in recovery, who are trained to effectively support recovery in other individuals' lives. Now in its seventh year, the Warm Line continues to deliver a necessary and meaningful service for residents of Illinois and is characterized by a unique blend of caring, empowering service and effective use of reliable, user-friendly technology. During FY2015, the Warm Line received 5,988 calls. This is a 35% increase in annual call volume from FY2014 which is attributed to heightened marketing efforts. The Warm Line is now averaging 499 calls per month as compared to a monthly average of 324 in FY2014. The warm line has been a successful DHS/DMH investment by assuring the accessibility of a human connection at a time when it is needed. In addition to the Warm Line, consumers and family members may contact the Consumer and Family Care Line with compliments and complaints about the mental health services they receive. Each complaint is reviewed by the staff, referred to the appropriate agency or authority for investigation or resolution, and followed up. Written feedback is provided to consumers and family members on the progress or resolution of their

complaints and assistance is offered to obtain further review or to appeal a decision as necessary.

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

- The Wellness Recovery Action Plan (WRAP) model is well established in Illinois. Through WRAP classes in community agencies and the introduction of the principles of WRAP at consumer forums and conferences, thousands of consumers throughout the state have benefited from receiving orientation and education in the principles and components of this evidence-based practice in recovery-oriented services. A recently recognized evidence-based practice, WRAP® is a multi-week program led by certified facilitators. WRAP® teaches people living with mental illnesses how to identify and use illness self-management resources and skills that help them stay well and promote their recovery. Studies show that WRAP® improves participants' quality of life and reduces their psychiatric symptoms. DMH RSS provides annual WRAP® Facilitator Training and has trained over 400 people how to deliver WRAP® statewide since 2002. The community support services WRAP® facilitators provide are Medicaid-reimbursable, making WRAP® an affordable program for many agencies. However, the majority of individuals who have completed WRAP® Facilitator Training have not gone on to provide WRAP® classes. DMH Recovery Support Services (RSS) is working to increase number of trained facilitators who are providing WRAP® classes and to increase access to WRAP® Facilitator Training in Illinois.

- DMH Recovery Support Specialists work with stakeholders to design, plan and convene annual recovery conferences in each DMH region. These conferences frequently have a well-known and /or national speaker who delivers the keynote address and who sets the "tone of recovery" for the conference.

- DMH conducts a series of statewide teleconference calls designed to disseminate important information to consumers across the State. These calls provide a forum for discussion of service information, performance data, new developments, and emerging issues to promote consumers' awareness and knowledge and provide consumers with the tools they need to cogently and effectively participate in the development and evaluation of the service system. The goal of the Consumer Education and Support Initiative is to ensure that consumers of mental health services receive current, accurate and balanced information regarding changes in the service delivery system, empowering them to take an active, participatory role in all aspects of service delivery. Ten teleconferences have been conducted

annually. The aggregate participation on the calls in FY2015 was 4,889 (duplicated) consumers.

- CRSS is the professional credential for individuals providing peer recovery support services in Illinois. It is a competency-based credential, managed by the Illinois Certification Board. In order to obtain the CRSS, individuals must complete:
    - 100 hours of training/education
    - 2,000 hours on-the-job experience
    - 100 hours of supervision
    - CRSS exam

The CRSS is required for positions with the State of Illinois in state hospitals and region administration and as part of Medicaid reimbursed team services (ACT & CST) and BIP Enhanced Services. The CRSS credential assures competence in advocacy, professional responsibility, mentoring, and recovery support. Certified Recovery Support Specialists are persons with lived experience who provide mental health or co-occurring mental illness and substance abuse peer support to others using unique insights gained through personal recovery experience and 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.

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. Information regarding this credential can be found at http://www.iaodapca.org/forms/crss/CRSS_Model.pdf

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. In FY2016 DMH RSS is partnering with a Title XX provider to finalize a CRSS Provider Workbook.

The **Illinois Recovery Partners Forum** is a newly organized group comprised of leadership of persons in recovery from eight statewide organizations with mental health recovery as part of their mission:

- Coalition for Citizens with Disabilities in Illinois (CCDI)
- Depression & Bipolar Support Alliance Grassroots Organization (DBSA GO)
- Faces & Voices of Recovery (mental health & substance use recovery)
- GROW in Illinois
- Inter-Faith Mental Health Coalition (IFMHC)
- NAMI Connection
- Sacred Creations
- VetNet

The proposed vision of the Forum is *to work collaboratively and effectively toward a system that promotes wellness, resilience & recovery*. Working together toward shared goals, Recovery Partners will have an opportunity to provide input into the continuing development of Recovery in Illinois. During FY2016 and FY2017, DMH is seeking to advance the development of the Illinois Recovery Partners Forum by both increasing the number of Recovery Partners participating in Forum meetings and developing a recovery resources repository.

