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# Division of Mental Health Services

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## 2008 PROGRAM REVIEW AND EVALUATION

### SERVICE DESCRIPTIONS

Research indicates that the number of persons who will experience some degree of mental illness within a year is 1 out of 5 individuals. In Illinois for SFY 06, this amounts to more than two million persons. For roughly one-third of this population, these illnesses will be severe enough to disrupt normal life in areas such as education, employment, and personal relationships. While treatment for these serious illnesses is essential to avoid greater disability, access to treatment is not easy to obtain, because this population is disproportionately uninsured. Even for persons in this group who have some health insurance coverage, this coverage rarely includes treatment for their psychiatric disorders. As a result, this population depends heavily upon the public-funded mental health system.

In response to this reality, as the federally designated State Mental Health Authority (SMHA), the Division of Mental Health (DMH) is responsible for coordinating a comprehensive array of public and private mental health services for adults with mental illnesses and children and adolescents with serious emotional disturbances. Mental Health services are coordinated through a statewide geographical organization of five Comprehensive Community Mental Health Regions (Regions). The DMH coordinates and assures the provision of public funded mental health services through a network of 162 community mental health centers/agencies, 28 community hospitals with psychiatric units and nine state operated hospitals. Within this structure, the DMH funds services that include crisis intervention, psychiatric services, community-based case management, supported and supervised residential services and psychosocial rehabilitation programs. Treatment among the sites operated by, or funded by DMH, is coordinated through a statewide-standardized Continuity of Care Agreement (COCA). The primary Mission of the DMH is to assure that children, adolescents and adults most in need of mental health services may be empowered to recover, succeed in accomplishing their goals and live full and productive lives in the community. DMH offers recovery/resiliency-oriented, evidence-based, community-focused, culturally-sensitive, outcome-validated treatment and supports that are accessible, through fiscally efficient use of public funds, to all citizens of Illinois. The primary vision of the DMH is that all persons who experience mental illnesses will recover and that effective treatment and supports, essential for full participation in one's community, will be accessible and available at all stages of a person's life.

In order that the DMH might work most efficiently and effectively toward the realization of this Mission and Vision, early in SFY 04 the DMH Executive Leadership Staff with membership from both its Central Office and Regions, made a commitment to work toward service system transformation within the context and structure of the President's New Freedom Commission Report (Report). The DMH's SFY 05, comprehensive strategic plan was an initial step in the development of a plan within this framework. The DMH's expectation is that a Comprehensive State Mental Health Plan, a Report requirement, will be realized in early SFY 08.

"Recovery," as defined in the Report, "refers to the process in which people are able to live, work, learn, and participate fully in their community. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery."

Although transforming our system so that it will be both consumer and family-centered and recovery/resiliency-oriented in its care and services presents invigorating challenges, the DMH is confident that it is prepared to face those challenges toward the achievement of a transformed mental health delivery system for the consumers served within it. The Report and the vision of Olmstead provide a solid foundation for that achievement and offer hope and light that a transformation is possible.

### Consumer/Family Participation and Involvement

In the past several years, one of DMH's most significant and foundational achievements in its ongoing development of a recovery/resiliency-oriented, community-focused service system has been the increased consumer/family participation and involvement in all areas of service delivery and system restructuring. With leadership from the DMH's Recovery Services

Development Group (RSDG) and with membership of on-staff Recovery Support Specialists from all of the DMH's Regions, consumer participation and involvement have evolved from an ongoing presence in the daily operations of the state hospitals to the articulation, dissemination and implementation of an emerging recovery culture focus in all areas of hospital and community service delivery.

The number of on-staff consumers in community agencies, for example, has increased dramatically, and consumers have moved to positions of leadership and influence throughout the DMH and its Regions. And for the ongoing System Restructuring Initiative (SRI), the DMH's current fee-for-service project, the 30 community Field Test agencies have Consumer Liaisons who were expected to facilitate developing models for statewide consumer leadership.

In addition, the SFY 06, RSDG initiatives are already showing dramatic results which are expected to have a long-term impact on consumer/family participation and involvement and the movement of consumers to a more positive living, working, learning environment. In the first of these initiatives, over 300 consumers have been trained in the principles of the Wellness Recovery Action Planning (WRAP).