It is noteworthy that DMH has given significant attention to incorporating Recovery principles and philosophy at inpatient facilities. Treatment Recovery Philosophy and Policy (TRPP) is an initiative designed to improve the recovery orientation of services provided at state-operated hospitals in Illinois. It was piloted at two hospitals in 2013-2014 and officially launched in all hospitals in May, 2015. The TRPP includes the following practical elements:

- Mandatory Staff Training
- Recovery Ambassador Training
- Recovery Competencies
- Recovery Rounds
- Recovery Stories
- Continuous Quality Improvement

Full implementation of the TRPP in all hospitals will require ongoing monitoring and support.

Family Participation

The participation of parents/caregivers and adolescents in planning and evaluating the quality of mental health services is an important aspect of the Illinois public mental health system. DMH has maintained this effort as a priority with activities directed toward increasing family voice and participation in the provision of C&A services statewide and in DMH Regions. Planning is currently underway to develop and establish a statewide family organization to support parents and caregivers of children with Serious Emotional Disturbance.

- DMH is advancing Family Driven Care in Illinois by certification of parent providers as Family Partner Professionals and monitoring the extent of their statewide deployment. Family peer-to-peer support is vital for families overcoming the challenges of raising and supporting a child with emotional, mental, or behavioral disorders. Certified Family Partnership Professionals (CFPPs) are individuals trained to incorporate their unique life experiences gained through parenting a child whose emotional and/or behavioral challenges required accessing resources, services, and supports from multiple child-serving systems as they progressed toward achievement of the family's goals. The Illinois Model identifies the functions, responsibilities, knowledge, and skill bases required by the professional CFPP in the performance of his/her job regardless of the treatment setting in which the work is performed. Certification is accomplished through a mandatory training and experience protocol that includes a 100-hour training requirement, supervised work experience and the successful completion of a written examination. As of the end of FY2014, 20 individuals had received the CFPP certification. It is anticipated that this credential will be recognized under the Illinois Medicaid Rule (Rule 132). Further information on the CFPP credential is available at: http://www.illinoismentalhealthcollaborative.com/consumers/consumer_cfpp.htm

- DMH employs Family Consumer Specialists (FCS) as C & A staff members of DMH in each region of the state. All five of the DMH regions now have a Family Consumer Specialist actively involved.
- Family Consumer Specialists host monthly statewide 'Parent Empowerment Calls' to provide parents with information that will allow them to more effectively drive and evaluate their children's care and the system at large.

- Family participation in Regional Planning Councils and the IMHPAC is increasingly significant. The Child and Adolescent sub-committee of the Illinois Mental Health Planning and Advisory Council has been successfully co-chaired by a parent who exhibits strong leadership and advocacy skills and a community mental health agency director. This committee has contributed influentially within the IMHPAC.
- DMH has required that Family Resource Developers (FRDs) be hired in SASS agencies. Increasing value has been placed on the expertise FRDs bring to the SASS teams and their support role has expanded. Monthly meetings are held for the FRDs in order to provide education, resource development and support for the positions.

Additionally, NAMI-Illinois is a very active education and information resource for consumers and families in the State. NAMI Affiliates conduct Family-to-Family classes across the State, including classes specifically for veterans and their families; Peer to Peer classes, and NAMI Connection Recovery Support Groups. Family to Family is a free 12-week education course for family members and friends of individuals with mental

illnesses taught by NAMI family members and covers information about illnesses of the brain and their treatment; coping skills; and advocacy.

Implementation of self-directed care in its fullest sense remains distant in Illinois. The current economic climate of the State is not allowing for the allocation of funds directly to consumers nor the infrastructure required to carry out the tasks associated with self-directed care. However, current recovery oriented and consumer education efforts are orienting and positioning consumers and clinical providers toward person centered planning and consumer /family self-directed care.

Employment

The DMH continues to invest in the implementation of Individual Placement Services (IPS)/Supported Employment through collaboration with the DHS Division of Rehabilitation Services. Additionally, DMH was awarded a three year IPS transformation grant in federal fiscal year 2015 which further expands the delivery of IPS. Illinois and IPS providers have received national recognition with regard to its IPS initiatives.

Housing

Illinois has been consistent in its efforts to develop housing options and support services for consumers of mental health services to assure that individuals live in the least restrictive setting possible. Community supports range from in-home help for families, to community integrated living arrangements where people share a home with services individually tailored to their needs, or independent apartments with support services. See the next Section for a discussion of the Permanent Supportive Housing (PSH) initiative.

17. Community Living and the Implementation of Olmstead

The "Money Follows the Person" Federal Demonstration

Illinois is receiving $55.7 million dollars in federal Medicaid reimbursement to assist individuals across disability populations (the elderly, those with physical disabilities and those who have serious mental illnesses and those with developmental disabilities) who reside in non-IMD nursing facilities or State Developmental Centers with seamless transition to community residential alternatives-(non-group home settings) and necessary support services. The "Money Follows the Person" (MFP) demonstration facilitated the cumulative transition of more than 1,350 persons, between the involved state Departments, into home communities of preference over the course of several years. 368 individuals diagnosed with mental illnesses have been transitioned since inception. The Department of Healthcare and Family Services, the lead agency for the initiative, is working closely with the IDHS divisions of Developmental Disabilities (DDD), Rehabilitation Services (DORS) and DMH, the Department on Aging, and the Illinois Housing Development Authority (IHDA) on the initiative. IDHS is committed to maximize reimbursement in support of the goals of consumer self-direction, independence and community reintegration.

Due to DMH's success with implementation and the effectiveness of this MFP initiative for individuals with mental illnesses, in FY15 community transition services were expanded to 12 community mental health agencies located predominantly in the collar counties surrounding Cook County (Chicago and suburban areas) where the greatest need was determined. A total of 8 counties are now being served under MFP expansion. Within this past year a comprehensive Resident Review component process was added to the MFP process. The review is conducted after a 'pre-screening' by an Engagement Specialist. If an individual is determined to be appropriate for community transition based on the review, the individual is assigned to the appropriate Transition Coordinator. A DMH-MFP expansion coordinator conducts monthly calls with Resident Reviewers and Transition Coordinators to assess progress in community transitions, problem solve, and share topics of interest. There are also periodic webinars held by DMH Housing Coordinators for Transition Coordination training.

Thus far, the DMH MFP expansion has a cumulative total of 446 first contacts and 73 transitions. This total contributed to the national recognition of Illinois being second in the nation in terms of transitions for those persons with mental illness who reside in nursing homes.

Housing

Illinois has expanded housing resources for individuals with mental illnesses by implementing Permanent Supportive Housing (PSH), a specific Evidence Based model in which a consumer lives in a house, apartment or similar setting, alone or with one other consumer upon mutual agreement. The criteria for supportive housing include: income level at 30% or below Area Median Income, housing choice, functional separation of housing from service provision, the consumer's right to tenure, choice of services, service individualization, and service availability. Housing is also integrated with housing for persons who do not have mental illness and affordable (consumers pay no more than 30% of income on rent). Ownership or lease documents are maintained in the name of the consumer, so tenant landlord relationships are maintained.

Permanent Supported Housing is provided in a manner consistent with the national standards for this evidence based practice. The DMH Bridge Subsidy model provides tenant-based rental assistance designed to act as a "bridge" from the time the consumer is ready to move into his or her own housing unit until the time he or she can secure a permanent rental subsidy. Consumers who have a serious mental illness or a co-occurring mental illness and substance abuse disorder whose household income is at or below 30% of Area Median Income (AMI) as defined by HUD are eligible to apply to the program. DMH has targeted a defined population of consumers, including: those in long term care facilities or at risk of being in a nursing facility, long-term patients in state hospitals, young adults aging out of the ICG/MI program or out of DCFS guardianship, residents of DMH funded supported or supervised residential settings, and those who are determined by DMH to be homeless. The goal is to promote and stabilize consumer recovery by providing decent, safe, and affordable housing opportunities linked with voluntary DMH-funded community support services.

The number of consumers benefitting from permanent supported housing has steadily increased, due in fact to the Williams and Colbert Consent Decrees. In FY2015, as of June 30 2015, Permanent Supportive Housing Bridge Subsidies were approved for 1,306 subsidies for Williams Class Members. In total, more than 3,500 consumers of mental health services have received subsidies. DMH has met its target number of Class Members for transition since the inception of the Consent Decree.

As of June 30, 2015, a cumulative total of 4,140 consumers diagnosed with serious mental illnesses have been approved for Bridge subsidies to transition into PSH. The state continues to pursue all available opportunities and partnerships to increase subsidized housing options, including being a recipient for two HUD released 811 vouchers 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.

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**

DMH's defined target population is listed in the Table above 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.

Williams vs. Rauner (previously Williams vs. Quinn) Consent Decree

The *Williams vs. Rauner* Class Action lawsuit was filed in 2005 and settled in 2010. The suit targeted 4,500 resident of nursing facilities designated as Institutes for Mental Disease (IMD) – more than 50% of the residents had a diagnosed mental illness. The suit contends 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.
State agencies named in the lawsuit are the Department of Human Services Division of Mental Health, Division of Alcoholism and Substance Abuse, the Department on Aging, the Department of Public Health and the Illinois Department of Healthcare and Family Services.

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 to address the housing needs of Class Members. 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 transition coordination services that include: 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 DMH and the use of the PSH model with a bridge subsidy. 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. Additionally, in FY15, the state expanded the Cluster Housing model to better address the needs of some Class Members requiring expanded services. Partnering with two Williams community mental health centers, the state invested resources to house up to 32 Class Members in 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.

DMH contracts with eleven community mental health centers to provide a full array of services and supports to Class Members, including Assertive Community Treatment (ACT) and/or Community Support Teams (CST), plus an additional nine agencies that provide transition coordination services and case management. Individuals who have an interest in IPS/Supported Employment are being provided access to those services. DMH

perform quality of life assessments using direct information obtained from Class Members regarding community integration.