These trained WRAP Facilitators are currently offering WRAP Groups to consumers under the auspices of community agencies, and the positive results reflected through follow-up surveys and evaluations are already most impressive. Plans are underway also to evaluate the outcomes of WRAP, a nation-wide Emerging Practice, to validate the efficacy of its utilization with a growing number of consumers. Further, to work on the employment aspect of community-focused care, the RSDG is working collaboratively with the Division of Rehabilitation Services (DRS) and with community consumer leadership in the development of a Supported Employment Program (SEP) Initiative which will target the development of SEP Pilots throughout the state, intended to expand the employment options for consumers and enhance their skills for staying out of the hospital and moving through available levels of care, until they reach their maximum potential. A recently received national Johnson and Johnson Grant will assist in supporting this Initiative.

### **Community Medicaid Billing**

Unlike programs for other groups of individuals with disabilities, services for adults 22 - 64 years of age with mental illness in institutional settings of 16 or more persons, remain ineligible under the Social Security Act to receive federal Medicaid matching funds. Thus, the type of federal Medicaid waiver programs that permit deflection of individuals at the front door of institutional settings with funding for home and community-focused services, such as waiver programs administered by the Department on Aging and IDHS' Divisions of Developmental Disabilities and Rehabilitation Services, are not available to the DMH. Nonetheless, the DMH has pro-actively utilized the Medicaid program to support and enhance its community-focused mental health service systems. During the past two years, the DMH has worked to revise and expand its Mental Health Medicaid Rule 132 with the goal of enhancing and increasing the financing of a broad range of community-focused services that are essential for supporting persons with mental illness in community-focused settings. These services include supported and supervised residential programming, psychosocial rehabilitation, medication monitoring, and Assertive Community Treatment. The new revision of the Rule 132 was designed to utilize existing General Revenue Fund dollars as the basis for the State's match. The DMH's work in this area, and in the SRI, which moves the community agencies from a grant-based funding structure to a fee-for-service structure, has become a major collaborative systemic undertaking.

From a Medicaid Billing total of just over \$100 million in SFY 02, the SFY 06 total increased to \$176.6 million and continued to increase through succeeding Fiscal Years. That 57 percent increase in four years has resulted in a service system expansion that could have not occurred without the increased Medicaid funding. With the current SRI underway, the DMH's projections are that Medicaid billing and payments, will continue to increase.

### **System Restructuring Initiative**

Clearly, the most significant administrative undertaking in the past several decades for the DMH has been its recently effected SRI. Initially envisioned as a shift in its community funding structure from a grant-in-aid system to a fee-for-service system, the SRI has expanded to become a comprehensive transition to a true recovery/resiliency-oriented service delivery system. With this expansion, not only will there be increased participation in the Federal Financial Participation (FFP), but also there will be enhanced service system changes to allow consumers greater choice and access to services designed to facilitate their growth toward recovery. Currently, the SRI includes work with 162 agencies, through which SRI evaluation and assessment will be completed, and Technical Assistance for all agencies by nationally known and recognized experts in the field of recovery oriented systems and fee-for-service conversion, will be provided. It is currently expected that the community service system will take the next step toward fee-for-service by implementing a partial advance and reconciliation process in SFY 08.

### **Mental Health State Hospitals**

Hospital care and treatment is a vital component in the continuum of treatment services provided to individuals with serious mental illnesses. State psychiatric hospitals, administered by the IDHS' DMH, serve unique

functions in the DMH's overall community-based service system. One function is to provide a secure, therapeutic environment within which to meet the needs of persons who, due to a psychiatric disorder, may be a danger to themselves or to others. Another function of the hospitals is to offer inpatient psychiatric treatment that is not available in community-operated hospitals because consumers have little or no capacity to pay for extended treatment, either directly or through an insurance plan (including Medicaid or Medicare).

A third function is to provide court-ordered treatment in forensic units for persons who are found Unfit to Stand Trial (UST) or Not Guilty By Reason of Insanity (NGRI). The accompanying table indicates the type of treatment available in each of the DMH's nine state psychiatric hospitals.

All of the state psychiatric hospitals are accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) to provide hospital level of care. Each hospital utilizes Continuous Quality Improvement methods to improve treatment processes and outcomes, and to monitor activities such as the use of restraints and seclusion. Community mental health agencies are closely involved with consumers who utilize the state hospitals, by performing a preadmission screening and evaluation of treatment needs, routinely participating in discharge planning and post-discharge linkage. This coordination with outpatient services is very important because, contrary to continued opinion, state psychiatric hospitals are no longer places for long-term residential treatment. Most patients leave treatment in state hospitals after fewer than 30 days of inpatient treatment but still needing to continue with outpatient services after discharge. In the hospital setting, assessment, treatment planning, clinical services and therapeutic interventions target the goals of recovery and return of the individual to his/her home, community, or other more integrated setting in the shortest time possible.