18. C&A Behavioral Health Services

The DMH Child and Adolescent Office facilitates the delivery of 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. DMH collaborates closely with a range of child-serving agencies and has provided consultation and support to interagency efforts in areas of child health and education. In the past few years the Office has been active in overseeing the implementation of several local SAMHSA System of Care grants.

System of Care Initiative

DMH has been awarded the System of Care Expansion Implementation Cooperative Agreement that became effective on 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.

Illinois United for Youth (IUY) has been the System of Care (SOC) planning initiative that resulted from a Substance Abuse Mental Health Services Administration (SAMHSA) Statewide SOC Expansion Planning Grant awarded in FY2013. The primary objective of IUY was to develop 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. The IUY Initiative leveraged the commitment of youth, their families, the child-serving state Departments, a myriad of stakeholders, the collective experience gained from SAMHSA-funded local Systems of Care, and built upon the successful work and lessons learned in behavioral health since the implementation of the Children's Mental Health Act of 2003. The initiative seeks to enact a statewide shift towards the adoption and integration of Systems of Care Principles across the service delivery systems for youth and has identified a set of multiple strategies that will continue to push Illinois closer to the full realization of a delivery system that is reflective of the SOC principles and values. The blueprint for this effort was completed to SAMHSA as "Pathways: Illinois Strategic Plan for Children's Mental Health". A central feature of the IUY Pathways approach is the establishment and availability of training, technical support, and infrastructure development designed to inform stakeholders, persons in leadership positions, and the public about the benefits of the System of Care framework. . A central feature of the IUY Pathways approach is the establishment and availability of training, technical support, and infrastructure development designed to inform stakeholders, persons in leadership positions, and the public about the benefits of the System of Care framework. Successful implementation of Pathways relies heavily on the ability to apply the strategic planning efforts to multiple

locations within the state, each with varying degrees of need, resources, infrastructure, funding and other supports.
Consistent with this extensive planning, a System of Care Technical Assistance Center for Illinois (STACI) has been established 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. Current plans are to staff STACI with a Director of Training and a Communications Director. The Director of Training will focus on development of the trainings including: assessment and screening, CANS certification, SOC principles, High Fidelity Wraparound, care coordination, evidence based practices, promising approaches and frameworks, and family and youth leadership. These trainings will be necessary in order to support the expansion of the SOC framework statewide. The Communications Director will focus on the development of the SOC Social Marketing Campaign, the development of an annual SOC conference, SOC education and awareness plans, and ensuring that cross-agency committees and initiatives have the necessary supports to incorporate SOC values and principles into their planning processes.

The System of Care initiative aims to strengthen family-driven and youth-guided services, and strengthen the youth and family voice at all levels of policy and program development. This will be accomplished through: (a) supporting the capacity of Youth MOVE-Illinois to expand their platform for youth sharing their perspectives on mental health and the services they receive; (b) supporting the capacity of the Illinois Family Organization to expand their opportunities for engaging and supporting families of youth involved in the mental health system, and, (c)ensuring and encouraging participation of youth and families and their representative agencies in the IUY Stakeholders group and the IUY Facilitation Team.

Over the past five years DMH has worked in collaboration with other state systems to build the capacity of community mental health agencies to utilize evidence informed practices in the children's mental health services system. A collaborative workgroup that included families, community level practitioners, and secondary education professionals from across the state identified and implemented evidence –informed practices that are culturally and linguistically appropriate to the needs of children and families, reflective of available research, and measureable enough to ensure that the selected practices are leading to improved functioning at home, in school, in the community and throughout life. Training initiatives designed to increase competence of providers in Evidence Informed Practices have been ongoing. DMH C&A and the collaborative workgroup have defined a set of core competencies for a strong Children's Mental Health System throughout the state and identified the infrastructure within agencies and the redirection of funding that would allow staff members to attend training, coaching and clinical consultation.

N.B. vs. Norwood: A Class Action lawsuit filed in FY2013 posited that Medicaid-eligible children with behavioral or emotional disorders who need intensive mental (behavioral) health services in order to correct or ameliorate their conditions are entitled

to receive these medically necessary services in the community under the Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) provisions of Title XIX of the Social Security Act. It has also been alleged that the state has failed to meaningfully provide intensive community-based residential or outpatient care for children with mental illness and emotional or behavioral disorders. The class for this lawsuit is defined as: All Medicaid-eligible children under the age of 21 in the State of Illinois: (1) who have been diagnosed with a mental health or behavioral disorder; and (2) for whom a licensed practitioner of the healing arts has recommended intensive home- and community-based services to correct or ameliorate their disorder. To date, a collaborative team representing IDHS, HFS, DCFS, DJJ and ISBE has been working on this. This Multi-Agency Clinical Staffing (MACS) process was formalized in December, 2014. The MACS Group is staffed by personnel, already identified from their respective agency/division, from each of Illinois' child-serving agencies (DHS, DCFS, HFS, and DJJ), so that the State may take an integrated, multidisciplinary approach to addressing the needs of the youth presenting before the group. The role that DMH will play in the implementation and oversight of a consent decree has yet to be determined. This Class Action Suit may result in extensive change and re-organization of the C&A Behavioral Health service system within the next two years.

19. Pregnant Women and Women with Dependent Children

This section is not applicable to the MHBG. It will be addressed by DHS DASA in the SABG.

20. Suicide Prevention

The SAMHSA 2014 Behavioral Health Barometer for Illinois, reports that approximately 340,000 adults (3.5% of all adults in Illinois) in the five year period from 2009 to 2013 had serious thoughts of suicide within the year prior to being surveyed. The percentage did not change significantly over this period. More than 1,000 persons die by suicide each year in the state and suicide fluctuates yearly between being the second or third leading cause of death for adolescents. Interest, organized efforts, and advocacy for suicide prevention in Illinois resulted in legislative action. In 2004, the Suicide Prevention, Education and Treatment Act (PA093-0907) was passed by the General Assembly and signed by the Governor directing the Illinois Department of Public Health (IDPH) to appoint the Illinois Suicide Prevention Strategic Planning Committee composed of representation of statewide organizations and local agencies that focus on the prevention of suicide and support services to survivors. To unify planning and suicide prevention efforts, an alliance was formed between a coalition of stakeholders and the strategic planning committee that was recognized in law by the General Assembly in 2008. The mission of the Illinois Suicide Prevention Alliance (the Alliance) as stated in the law is "to reduce suicide and its stigma throughout Illinois by collaboratively working with concerned stakeholders from the public and private sectors to increase awareness and education, provide opportunities to develop

individual and organizational capacity in addressing suicide prevention, and advocate for access to treatment."

Recently, the thrust of Illinois suicide prevention has been to develop training opportunities, increase public and professional awareness of state and local suicide prevention resources in Illinois, and increase opportunities for linkages. Activities have included a Webinar series on available Illinois resources such as LOSS (Loving Outreach to Survivors of Suicide); a statewide suicide prevention conference, a "Zero Suicide" workshop with Mike Hogan that resulted in a number of CMHCs and other providers signing on to implement this comprehensive approach; an event for addiction / substance abuse professionals co-sponsored with IODAPCA, and plans for working on training for Juvenile Justice professionals.

In reference to military personnel and their families, it is notable that Illinois Joining Forces (IJF), which has been quite active in Illinois since the initiative was undertaken nationally, formally joined the Illinois Suicide Prevention Alliance(ISPA)this year. The IJF activists became a standing committee of "The Alliance" in order to potentiate both ISPA and IJF resources. Representatives from the Veteran's Administration programs in Illinois have been active stakeholders and have attended Alliance meetings for the past several years. DMH is a member of the Alliance and actively participated in the development of the 2007 Illinois Suicide Prevention Strategic Plan. The Plan was attached to the FY2012-2013 Application. It may also be accessed at:

http://www.idph.state.il.us/about/chronic/Suicide_Prevention_Plan_Jan-08.pdf

The Alliance and IDPH are required to provide an annual report to the General Assembly. In FY2012 the Alliance updated the Suicide Prevention Plan which still remains in draft form and under review by IDPH and the Alliance. This plan that updates suicide prevention planning in Illinois as of February 2012, is attached to this Application.

21. Support of State Partners

The **Division of Mental Health** purchases services from 180 Community Mental Health agencies statewide, operates seven state mental health hospitals, and manages one treatment detention facility. Additionally the Division maintains working partnerships with many state agencies that support mental health services and offer specialized interventions. T**he Department of Healthcare and Family Services (**DHFS) purchases an array of mental health services. The DHFS behavioral health focus over the next five years includes six key areas: (1) care coordination, which is the centerpiece of Illinois' Medicaid reform efforts, (2) housing, (3) pre-admission screening/resident review, (4) community stabilizations strategies, (5) children's mental health services and (6) enhanced community services. **The DHS Division of Alcoholism and Substance Abuse** (DASA) has collaborated with DMH for many years to address services for individuals with co-occurring mental health and substance use disorders, and the **Division of Developmental Disabilities (DDD**) and the DMH share leadership tasks in addressing