?FACILITY	Civil Treatment		Forensic Treatment	
	For Persons Younger than 18	For Persons Older than 18	For Persons Younger than 18	For Persons Older than 18
<b>Chicago-Read MHC, Chicago</b>	No	Yes	No	No
<b>Madden MHC, Hines</b>	No	Yes	No	No
<b>Tinley Park MHC, Tinley Park</b>	No	Yes	No	No
<b>Elgin MHC, Elgin</b>	No	Yes	No	Yes
<b>Singer MHC, Rockford</b>	No	Yes	No	No
<b>McFarland MHC, Springfield</b>	Yes	Yes	Yes	Yes
<b>Alton MHC, Alton</b>	No	Yes	No	Yes
<b>Choate MHC, Anna</b>	Yes	Yes	No	No
<b>Chester MHC, Chester</b>	No	Yes	No	Yes

### Community Mental Health Services in Community Agencies

A second major component of the public-funded mental health system is the community mental health system within which agencies provide a wide range of services. These services are provided through contracts between 162 community agencies and the IDHS' DMH. As the state does not provide outpatient mental health services, these necessary treatment components are provided by community agencies.

The primary responsibility of community services is to help individuals maximize their potential and independence through an array of community based services which are designed to maintain an individual with mental illness in his home and community and sustain an enhanced quality of life. This array of core community-based services includes:

- Crisis-emergency services including crisis intervention and stabilization programs;
- Mental health outpatient services such as assessment, treatment planning, therapeutic counseling, psychiatric services, medication management, substance abuse assessment and counseling for consumers with cooccurring mental illness/substance and mental health pre-admission screening;
- Care management services;
- Supported Employment Programs;
- Supported and supervised residential services;
- Psychosocial rehabilitation programs; and

- Consumer developed and operated services

## **Inpatient Psychiatric Treatment in Community Operated Facilities**

For many years, DMH has provided funding for the purchase of short-term emergency psychiatric inpatient care from community-operated hospitals. In 2002, this activity was significantly expanded when IDHS reduced the bed capacity for the treatment of non-forensic consumers in two hospitals, Elgin and Alton Mental Health Centers, and closed the Zeller Mental Health Center in Peoria. With the closure of these beds, additional contracts were established with private hospitals to replace the capacity lost with the reductions in the state facilities. These contracts continued to increase through SFY 06, and the established Community Hospital Inpatient Psychiatric Services (CHIPS) programs, are now an essential part of each Region's comprehensive service delivery.

## **Treatment And Detention Facility**

The Treatment and Detention Facility (TDF) was established in response to the Sexually Violent Persons Commitment Act, Public Act 90 40, which was signed into law by Governor Jim Edgar on June 30, 1997, and became effective January 1, 1998. The purpose of the TDF is to help protect the survivors of sexual violence, the general public, and the program staff members, by treating and managing sexually violent persons who are detained or committed under the Sexually Violent Persons Commitment Act in a safe and secure detention and treatment facility, and by supporting intensive and specialized community supervision as ordered by the Circuit Court in the State of Illinois.

The Sexually Violent Persons Commitment Act provides for the detention and treatment of certain sex offenders who (1) have been convicted, adjudicated delinquent, or found not guilty by reason of insanity of a sexual offense; and (2) remain dangerous due to a mental disorder that makes it substantially probable that they will engage in acts of sexual violence. The qualifying offenses under the Act include the following: criminal sexual assault; aggravated criminal sexual assault; predatory criminal sexual assault of a child; aggravated criminal sexual abuse; sexually motivated first degree murder; or solicitation, conspiracy, or attempt to commit any of the aforementioned crimes.