the needs of persons with Autistic Spectrum Disorders (ASD) and individuals with co-occurring developmental disabilities. DMH and **Division of Rehabilitative Services** actively collaborate to increase the access of persons with serious mental illnesses to vocational rehabilitation services and to improve the coordination of psychiatric and vocational services through initiatives such as Individual Placement Services/Evidence-Based Support Employment (IPS/EBSE). The **Illinois Housing Development Authority** and DMH are working on a number of initiatives including the Williams vs. Quinn Consent Decree and permanent supportive housing. The availability of safe, decent, and affordable housing is a necessary component of a comprehensive community support system. The DMH works closely with **the Illinois Department on Aging (DOA**) to increase training opportunities in the geriatric field and to improve the quality and accessibility of services for elderly persons with mental illnesses. There are a substantial number of individuals with serious mental illnesses who require long-term care services, thus the DHS/DMH is collaborating with the **Department of Public Health and HFS** to address the issues for a substantial number of individuals in this population. The DMH Forensic Services collaborates with a range of agencies in the Criminal Justice System including: the **Illinois Department of Corrections, the Illinois Department of Juvenile Justice, Administrative Offices of the Illinois Courts, the Illinois Criminal Justice Authority, the Illinois State Police, the Illinois Sheriff's Association, the Cook County Department of Corrections, County Jails and Juvenile Detention Centers and local law enforcement** agencies and organizations. The DMH has pursued the Positive Behavioral Interventions and Supports (PBIS) model of collaboration between education (the **Illinois State Board of Education and the Chicago Public Schools)** and mental health primarily through work on System of Care Grants and through collaborative efforts with the **Children's' Mental Health Partnership**. DMH continues to work closely with the **Department of Children and Family Services (DCFS)** on a number of initiatives including Screening, Assessment, and Support Services (SASS) and a training initiative for child welfare staff and service providers to examine and respond to the trauma children and families have experienced as a result of physical abuse, neglect, sexual abuse and domestic violence.

22. The Illinois Behavioral Health Planning and Advisory Council and Input on the Mental Health Block Grant Application

Description of Role and Activities

The Illinois Mental Health Planning and Advisory Council (IMHPAC) advises the DMH on mental health issues. The Advisory Council currently is a body of 42 members, which includes consumers and representatives from public and private organizations that plan, operate, and advocate for mental health and support services for persons with serious mental illness. Established in 1992, the Advisory Council's participation in the analysis of Illinois' mental health system has yielded a significant public/private partnership that focused on restructuring public mental health services in Illinois and guided the development of a strategic plan for consumer-responsive, community-based, and cost-effective service delivery. The Council approved a set of By Laws at the end of FY2002 and has revised them periodically as needed.

Each DMH Community Comprehensive Service Region (CCSR) is represented on the Council. Providers, consumers, family members and parents of children with SED who are members of the Council may also act in an advisory capacity in the Regions. State employees representing principal state agencies with respect to mental health, education, criminal justice, vocational rehabilitation, housing, and a variety of social services as well as representatives of organizations that are significant stakeholders and advocates are full members of the Council. Expansion of the Council membership to encompass behavioral health including representation of the Alcoholism and Substance Abuse community of providers and consumers, representation of primary health care, and representation of the Health Information Exchange Authority is currently being discussed.

The Advisory Council currently has several sub-committees including an Executive Committee, a Council Development Committee, and Substantive Committees. The Substantive Committees include: Adult Inpatient, Child and Adolescent Services, and Adult Community Services. Other committees may be appointed as needed. The Council as a whole meets six times a year to review new developments, monitor the progress of initiatives, and discuss problematic issues in the mental health service system. Each subcommittee also meets at least six times a year, during alternating months of the full council meeting. Each subcommittee is co-chaired by a consumer or family member and a provider or other council member. The Council advises DMH on its policies and plans and advocates for improvements in the mental health system. The Council has identified critical funding needs in the public mental health service system, and members of the Council, privately and through their affiliations developed a Mental Health Summit to lobby for additional funding. The focus, coordination, and organization of their efforts have been instrumental in bringing mental health issues to public and legislative attention, founding an infrastructure for further advocacy, and participating in DMH efforts to generate more revenue for community mental health services.

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

Public Comment on the FY2016/FY2017 Illinois Mental Health Block Grant Application:

The development of the state mental health block grant plan is made available for public comment in multiple ways. (1) The Illinois Mental Health Planning and Advisory Council (MHPAC) includes consumers of mental health services and family members who also participate in a range of advocacy groups such as the Mental Health Summit, the Mental Health Association, and NAMI-Illinois (National Alliance for the Mentally Ill-Illinois). Council members regularly consult with their respective advocacy groups during the development of the state plan. (2) All Council meetings are open to the public.

Council meeting dates are set up a year in advance to facilitate participation. Persons with an interest in the state plan may attend meetings at which the plan is discussed and provide feedback and comments. (3) The Illinois Mental Health Planning Advisory Council (MHPAC) has delegated detailed work on the Mental Health Block Grant Application to the IMHPAC Executive Committee which is comprised of consumers, a parent of a child with SED, providers, advocates, and is staffed by the mental health block grant planner. The Executive Committee reviewed the FY2016/2017 Block Grant Plan during its development and provided comments and input on the plan. Developments and issues in Block Grant Planning have also been discussed at all IMHPAC meetings in the past year. (4) The final state block grant application and proposed plan will be posted on the web site for the Division of Mental Health (www.dhs.state.il.us). The public can access this DHS DMH Internet site. Interested parties have been instructed to contact Dr. Mary E. Smith to provide comment. Contact information is provided on the website. Detailed comments that have been provided thus far are on file at the DMH. Additional comments submitted after the final draft of the plan is posted will be reviewed by the IMHPAC Executive committee.

State Mental Health Planning Council Membership List
As of 8/25/15

Table 11: List of Planning Council Members

Name	**Type of Membership**	**Agency /Organization Represented**	**Address, Phone, Fax & E-Mail**
Abate, Mary Ann	Provider	Rosecrance Health Network (Janet Wattles)	9134 River View Trail Roscoe, IL 61073 (815) 623-6740 mabate@rosecrance.org
Backstein, Cindy	Family Members of Children with SED.		26 Camberley Road Springfield, IL 62712 217-498-8774 backstein@mchsi.com
Blank, Wendy	State Employees	IL Dept. of Corrections (Criminal Justice)	Stateville CC 16830 South Rt. 53 Crest Hill, IL 60403 815-727-3607 ext.6220 630-450-2204 (cell) Wendy.Blank@DOC.Illinois.gov
Brien, John	Family Member		9726 S. Seeley Ave. Chicago, IL 60643 773-756-7789 773-238-8563 (Fax) Johnbrien312@att.net
Broughton, Geogianne	Provider	Community Resource Center	101 South Locust Centralia, IL 62801 618-533-1391 618-533-0012 (fax) gbroughton@crconline.info
Buss, Donna	Individual in Recovery		620 Dakota Street Crystal Lake, IL 60012 815-354-1577 815-455-2925 (fax) donna.buss@alexian.net
Carmichael, Michele	State Employees	Illinois State Board of Education	100 N. 1st Street Springfield, IL 62777-0001 217/782-5589 mcarmich@isbe.net

Name	Type of Membership	Agency /Organization Represented	Address, Phone, Fax & E-Mail
Carmichael, Terry	Others (not state employees or providers)	Community Behavioral Health Association (CBHA)	3085 Stevenson Drive Springfield, IL 62703 217-585-1600 tcarmichael@cbha.net
Carter, N'Dana	Individual in Recovery		4915 S. Washington Park Court Chicago, IL 60615 (773) 624-6281 ergoqueen@hotmail.com Topergoqueen@gmail.com
Chandraseker, Edwin	Provider	Executive Dir., Asian Health Coalition	180 W. Washington Suite1000 Chicago, IL 60602 (312)372-7070, ext 223 (312) 372-7171 (fax) edwin@asianhealth.org
Connor, Ray	Family Members of Children with SED.		1218 N. Grove Ave Oak Park, IL 60302 847-426-3692 847-649-8915(Fax) rayconnor@comcast.net
Cooke, Andrea Council Co-Chair	Individual in Recovery		11324 S. Langley Ave. 2nd Floor Chicago, IL 60628 708-381-9088 a-cooke@sbcglobal.net
Daxenbichler, Cindy	Family Members of Children with SED.		114 Daddono Circle Bloomington, IL 61701 309-642-1080 Taurus463@gmail.net
Emrich, Cara	Individual in Recovery		402. N. Ward Street Benton, IL 62812 618-513-9762 c.emrich.tigerlily@gmail.com
Frazier, Sondra	Family Members of Children with SED.		6957 South Jeffery Blvd. Chicago, IL 60649-1521 773-324-6644 Slfrazier@aol.com
French, A.J	Individual in Recovery	Gift of Voice	2735 E. Broadway, Suite B Alton, IL 62002 618-792-2049 Aj.french@giftofvoice,com

Name	Type of Membership	Agency /Organization Represented	Address, Phone, Fax & E-Mail
Friedman, Fred	Individual in Recovery	Next Steps, NFP	2442 N. Kilbourn Ave. 1st Floor Chicago, IL 60639 773-661-6705 fred@nextstepsnfp.org
Heyrman, Mark	Others - Representative of Advocacy Organizations	Legal Assistance Foundation University of Chicago	6020 S. University Ave. Chicago, IL 60637- 773-753-4440 773-702-2063 (Fax) m-heyrman@uchicago.edu
Hopkins, Dennis PsyD,	Provider	Iroquois Mental Health Center	323 West Mulberry Street Watseka, IL 60970 815-432-5241 dhopkins@imhc.net
Irving, Anne	Others (not state employees or providers)-	Representative Labor Relations AFSCME	29 N.Wacker Dr, Ste 800 Chicago, IL 60601 312-641-6060 312-346-1016 (Fax) AIrving@afscme31.org
Kalra**,** Antar	Individual in Recovery		211 Elgin Apt. 6J Forest Park, IL 60130 708-771-0472 antar7@sbcglobal.net
Langley, Steve	Provider	Executive Director, Stepping Stones of Rockford,Inc.	706 N. Main Street Rockford, IL, 61103 815-963-0683 815-963-6018 (fax) sel@ssrinc.org
Larson, Nanette	State Employees	Director of Recovery Support Services Division of Mental Health	200 S. 2nd St., Suite 20 Pekin, IL. 61554 309-346-2094 Ext. 407 Nanette.Larson@illinois.gov
Madlock, Pearl	State Employees (Housing)	IL Housing Development Authority Office of Housing Coordination Services	401 North Michigan Avenue, Suite 900 Chicago, IL 60611 312-836-5354 312-832-2191 (Fax) pmadlock@ihda.org