Under the Act, IDHS must provide "control, care, and treatment until such time as the person is no longer a sexually dangerous person." In accordance with this legislative mandate the IDHS has the responsibility to: manage a safe and secure environment for the protection of program staff and visitors, court ordered detainees, and civilly committed sexually violent persons, as well as state and personal property; ensure the provision of humane care and treatment in the management of court ordered detainees and sexually violent persons; provide assistance to the courts through the provision of comprehensive sex offender specific evaluation and treatment; offer individualized treatment and risk management services to detainees and sexually violent persons to promote healthy, prosocial, and law abiding behavior and individual accountability; utilize treatment approaches that enable sex offenders to understand and take responsibility for their behavior, increase motivation to change their harmful behavior, and learn the skills necessary to change those behaviors; implement policies and practices that are sensitive to the needs and safety of victims and their families and ensure timely notification to victims of sexually violent offenders of their conditional release or discharge; evaluate the effectiveness of specialized sex offender treatment and risk management methods; and manage an organizational environment, which fosters teamwork, provides education and training, ensures excellence from all staff, and provides resources and policy guidance to accomplish our purpose.

The TDF has been located in Rushville since August 2006, and is projected to have 360 residents by the end of SFY 09.

## **Child and Adolescent Services**

In collaboration with the Department of Healthcare and Family Services and the Department of Children and Family Services, the DMH has worked successfully to contribute to the design and implementation of the enhanced Screening, Assessment and Support Services (SASS) Program. While the Program is only in its early years, the results indicate that it is significantly preventing the unnecessary hospitalizations of children and adolescents, and providing increased access to more appropriate community treatment alternatives. This collaborative program is the cornerstone of the DMH's expected move to a more preventative strategy in its work with children and adolescents.

The DMH's Child and Adolescent Services also administers services for the Individual Care Grant (ICG) program. This program provides intensive residential-based treatment for children and adolescents with severe emotional disturbances or mental illnesses.

## **FAMILY IMPACT**

Mental health is important to the stability of family life. The goal of DMH services is to support individuals most in need of mental health services to lead productive lives in their families and their communities.

## **NEED AND POPULATIONS SERVED**

### **Prevalence Estimates**

**Adults and Children and Adolescents with Mental Illnesses**  
**Adults** The Federal Substance Abuse and Mental Health Services Administration, Center for Mental Health Services 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 individuals who have Serious Mental Illnesses, age 18 and older in Illinois. This estimate does not include persons who are homeless and institutionalized. The prevalence estimate for adults in Illinois is 5.4 percent. Based on the adult population for Illinois, is estimated that in SFY 05 (latest estimate), there were 510,469 adults with serious mental illnesses residing in Illinois.

### **Children and Adolescents**

The Federal Substance Abuse and Mental Health Services Administration, Center for Mental Health Services has also developed prevalence estimates for Children and Adolescents with Serious Emotional Disturbances. The DMH uses the estimate provided in the CMHS notice in the Federal Register, Volume 63, Number 137, July 17, 1998 based on a level of functional impairment of 50 (reflecting a moderate degree of interference in functioning). Using 2005 census figures, it is estimated that 115,615 to 148,648 or 7 percent to 9 percent of children and adolescents aged 9 to 17 residing in Illinois have serious mental illnesses. Estimates are not available for children younger than 9, thus this is an underestimate in prevalence rates for the child and adolescent population.

### **Definitions of DMH Population Eligible to Receive Services**

Descriptive eligibility criteria for core services provided in the Illinois public mental health system have been developed and specified using certain broad clinical-diagnostic categories as well as more specific indicators of need based on functional impairment and history of disability. The concept of "eligible and target populations" demarcates, respectively: A) a broader eligibility definition for the population who meet minimum criteria and may be served and B) a narrower priority or target population who must be served. The CMHS prevalence estimation methodology quoted above overlaps with the target and eligible population definitions that are currently used by the DMH. While there is a substantive gap between the total prevalence and the annual numbers served, we know that a certain percentage of these individuals may not need or request service in a particular year and an unknown proportion of those who need service may be served in the private sector. Estimating the size of the underserved portion of the total estimated prevalence is contingent upon the availability of utilization data for privately provided psychiatric services that are not currently available.

### **Definitions of DMH Eligible and Priority Populations (Adults and Children/Adolescents):**

- Must have a mental illness, defined as "a mental or emotional disorder verified by diagnosis contained in the DSM-IV or ICD9-CM which substantially impairs the person's cognitive, emotional and/or behavioral functioning, excluding the following unless they co-occur with a diagnosed mental illness: V-codes, organic disorders, psychoactive substance-induced organic mental disorders, mental retardation, pervasive developmental disorders associated with mental retardation, and psychoactive substance-use disorders.
- Must have significant impairment in an important area of life functioning as a result of the mental disorder identified above and as indicated on the Global Level of Functioning (GAF) for adults and Children's Global Assessment Scale (CGAS) for children.
- Birth to 18 years of age.

### **The Adult Priority Population:**

- 18 years of age or older.
- Must have a serious mental illness (SMI) defined as, "emotional or behavioral functioning so impaired as to interfere with their capacity to remain in the community without supportive treatment. The mental impairment is severe and persistent and may result in a limitation of their capacities for primary activities of daily living, interpersonal relationships, homemaking, self-care, employment or recreation. The mental

impairment may limit their ability to seek or receive local, state, or federal assistance with housing, medical and dental care, rehabilitation services, income assistance and food stamps, or protective services".

### Definition of Child and Adolescent Target Population:

- Birth through 17 years of age.
- Must have a serious emotional disturbance as defined by diagnostic, functional, and utilization criteria.

### Projection of Need

The prevalence data reported above is clearly indicative that there is a need for mental health service in Illinois. The Federal prevalence estimates for adults and children and adolescents combined are indicative that the number of individuals in need of mental health treatment ranges from 626,084 to 659,117. As noted, some of these individuals will seek and receive treatment in the private sector or through other agencies; however the need for publicly funded mental health services is evident. The DMH has identified a subset of these persons who represent priority populations of children and adolescents and adults that are comprised of individuals who are the most in need by virtue of the seriousness of their illnesses. The DMH will focus on both the number of persons accessing mental health services through DMH-funded services, and the DMH priority populations. The DMH population is comprised of both groups of individuals.

### Actual and Projected Service Data

As the DMH moves forward with its System Restructuring Initiative and the increased use of fee-for-service as a payment mechanism, DMH will strive to assure continued access to services. Therefore, we plan to maintain services levels across fiscal years.

#### MENTAL HEALTH SERVICE DATA

?Program	SFY08 Actual	SFY09 Estimated	SFY10 Projected
Number of adults receiving services	142,492	142,492	142,492
Number of children and adolescents receiving services*	40,313	40,313	40,313

\*May exclude DMH funded SASS for which data is not available.

### PERFORMANCE MEASURES

?Performance Measures Description	SFY08 Actual	SFY09 Estimated	SFY10 Projected
Number of bi/multi-lingual direct contact staff working in DMH state operated hospitals.	67	72	75
Number of bi/multi-lingual professional staff working in DMH state operated hospitals.	22	24	28
Number of DMH staff attending diversity management training.	336	400	510
Number of DMH consumers enrolled in evidence-based supportive employment services.	1,100	1,300	1,450
Number of community mental health providers trained in Core Competencies for the Certification of Recovery Support Specialists (CRSS) initiative.	300	300	300
Number of consumers living in permanent supportive housing.	40	100	140
Number of detainees and sexually violent persons served in TDF.	347	360	383
Average staff to patient ratio in DMH state operated hospitals.	1.9	2	2
Percentage of mental health clients discharged that are readmitted within 30 days.	15%	11%	12%

<b>?Performance Measures Description</b>	<b>SFY08 Actual</b>	<b>SFY09 Estimated</b>	<b>SFY10 Projected</b>
<b>Persons receiving mental health treatment as a percent of the estimated number of persons in need of mental health treatment.</b>	24%	23%	24%

## **STRATEGIC GOALS, OBJECTIVES AND ACCOMPLISHMENTS SFY 08**

### **Priority I - Self Sufficiency**

Collaborate with human service agencies to help families and individuals obtain economic stability.

#### **Strategic Goal/Initiative 1**

Increase access to IDHS services for the limited English proficient population.

##### ***Objective(s)***

Through June 30, 2011, increase the number of DMH staff attending diversity training by 10 percent.

##### ***Accomplishment(s)***

DMH increased the number of staff attending diversity training by more than 60 percent in 2008. The number of hospitals reporting staff training in diversity indicates a range of 20 - 90 percent participation. DMH is on track to meet and exceed this very important training target.

#### **Strategic Goal/Initiative 8**

Expand supportive employment to assist persons with mental illness in achieving the highest level of self-sufficiency.

##### ***Objective(s)***

- By June 30, 2009, increase by 10 percent the number of DMH consumers receiving evidencebased supportive employment services 1,300 to 1,450.