Name	Type of Membership	Agency /Organization Represented	Address, Phone, Fax & E-Mail
Martinez, Daniel MD	Provider	Child Psychiatrist Lutheran Social Services	4840 W. Byron St. Chicago, IL 60641 773-282-7800 dmartinez@discoverccs.org
McGinnis, Robin Dawn	Provider	CEO Infant Welfare Society of Chicago	3600 W. Fullerton Ave. Chicago, IL 60647 773-782-5018 mcginnisr@infantwelfare.org
Melka, Ronald R. MPA	Others (not state employees or providers)	Lyons Township Mental Health Commission	6404 Joliet Road, Suite 204 Countryside, IL 60525 708-352-2992 708-354-7212 (FAX) ltmhc@lyonsts.com
Miller, Emily	Others (not state employees or providers)-	Behavioral Health Policy Analyst, Illinois Association of Rehab. Facilities	206 South Sixth Street Springfield, IL 62701 217-753-1190 ext 111 217-525-1271 (Fax) emiller@iarf.org
Morrison, Orson	Provider	Executive Director, DePaul Family & Community Service	2219 N. Kenmore St. Chicago, IL 60614 773-325-7787 omorrison@depaul.edu
Nance, Mike	Individual in Recovery	Heritage Grove	365 East Waggoner St. Decatur, IL 62526-4695 217-423-4715 mnance62@gmail.com
O'Shea, Lynn	Provider	Association for Individual Dev.	309 West New Indian Trail Court Aurora, IL 60506 630-966-4001 630-844-9884 (Fax) loshea@the-association.org
Oulvey, Gene	State Employees	Office of Rehabilitation Services (Vocational Rehabilitation)	618 E. Washington, 3rd Fl Springfield, IL 62794 217-720-9378 217-524-7549 (Fax) Gene.Oulvey@illinois.gov
Overturf, Anita	Individual in Recovery		1464 Queeny Ave Sauget, IL 62206 618-974-8424 Anitaoverturf.crss@gmail.com
Roethlisberger, Margo	Provider	Ada S. Mckinley Community Services	98 Chelsea Avenue Sugar Grove, IL 60554 (630) 466-5086 mroethlisberger@adasmckinley.org

Name	Type of Membership	Agency /Organization Represented	Address, Phone, Fax & E-Mail
Schreiner, Ann	Provider	President and CEO, Pillars	333 North LaGrange Road LaGrange Park, IL 60526 708-698-5500 aschreiner@pillarscommunity.org
Shustitzky, John Council Co-Chair	Provider	Private Practice	675 Rockefeller Road Lake Forest, IL 60045 (708) 302-6920 (cell) (847) 482-1638 (home) jwshust@gmail.com
Smith, Mary E. *Official DMH Representative	State Agency Rep	Chief of Decision Support, Evaluation, and Research Division of Mental Health	401 S. Clinton St., 2cnd Fl. Chicago, IL 60607 (312) 814-4948 MaryE.Smith@illinois.gov
Starin, Amy	Others (not state employees or providers)	Institute For Juvenile Research	University of Illinois College of Medicine Department of Psychiatry 1747 W. Roosevelt Road MC747 Chicago, IL 60608 (312) 355-2641 astarin@psych.uic.edu
Summerfield, Jean	State Agency Rep	Illinois Department of Healthcare and Family Services	401 S. Clinton Street Chicago, IL 60607 312-814-6784 Jean.Summerfield@illinois.gov
Thomas, Lora Council Treasurer	Others (not state employees or providers)	NAMI	218 West Lawrence Springfield, IL 62704 217-522-1403 Thomas.lora@sbcglobal.net
Walker, Christine	Family Members of Children with SED.		399 Ridge Avenue Winnetka, IL 60093 847-446-6436 (Home) 847-338-1505 (Cell) critique@sbcglobal.net

TABLE 12: Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP (As of 6/25/15)	**41**	
Individuals in Recovery	**9**	
Family Members of Individuals in Recovery	**1**	
Parents and Caregivers of Children or Youth with Behavioral Health Problems	**5**	
Vacancies (Individuals & family members)	**0**	
Others (Not state employees or providers)	**7**	
TOTAL Individuals in Recovery, Family Members & Others	**22**	**53.65%**
State Employees	**7**	
Providers	**12**	
Leading State Experts	**0**	
Federally Recognized Tribe Representatives	**0**	
Vacancies	**0**	
TOTAL State Employees & Providers	**19**	**46.35%**