##### ***Accomplishment(s)***

DMH is increasing its capacity to offer evidencebased supportive employment to more consumers. In 2008, DMH provided individual supportive employment to more than 1,100 consumers and will reach a new milestone of service in 2009, that exceeds the objective as reported. DMH is on track to meeting the FY 09 target of 1,450.

### **Priority III - Health**

Collaborate with human service agencies to improve the health and well-being of individuals and families and provide effective treatment to individuals in need.

#### **Strategic Goal/Initiative 41**

Develop a comprehensive state mental health system that embraces system transformation to a recovery-based, person-centered service system.

##### ***Objective(s)***

By June 30, 2008, maintain the quality of state hospital services by maintaining an average staff to patient ratio of at least 2.4:1.

##### ***Accomplishment(s)***

In 8 of the 9 state operated hospitals, the average staff to patient ratio of 2.4:1 was achieved. A state budget directive ordering a freeze in hiring resulted in one hospital having a higher than desired ratio of staff to patient.

#### **Strategic Goal/Initiative 42**

Increase access and utilization of the Illinois Mental Health system.

**Objective(s)**

- By June 30, 2008, DMH will determine access and utilization (i.e., "penetration rate") for 25 counties to benchmark underserved groups.

**Accomplishment(s)**

DMH has requested analysis of data by MIS to determine access and utilization rates for 25 counties as a benchmark indicator of services for populations typically underserved for mental health services.

**STRATEGIC GOALS AND OBJECTIVES FOR SFY 09 - 11****Priority I - Self Sufficiency**

Collaborate with human service agencies to help families and individuals obtain economic stability.

**Strategic Goal/Initiative 1**

Increase access to IDHS services for the limited English proficient population.

**Objective(s)**

- By June 30, 2009, increase the number of bi/multi-lingual direct contact staff working in DMH state operated hospitals by 4 percent (from 2,611 bi/multi-lingual staff to 2,715).
- By June 30, 2009, increase the number of bi/multi-lingual professional staff working in DMH state operated hospitals and central office by 5 percent (from 461 bi/multi-lingual staff to 484).
- By June 30, 2011, increase the number of DMH staff attending diversity training by 10 percent (from 30 to 33 in FY 09, 33 to 36 in FY 10 and 36 to 40 in FY 11)

**Strategic Goal/Initiative 8**

Expand supportive employment to assist persons with mental illness in achieving the highest level of self-sufficiency.

**Objective(s)**

- By June 30, 2009, increase by 10 percent the number of DMH consumers receiving evidencebased supportive employment services 1,300 to 1,450.
- Through June 30, 2010, increase by 20 percent the numbers of DMH consumers receiving evidence-based supportive employment services from 1,450 to 1,740.

**Priority II - Independence**

Collaborate with human service agencies to effectively help individuals with disabilities to maximize independence.

**Strategic Goal/Initiative 21**

Partner with consumers and providers of mental health services to implement principles of recovery and evidence-informed/Emerging-Best/Evidence-Based Practices.

**Objective(s)**

- By June 30, 2009, DMH will implement action plan for the establishment and implementation of a consumer-driven service system.
- By June 30, 2009, ensure FY 10 contract language requires mental health provider agencies to hire Certification of Recovery Support Specialists (CRSS) - credentialed peers.
- By June 30, 2009, ensure Rule 132 is modified to provide enhanced billing capacity for providers when services are provided by Certification of Recovery Support Specialists (CRSS) - credentialed peers.

**Strategic Goal/Initiative 22**

Expand supportive housing to assist persons with mental illness in achieving the highest level of independence.

**Objective(s)**



- From June 30, 2008, to June 30, 2011, DMH will place at least 100 DMH consumers in permanent supportive housing each year.

### **Priority III - Health**

Collaborate with human service agencies to improve the health and well-being of individuals and families and provide effective treatment to individuals in need.

#### **Strategic Goal/Initiative 41**

Develop a comprehensive state mental health system that embraces system transformation to a recovery-based, person-centered service system.

##### ***Objective(s)***

- By June 30, 2013, modernize and expand current TDF (Rushville, IL) facility to serve 160 additional individuals.
- By June 30, 2009, maintain current TDF facility to a census of 360.
- By June 30, 2009, maintain the quality of state hospital services by maintaining an average staff to patient ratio of at least 2.0:1.